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Editorial Committee

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

A Word from the Editor:

Matt Comeskey
Editor | Emergency Nurse NZ
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Letters to the Editor are welcome. Letters should be no more than 500 words, with no more than 5 references and no tables or figures.

Welcome to this, the first digital edition of the Emergency Nurse New Zealand Journal. Inside you will find some familiar and regular work alongside some new features. Digital publication will allow us to include web links and access to files directly from the online pdf. Your ideas, critique and feedback are welcome. Let's make the journal a true reflection of the work we do and a platform for learning and quality improvement.

Industrial action - (just like the proverbial elephant in the room) is hard to ignore. In the discussion of pay and conditions amongst my colleagues and on the internet it struck me, that funding for nursing education has seldom been raised. I understand the issues of safe staffing and pay equity are important and immediate concerns - but it saddens me that the erosion of our ongoing education is not being addressed. We need to be vigilant that we don't undermine the value of our professional development by focusing exclusively on equally critical issues.

We should insist that the support of professional development always be included in any discussion related to our pay and conditions.

Whatever the outcome of industrial action, and at the time this is written the outcome is very uncertain; my hope is that we remain respectful of voices and opinions different from our own. The best and safest decisions are made when people respectfully disagree but are prepared to defend their corner while continuing to seek common ground and understand the others point of view.

Subscription:

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

Website: www.cennz.co.nz

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 mcomeskey@adhb.govt.nz. 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 Matt Comeskey at: mcomeskey@adhb.govt.nz 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 to Emergency Nurses of Aotearoa.

It is a privilege to take over the Chair of the College of Emergency Nurses New Zealand (CENNZ) from Rick Forster. Rick has left the world of emergency nursing to a position that will support him to achieve Nurse Practitioner registration. On behalf of CENNZ I would like to thank Rick for the huge contributions he has made to the College and emergency nursing.

We'll miss you, go well.

The mission of the College is to promote excellence in emergency nursing. Our key work involves supporting individuals, groups, education, advocacy, position statements, influencing policy and submission work. But most important, is our duty to speak loudly on all things that impact on emergency nurses, emergency departments and patients and to be recognised as the leading authority on these things. To do this effectively we must articulate from a position that is supported by evidence. For this reason, I would like to acknowledge and applaud the work of Dr Sandra Richardson and her colleagues from the Christchurch emergency department. Sandra is a nurse researcher in the Christchurch emergency department and I feel very fortunate to say that she is also a member of the CENNZ committee. The study undertaken by her and her research group, "Violence and aggression in the emergency department is under-reported and under-appreciated "(2018), was published in the June edition of the New Zealand Medical Journal. This work gained considerable traction in the media and provided a platform for many emergency nurses across New Zealand to speak on this issue. Thank you for raising the profile on violence and aggression and I believe our challenge is to maintain momentum. We must collect objective data, we must report, we must publish and as a College we must work together to achieve a safe working environment that enables us to focus on our core business. That business is providing excellent emergency nursing care. In the coming months, the CENNZ committee will look to engage with Worksafe NZ on this issue and it is our hope that we can develop a productive relationship.

This is the inaugural electronic publication of Emergency Nurse New Zealand. It is somewhat of a milestone for the journal so congratulations to both the retiring editor Michael Geraghty and new editor Matt Comesky. Going electronic is a timely initiative that was mandated by the College membership. It is also an environmentally and financially responsible move.

The financial savings from this have contributed to the College's ability to invest more in education, grants and promoting nurse networks. We are currently working to establish grants that will fully fund NZ nurses to attend a highly regarded emergency nurse leadership course in Australia. We have also established a financial incentive to have your work published in the Emergency Nurse Journal. A gratuity will now be paid to the lead nursing article published in each edition of the journal. Along with this, CENNZ has supported the establishment of two new emergency nursing groups who have met in Wellington over the last year. They are the Charge Nurse Managers Network and the Nurse Practitioners Network. The committee believes that growing strong collaborative links across our small country enhances our ability to contribute to the direction of emergency nursing.

In the coming months, our CENNZ representatives from the Northland, Auckland and Southland regions will complete their terms on the National committee. Nominations and elections will therefore be held shortly.

If you feel you have the passion, enthusiasm, energy and credentials to represent your area and would like the opportunity to contribute at a National level please consider stepping up for the challenge. It is a rewarding role.

I look forward to connecting with many emergency nursing colleagues at the Emergency Nurses Conference in Hawkes Bay.

Jo King

Chairperson

College of Emergency Nurses New Zealand

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Compassion fatigue: the cost of caring

Compassion is a prerequisite for those entering the caring professions. It is expected by patients and the medical profession, and is central to effective clinical practice.[1] It is worth noting that *empathy* is the ability to feel the distress experienced by our patients, while *compassion* is going a step further and attempting to do something to alleviate that distress. This makes sense, but what happens when your emotional fuel tank is drained?

Across the healthcare professions there is increasing awareness of burnout: the chronic physical, mental and emotional exhaustion resulting from balancing a demanding job with everyday life. Compassion fatigue (CF) is a big component of burnout, specifically due to the cumulative stress caused by helping those who are suffering.[2] This aspect has been called secondary traumatic stress - *it's a trauma you hear about and think about, but didn't experience first hand. The trauma doesn't have to be physical - any distress or suffering counts. As one CF researcher says, "it's not about the most difficult story you have ever heard, it's about the thousands of stories you don't even remember hearing".*[3] The idea is that hearing, seeing and empathising with people in distress repeatedly can take it's toll. It is a well-documented phenomenon in people who work with trauma victims, cancer patients, psychiatric patients and even animals in distress. Whilst first studied in nurses in the 1950s, CF was barely spoken about until the 1990s, when a resurgence of research on the topic occurred. It has a higher prevalence in nurses than doctors, yet is distressingly common in both.

CF results in marked emotional, behavioural and cognitive changes in the clinician.[4] Emotionally there is a reduced ability to empathise or display compassion, a sense of helplessness, excessive blaming of oneself, a feeling of isolation, negative feelings towards patients, apathy and increased anxiety about work.[4,5] Behavioural changes include irritability, poor sleep, nightmares, compulsive behaviours (overspending, overeating, gambling), substance abuse, more sick days. On a cognitive level there is poor decision-making, decreased productivity, avoidance of certain patients or situations, increased errors and reduced satisfaction in clinical work. The effects on the department are similar to burnout: increased absenteeism, decreased productivity, negative attitudes, inflexible staff, increased staff turnover.[6]

Red flag symptoms include cynicism and abusive comments about patients.[7] We all partake in a bit of black humour to help us through, but repeated negative comments about patients should be an alarm bell. Empathy deficit is the reddest flag of all so when you find yourself clock-watching while Mrs B tells you about her horrific stillbirth, or thinking about your dinner when Mr S is groaning in pain with his urinary retention, it's time to get out.

Risk factors in developing CF include perfectionist tendencies, a lack of social support, increased personal stresses and those uncomfortable with displaying emotions. Lack of debriefing after difficult cases is a well-documented risk - the bottling up of emotions requires huge amounts of energy, hence depleting the stores. Departmental influences include high acuity, high workload, time pressure and extracurricular demands - the idea being that the busier you are, the less time you have to care so you find ways to avoid being compassionate.[5-8]

Whereas burnout has a higher incidence in doctors, nurses unfortunately come out top in the CF league, with one study finding 85% of ED nurses met criteria for CF.[13] Nurses usually spend more time with the patient and their family, witnessing more of the distress than perhaps the doctors do. Social workers are another high risk group for CF, while clerical staff exposed to all the stories and sights are at risk too. This emphasises the need for a supportive team environment, creating a departmental culture where looking out for colleagues is mandatory.

Researchers at Auckland University have identified three major barriers to maintaining compassion: distracting work environments (phone calls, handovers, questions from colleagues, trauma calls, other patients), difficult patients (rude, hostile, frequent flyers, language barriers), clinically complex situations (the brain becomes more analytical and less caring).[9] Being aware that these are difficult situations can enable us to be extra careful in these circumstances.

The converse of CF is compassion satisfaction: the pleasure derived from doing your job well. This is why we went into this job - to help people and get a buzz from doing so. Unsurprisingly, staff with higher scores of compassion satisfaction have significantly lower risks for developing compassion fatigue.10 A recent UK survey of ED consultants found that despite 98%

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Compassion fatigue: the cost of caring cont.

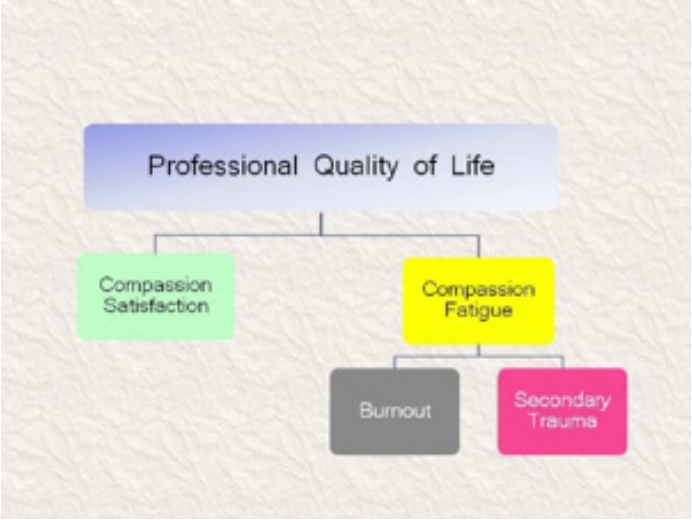
of them having "average" compassion satisfaction scores, over a third of the 681 respondents displayed behaviours consistent with CF at least monthly.[11] This suggests the two states are not mutually exclusive and there is a complex interplay of emotions.

Compassion is best thought of as the fuel that powers us through our job. Compassion fatigue occurs when our fuel tank runs empty. Many aspects of our job can punch holes in the fuel tank, causing it to drain more quickly, such as high patient turnover, overcrowding, frequent attendees, abusive patients, complex patients, deaths, paediatric resuscitations... it's not hard to see why the ED is a breeding ground for this. Compassion satisfaction is what refills your tank, hence this is an essential balancing component. Fuel sources include an appreciation of both the positive and negative aspects of ED work, clinical support, mentoring, departmental culture and the development of emotional resilience.

Resilience literally means to bounce back. A resilient person still experiences stress and adversity, but is better able to cope with it, experiencing milder and more transient symptoms. It is the ability to bend not break, to weather the storm. Five key traits have been consistently identified in resilient people: defined boundaries (knowing when to say no), self-awareness (knowing your limits and when to ask for help), acceptance (that mistakes happen, bad things happen, it's all part of our job), self-care habits (think exercise, eating well, getting enough sleep, mindfulness) and a well established support network (mentors, colleagues, friends).

We can't prevent compassion fatigue altogether, nor burnout or stress, but we can minimise the risks and maximise our defences. Creating a resilient team, a supportive culture and a department that has awareness of these issues will go a long way towards a sustainable career in our challenging work environment.

Suzanne Hamilton, FACEM, MBChB, Consultant Emergency Physician, Christchurch Hospital Emergency Department



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Understanding Some Commonly Used Statistics: Diagnostic Studies

Diagnostic studies attempt to determine how useful a test is for detecting a condition or disease. A perfect test will identify all patients with the disease and will not falsely detect disease in those that do not have the disease.

Sensitivity, Specificity and Accuracy

Existing diagnostic interventions are used to measure the performance of new diagnostic tests at identifying correctly those patients that do and do not have the disease. Data is categorised in terms of True/False Positive or negatives (*See Box 1*). These figures are then used to determine the relative sensitivity, specificity and accuracy of the test.

Box 1

True positives – Test is positive *AND* patient does have the disease

False positive – Test is positive *BUT* patient does not have the disease

True Negative – Test is negative *AND* patient does not have the disease

False Negative – Test is negative *BUT* patient does have the disease

The sensitivity of a clinical test refers to the ability of the test to correctly identify those patients with the disease. A test *with* 100% sensitivity correctly identifies **all** patients with the disease and **no** patients *without* the disease. This is calculated in the sum shown below and is usually expressed as a percentage.

$$\text{Sensitivity} = \frac{\text{True positives}}{\text{True positives} + \text{False negatives}}$$

[1].

Thus, a SENSITIVE test effectively RULES IN a diagnosis.

The specificity of a clinical test refers to the ability of the test to correctly identify those patients without the disease. Therefore, a test with 100% specificity correctly identifies **all** patients *without* the disease and **no** patients test positive when they do not have the disease. This number is calculated as below.

$$\text{Specificity} = \frac{\text{True negatives}}{\text{True negatives} + \text{False positives}}$$

[1].

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Understanding Some Commonly Used Statistics: cont.

Diagnostic Studies

Thus, a SPECIFIC test effectively RULES OUT a diagnos is [3].

Sensitivity and specificity give a numerical value that relates to the exactness of a test for ruling disease in or out, respectively [1]. The final term often used is accuracy, which reflects the test's ability to correctly identify patients with and without disease, this is calculated using the sum below.

$$\text{Accuracy} = \frac{\text{True Positive} + \text{True Negative}}{\text{True Positive} + \text{True Negative} + \text{False Positive} + \text{False Negative}} \quad [2]$$

Another way of looking at accuracy is as a factor derived from both sensitivity and specificity.

$$\text{Accuracy} = \frac{\text{Sensitivity} + \text{Specificity}}{2}$$

Thus, an ACCURATE test effectively RULES IN **AND** RULES OUT a diagnosis [3].

Likelihood Ratios

Likelihood ratios (LR) are used to measure the diagnostic utility of a test but also the probability that the patient has the disease or condition[4]. Put more simply, LR+ is the probability that a person with the disease tested positive for the disease divided by the probability that a person without the disease tested positive for the disease. LR- is the probability that a person with the disease tested negative for the disease divided by the probability that a person without the disease tested negative for the disease [4].

Positive test results are expressed as positive LR or LR+ and negative test results are expressed as negative LR or LR-; both are derived from sensitivity and specificity values (as below) [4].

A positive likelihood ratio is:

$$\text{LR+} = \frac{\text{probability of an individual } \textit{with} \text{ the condition having a positive test}}{\text{probability of an individual } \textit{without} \text{ the condition having a positive test}}$$

Or put another way

$$\text{LR+} = \frac{\text{sensitivity}}{\text{1-specificity}}$$

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Understanding Some Commonly Used Statistics: cont.

Diagnostic Studies

A negative likelihood ratio is:

$$LR+ = \frac{\text{probability of an individual } \textit{with} \text{ the condition having a negative test}}{\text{probability of an individual } \textit{without} \text{ the condition having a negative test}}$$

[1].

Or put another way

$$LR+ = \frac{\text{sensitivity}}{\text{1-specificity}}$$

Thus, LRs reflect the utility of a test for predicting the probability of a disease. To interpret the numerical value, the further away the calculated LR is away from 1 (which reflects no change in the likelihood of disease) in either direction, the more useful the test is for predicting disease [4].

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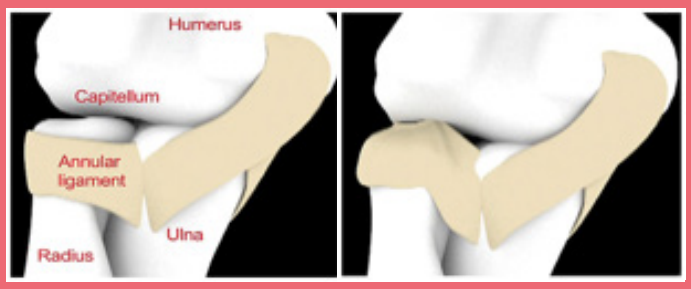
Pulled Elbow

What is it?

The annular ligament secures the radial head to the ulna. In children under 5 yrs it is only loosely attatched. If the arm gets pulled, then this will cause the ligament to slip over the radial head and become entrapped in the joint. NB: Only 50% of cases have a history of the arm being pulled!

Occurs in children aged 6 months to 5 years, with the peak incidence between 2 and 3 years of age.

Classically patients present with the affected arm hanging by their side and not wanting to use it.



Examination:

Look: Compare it to the other arm – it should look the same.

Feel: Along the entire arm. There should be no pain on palpation (distract them with bubbles so you can be sure)

Move: They are usually not distressed unless the arm is moved, passive elbow flexion is usually allowed but supination causes pain.

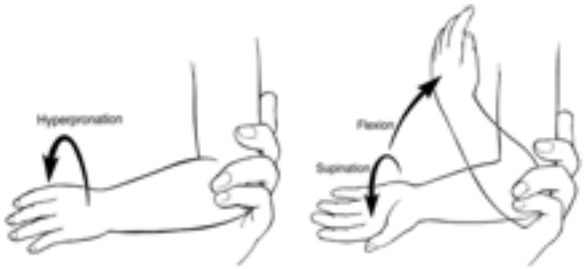
If the history is classic then you don't need to x-ray

How to fix it.....

Step 1: Warn the parent/s that their child will cry

Step 2: Cup the elbow with your hand, putting gentle pressure with your thumb over the radial head. With your other hand, hold the child's wrist/hand.

Step 3: There are 2 methods of reduction - 'hyperpronation' or 'supination then flexion'. The 'hyperpronation' method has been shown to be more.



If successful you will feel a click over the radial head.

What now?

The child will usually start to use their arm within 1-5 mins and can be discharged home without needing follow-up.

There is a "Pulled Elbow" advice sheet for families available through the link below

https://www.starship.org.nz/media/294011/pulled_elbow_advice_sheet.pdf

NB:

Occasionally it is unclear whether reduction has been successful. In these cases consider other possibilities (e.g. supracondylar fracture or osteomyelitis).

A sling ± backslab can be used for comfort, with review 24 hours later.

If the child is still not using the arm normally at this stage obtain x-rays (if not already performed) and consult the Orthopaedic team.

Useful Resources:

https://www.starship.org.nz/for-health-professionals/starship-clinical-guidelines/p/pulled-elbow/

https://www.rch.org.au/clinicalguide/guideline_index/Pulled_elbow/

Nominations now open

CENNZ National Committee Nominations

Do you want to make a meaningful contribution to the professional development and support of your nursing colleagues at a regional and national level?

The CENNZ National Committee welcomes nominations for four regional delegates on the committee.

- **Auckland Region (x2)**
- **Northland / Te Taitokerau**
- **Southern Region**

Details and a description of the role can be found on the CENNZ web page https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/contact_us#Committee_member

Nominations are open from 21 August 2018 to 18 September 2018.

Please contact the Committee Chair, Jo King for more information cennzchair@gmail.com

It is anticipated that the successful candidates will take up their positions from February 2019.

Regional Reports

Northland/Te Taitokerau
Auckland | Midland | Hawkes Bay/
Tarawhiti | Mid Central | Wellington
Top of the South | Canterbury/Westland
Southern

Northland/Te Taitokerau Region

Chris Thomas
(Cennz Treasurer)

Registered Nurse / Cns

Emergency Department
Whangarei Hospital

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Greetings form Northland.

Well winter is upon us with a wet and, at times, cold season well embedded. Presentations of chest/ breathing issues in both adults and children are definitely on the rise as well patients with flu like symptoms.

Whangarei ED has recently had some improvements in terms of staffing and our base line nursing FTE seems finally to have been addressed, recruitment of the extra staff has been protracted but largely successful as we near our full complement. New staff orientation is on-going, and they appear to be settling in well to the department. Other improvements will be the increase in educator hours to full time and the addition of an extra HCA working 12-8pm as a semi-permanent shift. (We trialled this last winter and it was a huge advantage to the department).

EDAAG is looming nearer with the roll out scheduled for July and staff are being educated around this new system which captures far more information than our current electronic whiteboard. Triage first will be re-introduced simultaneously with EDAAG and minor building work is due to commence now (mid-June) to help facilitate this.

The opening of a Medical Admission Unit is also scheduled for the beginning of August and it will be interesting to see if this addresses ED's bed block issues as the hospital does not gain any additional beds out of this. One of the existing medical wards will become the MAU, so this appears to be only a staffing and process reshuffle. At the time of writing this report bed block is virtually a daily issue with patients remaining in ED for sometimes greater than 24 hours which significantly impacts on our own targets and KPIs and the care patients receive. Because we are not set up as a medical ward even the simple issue of obtaining medications for these patients is a time-consuming exercise for nursing staff as we do not carry many of the medications they are prescribed. Obtaining a proper meal is another issue as these are not usually supplied within the ED, special orders have to be placed. While all this is do-able it often means delays and inferior service for the patients who also carry the expectation of being placed in a ward for their hospital stay not a busy, noisy ED. All staff within ED are impacted by bed block but for nurses it feels particularly frustrating as they are usually the most visible of the care providers and often have to deal with both patient and whanau dissatisfaction.

On a brighter note the Bay of Islands hospital re-build is progressing well and staff are looking forward to a new and up-dated emergency department to move into in early summer.

Other peripheral hospitals are managing day to day and also beginning to see an increase in presentations similar to those at Whangarei base hospital.

Let's hope these winter months pass quickly. Be well.

Chris

Auckland Region

Matt Comeskey
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In the first half of this year we have seen some significant changes made to patient pathways in the department.

In May the new CDU (Clinical Decision Unit) opened in time to take the increased winter workload. The unit is located on the same level as ED and the former APU (Admissions Planning Unit). Previously the space that it now occupies was an empty area used for storage and warehousing equipment. The CDU consists of 24 bed spaces, all single rooms, 3 of which are negative pressure rooms. In addition there are a procedure room, two staff bases, two store rooms and a large medications room. Innovations include each bed space having a wall mounted computer and a detailed call bell and alarm system which can signal if a space needs to be cleaned.

The CDU accepts direct admissions from triage (Australasian triage scale 3,4,5 only), based on differentiated (GP or Specialist referrals) and ED patients accepted by an inpatient specialty. The CDU is staffed by 5 RNs, with a nurse to patient ratio of about 4.8 patients to one RN. Since opening the CDU has been well received. There has been considerable thought put into its design details – which have highlighted how far infection control and work processes have come since the main department opened in early 2004.

Vacated space in the former APU will be re-configured to expand the space available to ED for ambulatory and short stay patients. In addition, it is anticipated that a multiple bed room will be reconfigured and dedicated as a secure or observation area. In the meantime, 8 monitored spaces and two side rooms have been dedicated to short stay ED patients, increasing our capacity for these patients and placing them in a quieter and more restful environment. A toxicology room has been developed for short stay ED patients observed for toxidrome or for administering antidote.

The department is trialling a Rapid Assessment and Treatment area – which has acquired the unfortunate name of the 'RAT Room'. This 5 bedded area is staffed by an SMO and nurses, in which presenting patients are given a 20 minute window in which a provisional impression or diagnosis is made, analgesia and appropriate tests ordered - before transfer to a suitable area of the department. Hopefully a new and perhaps less potentially stigmatising name may be found in the near future.

The department remains at sustained levels of capacity, placing staff and resources under stress. Patient volumes and acuity have been high. Additionally, in late April the department suffered a serious incident in which a fight between a number of opposing gang members broke-out in our waiting room. Two people fighting were admitted for significant injuries. A security guard was also injured. There was no opportunity for any kind of de-escalation. Fortunately, no patients or visitors were in the waiting room at the time. A debrief and EAP counselling were offered for the staff affected. We are grateful for a timely and effective police response.

This widely reported incident again highlights the issue of security in our ED, and the need to be continually innovative and proactive in addressing staff and patient safety. Planning was underway prior to this incident to address safety concerns raised by nurses. This includes a redesign of our triage area, the installation of additional duress alarms, an increased security presence and the ability to lock down the front entrance of the department.

Amongst the daily ebb and flow of work – there is plenty to celebrate and enjoy. There are a lot of new, keen faces, a number of staff have completed mindfulness training, babies have been safely delivered, long service recognised, marriages announced and plenty of outdoor adventure and sport has been had.

Matt

North Shore ED

Gabby Harsveld
ACCN, ED, NSH

Waitemata District Health Board

Emergency Department, North Shore Hospital

"Life is filled with highs and lows and valleys and peaks that will test your resilience, that will push you to overcome challenges. The lessons you'll learn on your way to the top will only make you stronger, better" Don't you love google quotes?.

I like this quote as we move through these turbulent times when personal resilience is put to the test. We at North Shore Emergency Department have had to learn resilience as we move through winter, staffing highs and lows and just to top it off an uncertain time through the highs and lows of industrial action for better pay and work conditions. It has brought us together knowing that issues faced here are felt across the nation and it is warming to stand united across the country... an exciting time for nursing.

In the mean time we have strived ahead with some great initiatives focussing on staff progression and timely patient care. Firstly, we are moving into our third cycle of the 'Aspiring Leader Programme' where two senior staff are selected to undertake a 3 month senior development program focussing on clinical and non-clinical leadership and management pathways to enable our senior staff consider future pathways. They complete a leadership level 4 portfolio which focuses on participation in leadership. We believe that 'growing our own' gives staff the opportunity to experience senior roles and plan for their future whether it is to be a clinical or non-clinical senior role and we in turn benefit from the growth of staff.

Waitemata DHB is going off the chart for population growth and is currently the fastest growing DHB in the country. The flow down effect means our presentations to ED have outgrown our capacity to resource the department. As a result, we looked at ways of working differently to streamline processes and maximise the resources we have. We then looked at our 'front of house' (FOH) staff and rejigged the roles to develop a 'front of house coordinator', with the aim to manage 'complex ambulatory' patients in the waiting room to free up cubicles in our main work area.

Senior staff run this role with processes developed to maximise prompt assessments and diagnostics of patients for timely care. As a side arm it was an opportunity for senior staff to work in leadership roles and develop themselves as they also lead the FOH team (triage nurse, assessment nurse and consults nurse). Over the past 6 months we have already seen some amazing results with reduced length of stay which directly benefits the patient and ultimately our department.

So in closing, we know we get exhausted by the 'fluff' that surrounds us, and it feels like sometimes we can't come up for air. We do ED nursing as we love to be a part of people's lives to make a difference through their ED experience. Nelson Mandela said "After climbing a great hill, one only finds that there are many hills to climb", we can't lose sight of what we are doing this for... the patients, as there are many hills to climb in our future, every so often we get to the top and that is our victory.

Gabby

TE TARI RONGOA OHORERE | **Middlemore ED**

Michelle Peperkorn
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Kia ora from Counties Manukau, It's so exciting to have our first CENNZ online publication. I hope that this finds you all well and energised from the last few months of glorious weather. I can't believe that we are half way through the year already. We are just past the shortest day, so from now on the days are getting longer meaning more sunlight hours although looking at the storms sweeping north it's hard to believe.

Influenza

According to the latest New Zealand Influenza report week ending 17th of June we are currently experiencing a slight increase from the baseline for seasonal influenza -like illness rates, this is translating to lower than expected numbers presenting to the ED.

We have had some lovely days recently, reminiscent of quieter times. We thought these numbers were long gone but have been pleasantly surprised lately with time to reconnect with our colleagues and get some of those things done that we have put off doing because we didn't have the time. Like PDRPS, portfolios and projects.

Projects

This short lived hiatus has enabled us to regroup and trial some alternative pathways for patients presenting to the ED. Our senior staff trialled an innovative and challenging pathway and named it S.T.A.M.P.E.D. (Senior-led Team-based Approach to the Management of Patients in the Emergency Department). The trial highlighted the advantage of having a senior clinician with the support of a senior RN, HCA and orderly at the front of house. ***Prior to this trial the statistics were as follows:***

- Waiting times TBS by a Nurse- 54-71minutes
- TBS by a Doctor/ Clinician-142-171 minutes
- Average LOS was 5 hours

Following the STAMPED trial the statistics showed:

- Decrease in waiting times to see a Nurse by 19minutes.
- Time to see a Doctor decreased by 35+ minutes
- Total LOS was reduced by 46 minutes

This also meant that 40% less people were put though into our assessment and monitored area.

Sepsis

The ED has also done a lot of work around the early detection and treatment of sepsis.

A project was commenced to compare the SIRS criteria with the qSOFA tool. The results were that the qSOFA tool has a higher predictive positive predictive value, which means it is better at picking up the patients who are likely to deteriorate.

E-radiology

E-radiology was introduced to the Emergency department earlier this year. It has freed up clinician and nursing time and enabled the Radiology department to prioritise their own work load and flow.

There are approximately 200+ radiology requests every day to the ED radiology suite and e-radiology has been embraced by the ED staff with <10 paper requests per day. E.g. on March 20th there were 239 radiology requests, 232 were electronic and 7 paper. Saving trees!!

TE TARI RONGOA OHORERE | **Middlemore ED**

Recycling

On the 28th of May Middlemore Emergency Department started re-cycling. Recycling containers for paper, plastic and mixed recycling were put into all clinical areas. We are currently saving 10's of 1000's of dollars a month in refuse disposal.

Another way to save trees and the environment. Counties Manukau is committed to Plastic free July!

Celebrations

Congratulations to **Carol Dewes** who has been employed into a Nurse Practitioner role in the Emergency Department.

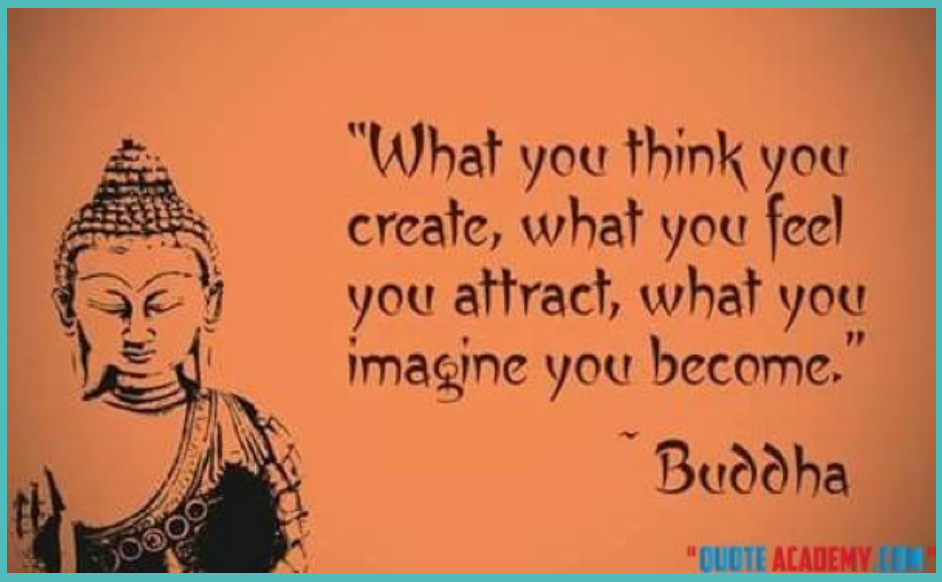
Carmel Rigby (nee Hassan) one of the Paediatric CNS group has successfully been to nursing council and is now registered as a Nurse Practitioner.

Bridget Venning has started a year long contract as a CNS Intern and is blossoming.

And across the Tasman; **Debbie North** has recently been registered as an NP in Australia.

Last note-Even though national media reports may give the impression that the nursing profession as a whole are feeling down trodden and underappreciated, the staff here at Middlemore Emergency Department continue come to work with a smile and treat their colleagues and patients with respect and dignity. We have a great pastoral care team made up of Doctors and Nurses including members of our CNS/NP team. One of the improvisations is a lovely care box full of chocolates and other treats which is brought out regularly to bolster spirits. Staff replenish the goodies out of their own pockets which is a testament to the generosity of our team. We all have challenging days but on the whole this is a great place to work and we wouldn't have it any other way.

Michelle



Stay safe over the winter and be nice to each other..... ***Nga mihi Michelle Peperkoorn***

Waitakere ED

(February 2018)

Late publication with apologies from the Journal Editor.

Jan Boyd Paediatric CNS

SWIFT Care

Waitakere ED has undertaken the SWIFT (System Wide Integration for Transformation) care project which is looking at ensuring our patients have the appropriate treatment in the appropriate environment. This has seen us streamlining patients that present with low acuity problems and has resulted in reducing the number of unnecessary investigations such as bloods, X-rays and scans.

White Cross Vouchers

WDHB has the lowest numbers of GP per population in the West Auckland region and as such many of our patients present due to the lack of appointments available at local GP services. Another barrier is the cost of urgent care medical centres for our population. The WDHB is working in conjunction with the team at White Cross.

Patients presenting to Triage with selected conditions are given the option of receiving a voucher that covers the cost of their visit to White Cross clinic. Patients are NOT "triaged away" and can choose to remain to be seen in ED if that is their wish.

New Graduates

We welcome the February 2018 of 4 new graduate nurses and hope that their first year at RN's will be exciting and full of learning. They will all be well supported by our coaches and ACCN's. Two new grads will start in our paediatric area and the others will orientate in 'Acutes' spending 3 months in each area. Two further new graduates will join us in September.

Staff news

Derek Lardenoye has retired after being a Clinical Charge Nurse in ED for the last 12 years. Prior to this many would know him from Auckland ED. We miss him as he was a much loved member of our team and had his own unique sense of humour which most of us appreciated!

Collette Parr -Owens Ops Manager of ED has left mid-January 2018 for a new role at Mercy Hospice we await the appointment of her successor.

The pull of better salaries across the ditch and house affordability within NZ has seen a large proportion of experienced RNs leave our department for Australia and other parts of New Zealand (a challenge that the education sector is also facing). "We are now fully recruited to our FTE but it has been challenging to get there"

Marja Peters CNM | Waitakere ED

Midland Region

Kaidee Hesford
Nurse Manager

Lakes District Health Board Emergency Department, Rotorua Hospital

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Winter has certainty started in the Midland region with Waikato seeing almost 300 and Tauranga close to 200 presentations in a 24-hour period.

Waikato

Katy Cryer is currently acting CNM in replace of Naomi who is currently evading the winter madness as she is on parental leave. Waikato ED is continuing to work with the Francis Group looking at ways to improve the patient journey. They are trialling a 'hot zone' where all patients that present to ED move through this area and are seen by a team of medical and nursing staff. A co-assessment and initiation of treatment occurs in the 'hot zone' before the patient is then moved to another area in the department. So far, this has been successful in terms of patient satisfaction, however they are looking into improvements to decrease the workload for staff in this area.

Unfortunately there seems to be a common theme nationally around violence and aggression in ED's. Within the Midland region the increase of abuse and violence towards staff over the past few months is disturbing to say the least. Waikato has formed a group of staff to look at ways to keep staff safe and remind the team of the 'Zero Tolerance to Abuse Policy' that they have in place. In Taupo there is a review of the support they have, as currently their escalation remains through the police due to not having onsite security.

Tauranga and Whakatāne

Both Whakatāne and Tauranga are looking at initiatives for their 'Front of House' (FOH) models. Tauranga has recently implemented a new test of change with the Nurse Practitioner (NP) moving from streaming to 'front of house decision maker'. With the NP to cover the whole model of care. To provide 'Front of House' decision making and support the bundles of care and pathways as well as see patients, complete care and refer to specialty teams. The second consideration is utilising an observation area as an ambulatory flow with the NP and the CNS being supported by the observation nurse and the role being developed to combine observation and ambulatory care. Whakatāne's 'Front of house' initiatives include the use of an initial care nurse at the weekends to facilitate monitoring and treatment within standards for triage codes. A short test of change trialled the use of an Emergency CNS at FOH for Rapid Assessment and Treatment aiming at earlier initiation of investigations and treatment for patients. ED CNSs Bronwyn Ives and Sharon Coombes continue to flex across the Department working with ED SMOs & RMOs on the historically busy shifts of Saturday, Sunday and Monday afternoons. Data shows this has a significant positive impact on KPIs. They are continuing to explore options to expand this role and service.

Whakatāne has been impacted by several factors recently including staffing numbers and increased patient presentations. 'Seen by' times since the start of the year are longer and the number of patients who 'Did Not Wait' was significantly higher from mid-Dec to mid-Mar. This has led to trial

Midland Region

several innovative solutions driven by the E3 Flow project and Francis Group to optimise Ambulatory Emergency Care and provide both a more timely initiation of care and exit from the ED for admitted and non-admitted patients. In an effort to reduce unnecessary admissions, a two week test of change will see Allied Health (OT, Physio, SW) and a Pharmacist have a physical presence in the ED at 0830, 1100 and 1400 to identify patients that would benefit from early allied health input or medication review.

NP Theresa Ngamoki implemented a test of change to scope the potential of a Kaupapa Maori/ NP role in Whakatāne ED. She observed the characteristics of Maori presentations to understand decision-making processes amongst this patient group and explore the effect of primary care services and influence on Maori patient usage of Whakatāne ED.

Lakes (Rotorua and Taupo)

Things have been ticking over nicely down here in Lakes; with winters 'early' arrival we now await the mountain injuries. We have recently exchanged four senior ED nurses between our two EDs (Taupo and Rotorua), for weeklong stretches to give a perspective on how each department works given the varying differences in staffing and size. This has been very positive and we are looking to make the exchanges regularly. Rotorua ED has also just had sign off for two CNS to NP pathway positions; Karleen McNab and Sandy Duff- Timoti. This will be a great asset to our department as we plan to utilize this role across the department.

Kaidee

Article submissions for the mid year issue of the journal are now open. Please contact the editor matt comeskey for more information!

email Matt at: mcomeskey@adhb.govt.nz

Hawkes Bay / Tarawhiti Region

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Hi Everyone,

Sending you all greetings and best wishes from a very cold, but very sunny Hawkes Bay!

Just like the rest of the country, we continue to be very busy, with over demand for our services both in ED and the rest of the hospital. Most days the hospital is running at and above capacity, especially ICU which has of course impacted on ED. Needless to say this has impacted on the ED LOS target.

There continues to be shifts with Resus providing ongoing care for ICU patients due to lack of beds and nursing resources. There have also occasions when patients requiring ICU, have been transferred from the wards to ED Resus. This obviously impacts on ED staffing resources.

Staffing continues to be run on good will, favours and good planning! Three of our senior RNs have moved onto new and exciting careers, and we are also providing extra shifts such as a night Triage nurse.

The Department has also employed a new Nurse Practitioner- Me! This brings the total number of NPs in the department to four who are working mainly in Fast Track. A business case has been submitted to provide extra nursing resources for Triage, Resus and the Waiting Room as these are our high risk areas.

This years' Influenza immunisation programme has been very successful, with over 80% of ED staff being vaccinated. The Fast Track team have also been very proactive with vaccinating high risk patients and children on an ad hoc basis.

Planning continues to go well for the CENNZ 2018 conference in Hawkes Bay. We have some exciting topics and excellent presenters arranged so if you haven't already booked, please do! We would love to see you there!

Paula

Mid Central Region

Katie Smith
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NZDF

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Palmerston North Emergency Department

Winter rain and colder weather is upon us, as our renovations continue. However staff and patients are managing to negotiate the temporary changes to our entrance and isolation rooms. The team is working effectively in the new sub-acute space which has recently opened. We are developing models of care to better suit our new environment and to encourage flow of patients from our waiting room. With this, we are looking at advanced nursing roles with a proposed position for an experienced Emergency Specialty Nurse Practitioner in the near future, which is exciting.

We have had some staff leave and new faces join our team, but recruitment continues with vacancies in nursing and SMO positions. If anyone is looking to move to Palmerston North do contact us.

Angela Joseph – Charge Nurse ED, Palmerston North.

NZDF

Another busy period for our nurses in the NZDF. Clinical placements continue to be conducted to regional DHBs and are well attended by our staff in EDs in MidCentral DHB, CCDHB, and Hutt Valley DHB. These placements continue to provide a mutual opportunity to develop and maintain critical nursing skills and knowledge for our NZDF personnel, as well as sharing of knowledge and skills within the ED setting with our colleagues.

Large numbers of our nursing staff were recently involved in Exercise Tropic Major, conducted in the South West Pacific during April/May. Ex Tropic Major involved more than 500 personnel from the Navy, Army and Air Force with a large health footprint. Ex Tropic Major aims to give NZDF personnel practice operating in a joint task force in a tropical environment to provide humanitarian aid and health care opportunities. The emergency nurses and wider health team were deployed to work on board the multi role vessel, HMNZS CANTERBURY and were tasked to provide trauma and surgical care within the Maritime Role 2 environment. The HMNZS CANTERBURY has an Emergency Operating Suite (EOS) which comprises 2 ICU beds, 2 resus beds, 1 OT, 5 MDU/HDU beds. This exercise provides opportunities for training, skill enhancement, team cohesion, and ultimately the opportunity to provide excellent clinical care to our soldiers, sailors and airmen and women.

Taranaki

A new Clinical Nurse Manager has been appointed – welcome to Therese Manning!

All the best in your new role.

Paula

Wellington Region

Kathryn Wadsworth
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It appears that life ticks on as usual in our three ED's in the Wellington region with trauma related presentations continuing to flow in the door. The weather has not given us any surprises with it cold, raining and generally miserable a lot of the time. Today however the sun is shining off the large dumping of snow on the Tararua's which makes for a lovely winter backdrop.

Evening and night shifts remain a significant concern with the volume of presentations and the high acuity level of patients affecting the flow and management within the departments. In saying that I feel the anticipated onslaught of winter presentations has not hit us yet. Numbers remain high, like everywhere else and have done so for the past year. They are now considered normal by many. Despite this, staff continue to work exceptionally hard and are always looking at ways of supporting patients that are caught in the middle.

Recruitment is ongoing with Hutt Hospital reporting success in this area following the challenges of 2017. They have implemented the Nurse Practitioner internship pathway as a trial with very positive results and are hoping that following review this may become a permanent role. The two Nurse Practitioners in ED in the Wairarapa are much respected for their contribution to patient care. The benefits of having this role are particularly significant in our rural setting.

The Trauma Symposium held in Wellington in May was another great success with every seat taken. This gives valuable information to a raft of specialties from a national perspective and allows opportunity to connect with a wider group of staff dedicated to improving and developing pathways for managing trauma patients.

Both CCDHB and Wairarapa have completed a mass casualty exercise with both Emergency Departments gaining significant knowledge around their existing plans and ideas of how to improve. Staff were extremely responsive to the exercises and the overall theme following was how much value there is in continuing with regular exercises and allowing staff the chance to become more familiar and well orientated to the expectations should an event happen. The tele stroke initiative continues with a significant increase in patients receiving thrombolysis. In the Wairarapa over the last 12 months, the percentage of patients receiving thrombolysis has gone from 7% to 31%.

Violence continues to plague our areas with ongoing discussion around resourcing to minimize the risk associated with this. This coupled with the increase in presentations essentially has our ED's at boiling point at times. There is a huge amount of resource going into contingency planning for impending strike action but the three DHB's in the Wellington region are well underway with this to ensure the patients presenting over this period will be safe. It really does show how vital our nurses are to patient care and management. It'll be an interesting few weeks ahead of us and despite the business and pressures our ED nurses continue to strive for the best for their patients which at the end of the day is what we all want now and in the future.

Kathryn

Top of the South Region

Jo King
CNS / Registered Nurse
(Chairperson)

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Greetings from the Top of the South where the cold temperatures have provided a magnificent backdrop of snow covered peaks. While this heralds much excitement about the opening of the ski season, the icy starts to the day are contributing to falls, fractures and problems on the roads.

The last few months have seen a bit of a hiatus between the summer and winter workload peaks. There have been improvements in the 6hr LOS and minor decreases in patient presentation numbers and minutes in the department. The admission rate has also returned to a more acceptable 23% after trending well above this over the last few months. One unexplained trend identified in May was a spike in Triage 4 patients of 15%.

Despite improvements in some emergency department KPIs, the ability to respond adequately to peaks in demand and workload variance, remains a major challenge. One of the pressure points is holding patients who are waiting on ICCU beds. We have begun to collect data around this and have identified that over the last 2 months we have provided 145 hours of 1:1 ICU level nursing care. This obviously has a significant impact on resourcing the rest of the department during these times.

We are eagerly awaiting the opening of a 'Medical Assessment Unit' in Nelson. While this will initially be a pilot we look forward to seeing how it impacts on ED. And still in 'pilot mode' are our CNS and HCA roles. These positions are both established and embedded in our departments and we are hopeful of obtaining permanency.

As a response to emergency department demand in our region increased DHB - funded redirection to primary care has been initiated. I am also aware this is a trend occurring in many organisations around the country. It is advantageous for the right person to be seen by the right service provider, however it is equally important to remember that the acts of triage and redirection are separate processes. This had led me to revisit ACEM and CENNZ publications on redirection. Both caution that the Australasian Triage Scale is not designed nor as yet proven to be a validated tool for redirection. Furthermore, they suggest that additional skills, education and competencies may be required to support triage nurses who undertake redirection. I do consider we must be cogniscent that "redirection is a complex clinical decision with both clinical and professional accountabilities for the health practitioner "(CENNZ, 2014).

The department has held a combined nursing / medical SIMS day. This was held off-site and was a wonderful opportunity to up-skill collaboratively and collegially. We have ongoing quality initiatives in paediatric oncology and hyperemesis pathway development. And we are all benefitting from having an enthusiastic bunch undertaking post-graduate study this year.

On a very concerning note we have seen a spike in Safety First notifications for staff safety over recent months. One of these represents a significant incident where police were unable to attend due to the critical nature of their own work demands. I know this is an escalating challenge facing all our departments and there is much work to be done.

As I write this, we are in turbulent times of negotiations and potential industrial action. Despite this, in the Top of the South, it's business as usual for emergency nurses.

Jo

Canterbury/Westland Region

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Canterbury District Health Board

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As for most regions currently, there has been focus on consideration around ensuring that life preserving services would be able to be in place should the nurse's strike be voted to take place, and how this might look from a practical perspective. The need to balance supporting those who are providing the LPS and those who will be striking is an ongoing challenge.

A major focus within the Christchurch Hospital and the ED has been the Ministry of Health certification which has been ongoing and for which we are now awaiting the outcome. Further quality reviews have seen the two yearly cold chain audit take place, and as part of these overall accreditations ten individual clinical and ED focussed audits are continuing. These have resulted in both positive feedback and also opportunities for further educational development. High numbers of staff continue to engage in the voluntary PDRP process and as part of this to engage in quality initiatives taking on roles as quality champions, initiating audits and engaging in long term quality projects.

Moving forward into July has seen a focus on the 'Dry July' movement, with increased staff and public awareness, and encouragement around the use of brief interventions. We have also had considerable media attention in relation to the recent release of a nurse led research project around the prevalence of violence and aggression in the emergency department setting. This included a focus on the implications of low levels of reporting together with an emphasis on the significance of verbal abuse and the resulting culture of normalisation and acceptance of violence. The project was led by Dr Sandy Richardson, Emergency Nurse Researcher, together with emergency nurse Polly Grainger, Clinical Co-ordinator Projects and colleagues Professor of Emergency Medicine Mike Ardagh and Russell Morrison, Injury Management Co-ordinator, CDHB. The publication of this research in the NZMJ resulted in widespread media interest, including television and radio interviews as well as print and online reporting. It was great to see relevant, nurse led and nurse fronted research gaining public attention.

On a similar note, we have also received public attention and recognition for the quality and contribution of the simulation programmes running in the ED, largely as a result of the consistent input and passion of Nurse Educator Leona Robertson. Leona has not only used this work as the impetus for her recently completed Master of Health Sciences dissertation, but is also a member of the executive for the New Zealand Association for Simulation in Healthcare. The programme was most recently highlighted through the Christchurch Health Precinct, Te Papa Hauora, and is showcased in their publication. The ED simulation programme is a demonstration of the collaborative ability of ED nursing and medical staff to work alongside others, in particular the wider CDHB Clinical Skills Team, Biomedical Engineering, and the NZ Defence Forces. In order to generate realistic trauma training, cross disciplinary input is necessary, with involvement from blood bank, specialty department including obstetrics, paediatrics, radiology and anaesthetics among others.

Patient numbers have remained steady with a slight lowering over the month of May. Staffing is at full complement, with a number of recent engagements. Recent innovations include the introduction of an ED Older Person's Special Interest Group, and introduction of Hearing Wands for use in the ED. Approval has been given to introduce 24/7 social work cover, located within the ED, as well as 24/7 CT coverage. Physio coverage within ED will also be increased, with 7 day cover from 0800-2100.

Sandy

Photo caption: Dr Sandy Richardson, Polly Grainger and Leona Robertson spokeswomen on the issue of violence in emergency departments.

Southern Region

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Triage Portfolio

Registered Nurse

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Dunedin

The big news for the SDHB this year is confirmation of a new hospital on the former Cadbury's site in Dunedin. Hopefully it will give us a new Emergency Department to cope with the increasing number of presentations from Dunedin and the Otago Southland region.

Staffing of the department has sometimes been challenging. Opportunities within the health environment have meant that some of our senior staff on the floor have moved to other positions with an impact on skill mix at times. The winter flex has been appointed and will start in July. This temporary position will continue through to September, helping the team with the anticipated increase in presentations over this period. Other staffing changes for the winter period relate to the CNS role. The CNS team will work in the Early Assessment Zone to facilitate flow through the department and onto the specialty disciplines. The staff in the acute area will extend their roles work on specific shifts to cover the minor injury treatment area.

Our two NETP nurses have settled into the emergency environment and we continue to have third year nursing students throughout the year. Six staff passed their triage exam and have completed their orientation to triage with the CNS and Educator team. Study days on 'Minor Injuries' and the resuscitation area have also been completed allowing further staff development.

The department has been involved in a lot of education and research over the last few months. Competencies are being developed around the Airvo as well as training around our new Neopuff. Our 'Don't be a Drip' project is currently running in an effort to decrease the number of unnecessary cannulations in ED and research into overdose in teenage community has been completed between Wellington, Dunedin and Invercargill.

Invercargill

Patient presentation numbers have been variable delivering challenges to staff and impacting on the emergency environment. Limited bed availability in the pre-winter period significantly affected the flow through the department. Illness and some resignations have impacted on departmental staffing with additional resource RN's and HCA's being utilized to ensure shifts are covered. The 'Winter Flex' has been recruited to cover the anticipated increase in presentations over the winter months.

Current strategies to facilitate patient flow including projects on laboratory, radiology, specialty referral and turnarounds. Consultants are also re-organizing their responsibilities to improve flow efficiency. This includes rapid assessments (RAT) where a single consultant is in charge of this process and bed availability is frequently reviewed by the Nurse Coordinator. The triage area has been redesigned to provide further efficiencies for the triage nurse. Other plans include relocating the Eye/ENT room to provide extra treatment space over the winter months.

Oamaru

Staffing issues have been to the forefront in Oamaru Hospital. The Otago Daily Times. reported that

Regional Reports

CEO Robert Gonzales resigned, suddenly, effective May 4th and the Oamaru ED, although actively recruiting staff are currently utilising locum doctors to cover the department. Nursing shifts starting times have been changed, reducing overtime by the night duty nurse. However, further assistance to cover lunch breaks remains an issue due to starting times of the swing shift and providing a nurse escort for ambulance transfers to Dunedin.

To deal with these issues there has been some recruiting of new nurses to replace those that have left including the possibility of recruiting a Nurse Practitioner. Presentations to ED continue to rise as does the acuity. Winter is expected to stretch services further.

Lakes District Hospital, Queenstown

Continuing growth in population and high visitor numbers and many sporting events continue to be a cause for the ever-increasing patient presentations to ED. The new ED should be completed by the end of 2018, with additional onsite CT services to provide an expanded service and reduce the number of patients transferred for further imaging and diagnostics.

Seasonal increased staffing has been made permanent, allowing two extra ED nurses from 0900 – 0030 hrs . This has provided a safer working environment and improved patient experience. Two nurses attend the Triage Course in Invercargill in March and have completed their orientation to ED under the preceptorship of senior nurses. Three nurses have completed the nurse Initiated X-ray course facilitating patient flow and developing nursing practice and scope within the department.

Upcoming opportunities for nursing staff include attending the EMST course in Dunedin in August as an observer and the TNCC later this year. Two nurses will attend TNCC as part of their on-going professional development. We are now at the start of another busy winter sports season with hopefully spring not too far away.

Erica

If you would like to submit an advertisement or article for the next issue of the journal please contact the editor matt comeskey for more information!

email Matt at: mcomeskey@adhb.govt.nz

What are you looking at?

This new feature of the journal will feature regular reviews of phone apps, websites, journals, texts and references that nurses working in EDs, Accident and Medical centers and GP practices might find useful. Contributions, reviews and feedback are welcome.

In my practice as an NP in a busy, urban, tertiary ED, it's impossible to have a single go-to text that will cover my expanding scope of practice. However, if I was working on a desert island with good wi-fi and had the choice of just one reference – this might be the one. The Family Practice Notebook app sits on my phone and gets used more than I'd like to admit to. It's not that I need an app to tell me what to do but it's jolly handy for a cognitive jolt when I ask "Am I missing something?" At this point I would suggest the app is perhaps mis-named. It covers a lot more than presentations commonly seen in a family or GP setting.

The app draws on collected evidence and entries that have been collated since 1995. It was started some time ago as a web page – which is still available with the same information and layout as the app. The current app and web page now contain 6407 topic pages divided into a chapter tree of 31 specialty books and 722 chapters. The content is updated monthly with newly published research and literature reviews. Most pages list the references employed with links directly to the relevant study or article.

The breadth of subject s covered presents a challenge to navigate. The 6000 plus pages seem like an awful lot of information to scroll through to find the single nugget of information needed at the time – but in fact the chapters and search function are relatively easy to navigate. Pages can be book marked – a particularly useful feature for finding those 'go-to' entries commonly used. General search terms tend to take you to the entry needed or will list a number of relevant suggestions. Individual pages are presented as a list of pertinent bullet points, avoiding masses of text. Differential diagnoses, red flags and "points- not- to-miss" are well highlighted. However, the prescribing information needs to be used with caution given that local guidelines may differ and local antibiotic sensitivities will likely vary also.

My single criticism is that the app is light on orthopaedic presentations – something a new- to- practice ED CNS might want to be aware of. For orthopaedic presentations there are better apps. Inevitably there are some – usually less commonly referred to pages, that are still being fully populated.

Who will use this?

Any RN or advanced practice nurse will find something useful here. Given that nurses in GP, rural and ED settings – or in fact any acute care setting, are going to see a wide scope of presentations – this app and it's associated web page are very useful.

Where will I find it and how much does it cost?

iOS and Android stores stock this app. For some weird reason to find it in the Apple app store you have to search under "FP Notebook". Typing "Family Practice Notebook" in the search box will take you to multiple kids learning sites. Or you can avoid the cost and just access it for free off the web – bearing in mind that that the single person who maintains the site probably deserves a reward for doing the work.

What is the AENN group? Can anyone attend their training days?

The AENN group is the Advanced Emergency Nurses Network, which is supported by CENNZ. This group was formed in 2010 as a way for Nurse Practitioners or CNS in ED to continue to meet and train together. Initially the group was made up of nurses, working predominately but not exclusively in the Auckland region hospitals. It was always anticipated that the group membership would expand to include members nationally – including nurses in advanced practice roles in Accident and Medical clinics. Happily this has been the case.

Training days are held three times a year and as much as possible are hosted by DHBs in both the north and south island to allow the best opportunity for members to attend. One of the three training days is held in association with CENNZ Annual Conference. The day typically consists of a series of presentations and case studies and hands- on procedural demonstrations given by group members and invited speakers that may include SMOs and members of the multi-disciplinary team working in ED. CENNZ financially supports the cost of hosting training days.

Anyone with an interest in advanced nursing roles in ED or A&M settings can attend the AENN days, but you must be a CENNZ member. Dates are advertised on the CENNZ website (under the AENN page) and in the journal or by an email reminder to listed AENN members.

The AENN group coordinator is currently Kathryn Johnson
kjohnson@adhb.govt.nz

https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/advanced_emergency_nurses_network_aenn

Snippets Winter 2018

Oxygen Therapy in Patients with Acute Myocardial Infarction: A Systemic Review and Meta-Analysis. American Journal of Medicine. 2018

The aim of this study is to perform a systematic review and meta-analysis to compare the outcomes of oxygen therapy versus no oxygen therapy in post-acute myocardial infarction settings. This meta-analysis confirms the lack of benefit of routine oxygen therapy in patients with acute myocardial infarction with normal oxygen saturation levels.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=1&ArticleID=79227#Data

Effectiveness of Brief Alcohol Interventions in Primary Care Populations. Cochrane Database Systematic Review. 2018

Brief interventions aim to reduce alcohol consumption and related harm in hazardous and harmful drinkers who are not actively seeking help for alcohol problems. Discussion informs the development of a personal plan to help reduce consumption. Brief interventions can also include behaviour change or motivationally-focused counselling. This is an update of a Cochrane Review published in 2007.

The authors conclude there is moderate-quality evidence that brief interventions can reduce alcohol consumption in hazardous and harmful drinkers compared to minimal or no intervention. Longer counselling duration probably has little additional effect.

https://plus.mcmaster.ca/EvidenceAlerts/NewArticles.aspx?Page=1&ArticleID=79059#Data

Improving Adherence to Standard Precautions for the Control of Health Care-Associated Infections. Cochrane Database Systematic Review. 2018

This paper assesses the effectiveness of interventions that target healthcare workers to improve adherence to Standard Precautions in patient care.

http://cochranelibrary-wiley.com/doi/10.1002/14651858.CD010768.pub2/abstract

Effect of Opioid vs Non Opioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial. JAMA. 2018 Mar 6;319(9):872-882.

The authors conclude treatment with opioids was not superior to treatment with non opioid medications for improving pain-related function over 12 months. Results do not support initiation of opioid therapy for moderate to severe chronic back pain or hip or knee osteoarthritis pain.

An audit of risk assessments for suicide and attempted suicide in ED: a retrospective review of quality. N Z Med J. 2018;131(1470):14-21.

This audit retrospectively analysed data from 376 files of patients who had presented to the ED in Waikato Hospital, Hamilton, following an attempted suicide between 1 July 2015 to 30 June 2016. The auditors evaluated the quality of psychiatric risk assessments conducted by Mental Health & Addiction Services staff members in the ED, to determine adherence to the New Zealand Ministry of Health Clinical Practice Guidelines for Deliberate Self Harm. The analysis found that clinicians routinely focused on the historical features of the suicide attempt presentation and failed to record judgements about future suicidal behaviours. Fewer than half of the cases recorded interactions with family members. The guideline with the lowest level of adherence was that requiring clinicians to check whether Māori patients wanted culturally appropriate services during the assessment and treatment planning; <10% of the clinical records reported following this guideline.

Debrief in Emergency Departments to Improve Compassion Fatigue and Promote Resiliency. Journal of Trauma Nursing. 2017. Sep/Oct;24(5):317-322

The purpose of this case study was to describe compassion fatigue using one nurse's experience as an example and to

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present the process of Personal Reflective Debrief as an intervention to prevent compassion fatigue in emergency department nurses. Debriefing after adverse outcomes using a structured model has been used in health care as a nonthreatening and relatively low-cost way to discuss unanticipated outcomes, identify opportunities for improvement, and heal as a group.

Dealing with the out of the ordinary: Most routine childhood immunisations are just that -- routine. But to keep us on our toes, situations crop up from time to time when we need to exercise both wisdom and knowledge, and to ensure that whatever crops up, our practice is evidence-based

Katherine Hunt. Practice Nurse. Feb 2018. 48 Issue 2, 10-14.

The article discusses how general practice nurses can deal with unexpected problems that emerge in childhood immunizations in Great Britain. It is said that nurses need to exercise both wisdom and knowledge to cope with situations that crop up from time to time. They should be up to date with national policy and changes to vaccination programmes.

Auscultation while standing: A basic and reliable method to rule out a pathologic heart murmur in children

Lefort B et al. Ann Fam Med. 2017. 15(6):523-8

This French investigation included 194 paediatric patients aged 2–18 years referred for heart murmur evaluation to paediatric cardiologists. All patients underwent heart murmur recordings while supine and then while standing, as well as an echocardiogram. Abnormal echocardiogram readings identified a pathologic (organic) heart murmur in 30 (15%) patients. Half (n=100) of the cohort had a murmur that was present while they were supine but completely disappeared when they stood up; a pathologic murmur was identified in only 2 of these patients, and only 1 of them needed further evaluation. The complete disappearance of murmur on standing excluded a pathologic murmur with a high positive predictive value of 98% and specificity of 93%, and a sensitivity of 60%.

If you hear a murmur when a child is lying – stand them up and listen again. This study suggests that if a murmur disappears it is most likely to be benign.

Do health professionals tell patients what they want to know about their medicines? Young, Tordoff, Leitch. Health Education Journal. 1-6. 2018.

This Otago University study employed two questionnaires sent to a sample of pharmacists and GPs, asking them to report the amount of time they spent giving medication related advice and education. A total of 119 pharmacists and 150 GPs responded. For new medicines, significantly more GPs than pharmacists reported giving verbal information all of the time. Significantly more GPs than pharmacists reported discussing most counselling points all or most of the time. Pharmacists were more likely than GPs to discuss counselling points only when requested to by patients. For repeat medicines, significantly more GPs than pharmacists were likely to consider counselling points very important.

The authors conclude, patients may not be receiving the information they want to know about their medicines, and there may be an overall lack of verbal communication about medicines with patients. Some information will only be discussed if the patient actively requests it; the likelihood of this increases with repeat medicines. The use of counselling aids and tools, such as a medicine information leaflet, could help healthcare providers provide patients with the information they need.

Managing gout in primary care: Part 1 - Talking about gout: time for a re-think. BPAC 2018.

BPAC (Best Practice Advisory Group, NZ) has over the years regularly released up dated practice guidelines for the treatment of gout. Despite their best efforts to raise awareness of the seriousness of this condition and to change

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treatment practice – the prevalence of gout and it's associated comorbidities indicates the message of early and on-going treatment, is still not being heard. It is particularly shameful that BPAC states Polynesian and Maori patients are now more likely to have sub optimal treatment, or no treatment at all, for gout than they were in 2006.

https://bpac.org.nz//2018/gout-part1.aspx

Education preferences of people with gout: Exploring differences between Indigenous and non-Indigenous peoples from rural and urban locations. Arthritis Care Res Hoboken. 2018. 70(2):260-7

Researchers compared education preferences of Māori and New Zealand Europeans with gout, and of those living in rural or urban areas, in a cohort of people with gout managed in primary care from 2 rural regions and 1 city. Focus groups involved 26 Māori and 42 New Zealand Europeans (44 rural, 24 urban). Participants discussed education preferences for diet, medication, and ways of communicating. When they individually ranked the three most important ideas for each topic, the most frequently prioritised ideas were knowing one's own food triggers, knowing side effects of medications, and communicating via a GP or specialist. More Māori participants prioritised natural remedies, easy to understand information, and communicating via television. More NZ European participants prioritised knowing the kinds of alcohol that trigger gout, communicating via GP/specialist, and receiving written information. More urban participants prioritised knowing to stay hydrated and medication doses as important information.

Inhaled corticosteroids for bronchiectasis. Kapur N, Petsky HL, Bell S, et al. Cochrane Database Systematic Reviews. 2018 May

Bronchiectasis is being increasingly diagnosed and recognised as an important contributor to chronic lung disease in both adults and children in high- and low-income countries. It is characterised by irreversible dilatation of airways and is generally associated with airway inflammation and chronic bacterial infection. Medical management largely aims to reduce morbidity by controlling the symptoms, reduce exacerbation frequency, improve quality of life and prevent the progression of bronchiectasis. This is an update of a review first published in 2000.

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Emergency Nurse Leadership

10 -11 May 2018
25 - 26 October 2018

Nurses with leadership skills are critical to advancing the nursing profession and developing a healthy work environment and culture. The ability of nursing leadership to give nurses an essential voice in the development of patient care environments is paramount (Australian College of Nursing, 2016).

The Emergency Nurse Leadership course is a two day program designed to prepare experienced nurses for leadership roles in the emergency department setting. It provides an opportunity for personal development and reflection whilst exploring key management concepts as they are implemented in the emergency department setting.

The two day workshop is highly interactive and participants are encouraged to openly discuss their own leadership experiences, challenges and aspirations.

Participants are required to complete approximately five hours of pre-learning activities and attend both of the workshop days.

Participants should have minimum five years nursing experience with at least two years in an emergency department setting.

This course is offered by The Alfred Hospital Emergency and Trauma Centre and Monash University.

WHEN

10 - 11 May 2018
25 - 26 October 2018

TIME

0800 - 1630

LOCATION

Monash University
553 St Kilda Road
Melbourne

COST

$450.00 (excl. GST)

MORE INFORMATION

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