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EMERGENCY NURSE NEW ZEALAND

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In this issue

Features

Regulars

A Word from the Editor

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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.

Any one of us who has 'worked the floor' in the past few months will know this has been a difficult and arduous winter. In my workplace, above seasonal average acuity and volume were dealt with by some tired and stressed colleagues. None of this is unprecedented, and none of it was unforeseen. The year-on-year workload is increasing in our departments. We know this to be true.

And you may agree, as the CEO of Auckland DHB did, that winter planning ensured the bulk of the winter workload was adequately catered for. But at times, for prolonged periods, this wasn't the case, both in Auckland and nationally. This is reflected in the regional reports in this edition. As a result, patient safety, equitable delivery and quality of care have been compromised.

There is good evidence that our overburdened EDs, bed-blocked hospitals and inability to access GP services are symptoms of a bigger problem in our health system, that being an ongoing trend of underfunding and persistent inequity in the delivery of health care (1).

Two things give me some small hope we have reached a tipping point. The first being the NZNO's attempt to lead the media debate as to why this occurs with a focus on the Auckland DHBs as examples of what is happening nationally. The second, - the Health and Disability System Review, undertaken by the Ministry of Health. This wide-reaching report will address issues like the duplication of DHB services, the health of the workforce and improved delivery of primary care.

Watch this space.

Moving on...

This issue features a rapid review of research into death in the Emergency department, College Activities including the dates for the 2020 Triage Courses, Good Fellow Conference and a report on the 2019 CENNZ Conference. A big thanks to everyone who have contributed to the journal this year. I trust the coming summer will be rejuvenating.

Matt

1. *Goodyear-Smith, Felicity. Ashton, Toni. Lancet (2019). New Zealand Health System:*

Universalism Struggles with Persisting Inequities. The Lancet. 3-9 August 2019, Pages 432-442.

Editorial Info

Subscription:

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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.

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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 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. **CENNZ NZNO Membership:** Membership is $25.00 and due annually in April. For membership enquiries please contact: *Kathryn Wadsworth*
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Chairperson's Report 2019 Annual General Meeting NZNO (CENNZ)

It is a privilege to present the Chairperson's Report to the 2019 Annual General Meeting of the NZNO College of Emergency Nurses New Zealand (CENNZ).

The committee is a cohesive and hardworking team who continue to work towards CENNZ's strategic aims of improving health outcomes, supporting the development of skilled emergency nurses and building a strong workforce. It is recognised that there are some key challenges facing our specialty. These are safe staffing in emergency departments, strategies to respond appropriately to unpredicted acuity and demand, and violence and aggression. These areas continue to be the focus of our work.

To be an influential organisation, we believe we must continue to work strategically to position the College as a leading voice for emergency nursing. Activities to achieve this have included; continuing to build and support national nursing networks, contributing to submissions and consultations, seeking engagement with key stakeholders, assisting nurses in education and advocating for safe staffing and work on violence and aggression.

- Providing the NZ Triage Course continues to be a key activity of the College
- 8 National Triage Courses were held
- The CENNZ social media platforms Facebook and Twitter have experienced increased activity and provide clinically relevant resources and communication
- The Emergency Nurse Journal has been published in electronic format
- Support of the Advanced Emergency Nurses Network who continue to be very active holding 3 study days per year
- Support of the CENNZ National Nurse Practitioners Network and the National Charge Nurse Managers Network. Providing a formalised structure for nurses across the country to collaborate on shared issues is seen as key to strengthening emergency nursing. Meetings were held in Wellington
- A remit was approved at the 2019 CENNZ AGM, to support the establishment of a CENNZ Emergency Nurse Educators Network. This will allow national meetings and the collaboration of educators across the country. This will enable the sharing and strengthening of initiatives to develop our workforce
- A CENNZ position statement has been formalised on 'Emergency Department Overcrowding'. A remit was approved at the 2019 CENNZ AGM to adopt this
- Allocation of funds for education, study and conference grants
- Support of the 28th CENNZ National Conference in Hamilton 2019
- CENNZ represented emergency nursing at the Australian College of Emergency Medicine (ACEM) Mental Health Summit held in Wellington in June. CENNZ supported 10 nurses from around the country to attend the symposium to ensure emergency nursing contributed to this discussion

- A CENNZ Emergency Nurse Leadership grant was established following a remit at the 2018 conference. High quality applications were received from around NZ. Two nurses will attend the highly regarded course in Australia in November this year
- A letter, on behalf of College members, was presented to the 2018 NZNO AGM to request NZNO prioritise work on violence and aggression. This resulted in NZNO establishing a working party, action plan for future initiatives and collaborating with Work Safe NZ. Following this, Work Safe NZ have presented the 'Draft good practice guidelines: Violence in the healthcare industry'. CENNZ continues to advocate for mandatory and enforceable regulations to ensure work place safety
- We have sought to optimise media opportunities to articulate our concerns regarding violence and aggression in emergency departments
- CENNZ position statements are being reviewed
- The CENNZ website is undergoing review and upgrade
- We continue to seek opportunities to engage with the Safe Staffing Healthy Workplace Unit (SSHW) / CCDM. The CENNZ Charge Nurse Managers Network continue to investigate methods to calculate base staffing, Variance Indicator Scoring(VIS) and contributing to the trial of Trend Care in emergency departments
- We have been very active in our submission and consultation work including -

  National Stroke Clot Retrieval Work Safe Draft Guidelines on Violence in Healthcare. Health and Disability Review
- 5 complimentary conference registrations were allocated to Christchurch emergency department to acknowledge their work in serving the community on Friday 15th March, 2019.

I would like to thank the CENNZ Triage Instructors for the success of the Triage Course. Their work is vital to ensure this course remains the highest benchmark for triage education. The revenue received from the national triage course also enables CENNZ to maintain its significant grant and education programmes. I would like to also acknowledge the tremendous work, support, knowledge and skills of Sharyne Gordon at the NZNO Wellington office and Suzanne Rolls our NZNO Professional Nurse Advisor.

I will shortly step down from the CENNZ committee as my 4-year term comes to a close. It has been a privilege to represent the 'Top of the South' region and to contribute to the world of emergency nursing in New Zealand. It has been a professionally challenging but rewarding role. I thank the CENNZ committee for their support and look forward to ongoing involvement in the College.

Jo King

Chairperson

College of Emergency Nurses New Zealand

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Conflicts of interest: None to declare

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Death in the emergency department: A rapid review

Abstract:

Those who work in emergency departments rarely consider them a 'good' place to die. Recent New Zealand research suggests that palliative patients and their whānau/family – particularly those living in more deprived areas – can benefit from hospital admission at the end of life, and this often occurs via emergency departments. Inclusive and compassionate end-of-life care is associated with family involvement, relationship-building and detailed contextual knowledge of the patient and family. Patient death in the emergency department can have unique and varied features and challenges. Death may be sudden and unexpected, or there may be uncertainty about the cause of death. The patient's background, key relationships, cultural and spiritual priorities may not be known. This rapid review provides an overview of the evidence base exploring care of the dying and bereaved in the emergency department. It asks: What are the features of death in the emergency department setting? What are the barriers to quality care? Do we know what bereaved whānau/family need and value when their loved one dies in the emergency department? Research to-date suggests emergency department staff readily identify common challenges, and more research-informed initiatives are needed to facilitate quality emergency care of the dying and bereaved.

Keywords: Death, Emergency Service, Hospital, Terminal Care, Bereavement, Emergency Department

Dying in hospital

Between the years 2000-2010 more New Zealanders died in public hospitals (34%) than any other single place (Palliative Care Council of New Zealand, 2014). Researchers and clinicians have classified some hospital admissions at the end of life inappropriate or avoidable, but death trajectories are complex and unpredictable (Gott, 2014). Recent findings from New Zealand (Robinson, Gott, Frey, Gardiner, & Ingleton, 2018) and around the world (Procter, Ooi, Hopkins, & Moore, 2019) show many patients and families benefit from hospital care, as death approaches. New Zealanders affected by poverty, prognostic uncertainty or social isolation may come to hospital at the end of life because they do not have the resources to be cared for at home, because they want to feel safe or they want to avoid being a burden (Robinson, 2017).

New Zealand researchers Gott et al. (2019) asked bereaved relatives of patients who had been in hospital at the end of life for examples of good care. Participants described the importance of family involvement, relationship-building and contextual knowledge of what was important to, and unique about, each patient and family. Concrete examples of compassionate actions included introductions, kind words, taking time, ensuring quiet and providing refreshments. Emergency care workers are skilled at quickly identifying needs and building rapport with diverse people. However, providing personalised care, taking time and ensuring privacy and quiet

Death in the emergency department: A rapid review cont.

in the fast-paced, noisy and dynamic emergency department setting can be difficult. Dying in the emergency department presents unique features and challenges, as discussed in the following section.

Dying in the emergency department: Unique features and challenges

Emergency nurses from all over the world cite business and lack of time as the most significant barriers to compassionate care of the dying and bereaved (Decker, Lee, & Morphet, 2015; Ka-Ming Ho, 2016; Kongsuwan et al., 2016; Wolf et al., 2015). Patient numbers are increasing, and emergency staff must work to accommodate the rapid turnover of patients, competing work demands and frequent interruptions (McCallum, Jackson, Walthall, & Aveyard, 2018). Even the emergency department environment itself has been described as 'hostile' and identified as a key barrier to dignified care at the end of life (Diaz-Cortes et al., 2018). Emergency departments are typically bright, sterile and impersonal, lacking in space, privacy, seating or facilities for family members to gather in numbers. Ultimately, emergency staff do not believe the emergency department is a good place to die (Decker et al., 2015; Hogan, Fothergill-Bourbonnais, Brajtman, Phillips, & Wilson, 2016).

Emergency care prioritises rapid assessment, life-saving actions and rapid turnover of patients. Emergency triage is a system which explicitly gives precedence to the prevention of deterioration and preservation of life. Saving lives is an important part of the emergency care identity, with patient death perceived as an unwelcome failure (McCallum et al., 2018). Emergency patient death trajectories are varied and unpredictable (Chan, 2011). Most patients dying in EDs are elderly, suffering from chronic diseases and could be classified by medical researchers as on a known death trajectory (Le Conte et al., 2010). However, some deaths are sudden and unexpected, and the cause of death may even be unclear (Keirns & Carr, 2008). Ethnographic researchers Bailey, Murphy, and Porock (2011b) noted emergency departments are better equipped to provide care in the case of 'spectacular' deaths such as young victims of trauma. In comparison, deaths from old age or at the end of a long illness - so-called 'subtacular' deaths – may be neglected.

There are sometimes significant barriers to facilitating patient and family-centred care in the emergency department. In some cases, the patient's background, key relationships, cultural and spiritual priorities – even their identify - may not be known. Some patients die before their families arrive. When family are present, they can be highly distressed, may have witnessed a traumatic event and may be asked to act as key sources of information or proxy decision-makers. An aggressive resuscitation effort may precede patient death. Research supports giving family members the option of supported presence during resuscitation (Toronto & LaRocco, 2019).

A catastrophic event may mark the team's inaugural contact with patient or family, with no prior chance to form rapport or build trust, making it difficult to establish a meaningful connection. The health professional team may include a number of doctors and nurses, with multiple hand-overs of care. Clinicians may not attempt to make an emotional connection with the patient and family, due to fatigue, feeling overwhelmed, uncertain or a belief emotional distancing is the safest, most professional approach. It requires some vulnerability and emotional labour to make a connection with a dying patient and their family, but this investment in the nurse-patient relationship is associated with better care for dying patients and bereaved relatives, and greater job satisfaction for emergency nurses (Bailey, Murphy, & Porock, 2011a). Nurses' first experiences with patient death can occur after they have qualified and may have a lasting impact (Anderson, Kent, & Owens, 2015). Wherever possible, experienced ED staff should try to mentor novice nursing colleagues in post-mortem care and support them to care effectively for a dying patient and their family.

Finally, there is a distinct lack of published, quality research into the needs of patients and families when patients die in the emergency department (McCallum et al., 2018). Rather than focusing exclusively on errors, barriers, complaints and failures, we need to identify and facilitate better care within the unique emergency department setting. Experience-based co-design involving patients, families and staff may have some utility (Blackwell, Lowton, Robert, Grudzen, & Grocott, 2017). Research using an appreciative inquiry approach (Cooper-Rider & Whitney, 2005) would help us to understand what good care looks like, what actions bereaved families appreciate, and what changes could make the most impact.

Conclusion

Although emergency care staff are experts at saving lives, mortality ultimately has a 100% success rate. Patients will continue to die in emergency departments, and with an aging and increasingly co-morbid population, the number of patient death is expected to increase. For disadvantaged patients with

Death in the emergency department: A rapid review cont.

limited personal, social or financial resources, hospital may be the best or only safe place for them to come at the end of life. Recognising, naming and demystifying dying is important. Research suggests those emergency nurses who invest in building a relationship with the patient and family as people and make a personal connection with them will deliver superior care and feel the greatest reward in caring for the dying.

What we know about the patient and family needs specific to death in the emergency department is mostly anecdotal – more research in this area is needed, particularly to look at how best to meet the needs of Māori, Pasifika and disadvantaged New Zealanders.

Acknowledgements

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Compassionate care of the dying and bereaved: What can we do?

Emergency nurses can provide compassionate care of the dying and bereaved. It is important to recognise and name dying – if you are unsure, ask the doctor if they think your patient is actively dying or might die today, and if the family are aware. Ensure patient wishes around resuscitation have been discussed and documented. If curative interventions are limited or discontinued, do not see or describe this as a 'withdrawal' of care, but an opportunity to redirect your focus to patient comfort and family support. Facilitating family presence and comfortable patient positioning in a dry bed, under a warm blanket may be your most important actions. De-mystify dying by helping to answer family questions and explaining the common features of dying including sleepiness and noisy, irregular breathing. Ask the patient or family members: What is important, to you? What are you worried about, right now?

When patients die in the emergency department, there can be an operational drive to move the body/tūpāpaku out of the department. It may be important that key spiritual leaders or family members attend the patient immediately after death. Involving family in post-mortem care can be very rewarding if they are keen.

It is often difficult to meet all the needs of the bereaved family, so specialised support services are a helpful resource for larger emergency departments. These supports may include specialist bereavement care teams, cultural, social and spiritual support workers, bereavement care packs of written information and follow-up bereavement care pathways.

Finally, don't forget to check-in with your colleagues after they have cared for a dying patient and their family. Let them know what a great job they've done and give them a chance to talk about it, if they want to.

Death in the emergency department: A rapid review cont.

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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

Buckle Fractures In Kids

Buckle fractures of the distal radius are common in children between 2 and 12 years of age

This type of fracture occurs in about 1 in 25 children and represents 50% of pediatric fractures of the wrist.

The fracture occurs when there is axial loading of a long bone. This most commonly occurs at the distal radius but can also occur in other long bones i.e tibia, humerus

Assessment

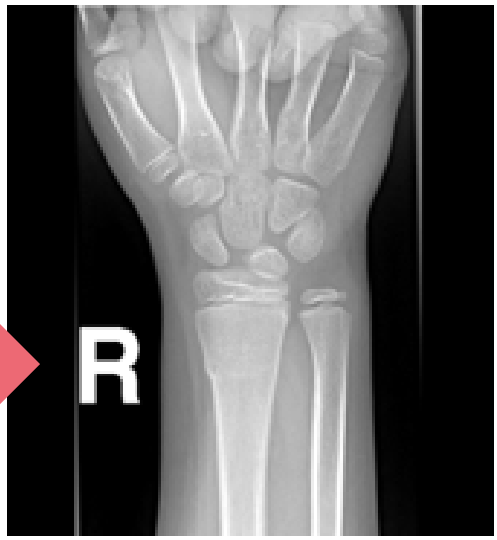
The wrist may be sore, swollen and painful to move but there is no clinical deformity.

Why do they occur?

Buckle (torus) fractures occur when the bony cortex is compressed and bulges. There is no extension of the fracture into the cortex.

Plain Radiographs:

- Distinct fracture lines are not seen
- Subtle deformity or buckle of the cortex may be evident
- In some cases, angulation is the only diagnostic clue



How are they treated?

This injury is treated in either of the following ways:

1. A below elbow back-slab
2. A removable orthotic wrist splint (this can be removed for bathing).

Simple analgesia i.e. paracetamol can be used for 24-48hrs if required.

Follow up

This injury is treated in either of the following ways:

No repeat x-rays required

GP review in 2-3 weeks from the time of injury to have the back-slab/splint removed and wrist reviewed.

It is common for the wrist to be a bit stiff and sore at first but this should resolve quickly.

Contact sport and rough play should be avoided for6 weeks.

Kathryn Johnson NP
Starship Children's Emergency Department

Regional Reports

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

Vacancy

The **Hawkes Bay/ Tarawhiti** delegate position is currently vacant. Please contact CENNZ for further information or to apply

Northland/Te Taitokerau Region

Sue Stebbeings
Nurse Practitioner

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New census population updates have confirmed the increase in Whangarei and regional population - one of the reasons for increasing ED presentations. The winter workplace stressors have been increased with the measles and meningococcal presentations. We appreciate the completion and commissioning of the new isolation cubicle.

Since June there has been a change to 5 code colours for ED status - GREEN - YELLOW - AMBER - RED - BLACK. The code calculation is based on:

1. Resus occupancy
2. ED capacity
3. CaseMix – acuity of presentations
4. ED wait - number of patients waiting for ED to see for more than an hour
5. IP wait – number of patients waiting for inpatient team to see for more than an hour
6. Bed Availability – number of patients waiting for bed allocation > 30 minutes
7. Transfer to ward – number of patients that have beds allocated but haven't left ED

Unfortunately, there have been whole shifts in Code Black territory even with ongoing development of hospital wide responses to acute care demand. As staff efforts and capacity overstretched and a high priority has been on supporting staff well-being.

On a brighter note we welcomed Lyndsay Kidd-Edis, another NP to the team this week.

Spring is here with the promise of longer days (& daylight saving) and return of warmer temperatures.

A recent quality initiative was 10 for 10 - the principle being that if can reduce EDLOS by 10 minutes for each patient this will allow more time to provide care. There were 10 initiatives - 1 each week for 10 weeks – using a plan, do, study, act process. These initiatives either focused on using existing processes better – such as early bed requests - or introduced new ideas – a brief team huddle / update at the start of each nursing shift. This also involves cross service collaboration – this last week of the initiative was a request for ambulance staff to do vital signs on arrival when ED is code red and status 3 arrival.

Thanks to Waikato for an inspirational conference and the reminder that Nurses need to be leaders in providing compassionate inclusive care – care for ourselves and colleagues as well as those coming through the front and back doors.

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Starship Children's ED

Winter hit us early like most other regions across NZ; May and June our busiest on record. This winter's poor 6-hour flow compliance has had a huge impact on additional hours for children and their families in CED. The extra workload from this was a challenge to manage.Then along came Measles! This challenged us even further with how to manage the department with only two negative pressure rooms.

We all learnt a new lingo "clean, clean", "clean dirty", "dirty, clean" and made a plan to try and keep one side of the department clean and the other buggy (dirty).

Our focus quickly turned to ensuring the vulnerable (the very young and the immunocompromised) were kept safe.

One of our nurses Graeme Bennett won the Local Hero Award - this is a monthly award given out by the CEO to an ADHB employee who makes a difference.

Graeme is a Level 4 RN who is our local immunisation legend, making sure CED staff are 99.5% vaccinated and promoting vaccination with families.

We have started work on converting a consultation room into a low stimulus room- a room that we can care for young people with challenging behaviours more safety and children ASD who may need a quieter room.

Anna Marie Grace

Auckland Adult ED

Graeme Bennett, ADHB Local Hero Award, with Children's ED team & ADHB CEO, Ailsa Claire

Auckland Region cont.

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Auckland ED continues to see record numbers of patients while working within a hospital operating at or over capacity throughout the Winter months, and now into Spring. In spite of the constant pressure, we continue to work hard to provide the best care we can. Along the way we have farewelled existing staff, welcomed new staff and continued to provide clinical mentorship to medical, nursing and paramedic students.

While the measles outbreak has created challenges, it also seems to have raised awareness of the importance of immunisations amongst patients and families.

We have had to adapt existing resources to protect and isolate patients at risk. A new rapid influenza testing system is also now embedded into practice.

Renovation of our built environment continues across Level 2, with new hoardings, room numbering systems and navigational routes keeping everyone on their toes. Builders have worked carefully to 'refresh' each emergency department patient bed-space individually, helping to minimise disruption to clinical care.

Our specialised team of health security staff are growing and proving their value to ensure the safety of patients, families and staff across the emergency department and clinical decision unit.

On a happy note, a large contingent from the Auckland Emergency Department recently enjoyed some 'team-building' at the Emergency Services Ball. It looks like everyone enjoyed the opportunity to relax and celebrate the end of the busy winter season.

Natalie Anderson

Contributions for Publication

We are always open to receiving submissions for publication. Submissions in the form of case studies, research posters and practice guidelines are welcome. There is a modest contribution for featured articles.

You can find guidelines for publication here: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal

Alternatively, email and enquire: mcomeskey@adhb.govt.nz

Midland Region

Kaidee Hesford
Nurse Manager

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The Midland region has seen its fair share of trauma this year, particularly road trauma. Most recently, we had a mass casualty incident in the Rotorua area in which 18 patients were transported to Rotorua ED and 3 patients flown to Waikato ED. This incident was similar to our recent EMERGO training incident and the teams were able to put into real life what had recently been practiced.

In Rotorua ED we are trialing a new "treatment corridor model" with our CNS's and select group of SMO's driving this. So far this has been very positive for the department particularly given the trial has been during the busy winter period. Over 40% of patients who have presented to ED are seen in this model which largely frees up the main ED for those who need more intensive treatment and beds. This has also shown the need for additional CNS's and we are now looking at developing and expanding this role.

Hamilton held the 2019 CENNZ conference which was well received with approx. 100 attendees. The mix of various speakers kept the audience captivated and the feedback from the conference has been all positive.

Waikato ED continue to await feedback from their service pressure document submitted earlier this year requesting an increased nursing and medical FTE to keep up with demand in ED and ensure safe staff to patient ratios (although there is no current way to calculate what this ratio should be at this point).

Their pressure points continue to be a full hospital with delays for inpatient beds leading to patients remaining in ED for long periods of time when their emergency care has finished and their ward-based care commences (this includes HDU level patients which feature a lot in bed delays).

Staff safety incidents continue to occur to frequently and they have created a working group consisting of mental health staff, integrated operations center nurse manager, St Johns, DHB security, Te Puna Oranga, ED champions, health and safety and quality and patient safety representatives to review all staff safety incidents and decide on an outcome eg: alert on iPM or a letter to the patient or their family / whanau re poor behavior and expectations if they present again with support services they can attend if needed eg: HAPE. This information is also fed back to staff eg: this month four patients had letters sent regarding behavior in ED in a confidential manner to ensure we close the loop and keep the staff aware of outcomes to incidents they are involved in.

Waikato ED continues to see record numbers with their busiest days being Sunday, peaking on a Monday and then starting to level out on a Tuesday - Wednesday.

Tauranga ED are soon to trail Trendcare in ED with this going live in November 2019. There was a lot of interest nationally from ED's and many attended the training held in Tauranga in August.

With winter coming to an end and the long summer days not too far away we are all looking planning for the summer influx in the midland region.

Kaidee

Mid Central Region

Katie Smith
Nurse Practitioner, ED
(Knowledge & Skills Framework & Website/Social Media)

NZDF
Palmerston North Hospital
Midcentral DHB

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Palmerston North Emergency Department

- High number of traumas that staff are managing well. Trauma network being managed by Sonya Rider. Have developed new trauma documentation sheets as a result of auditing required reporting information. Have also cemented the roles of trauma attendees with identifying roles on stickers.
- Increased numbers of staff has seen the educators working their magic at super high speeds. Now have minimum of 2 triage nurses 22 hours per day.
- Using MCH pastoral care provider as a pilot initiative in ED - she comes daily to the department and sees staff as individuals and groups depending on need. Has lead several debriefs after traumatic events. Uptake by staff has been fabulous. A focus on staff wellness has been forefront in the department.
- Associate team has new members to ensure ACNM cover 24/7 and protected time for quality improvement work.
- 2 security guards in the dept - one available for MH client reviews.
- CEO & Executive DON have spent a day on the floor - shadowing staff to get better understanding of the daily stressors and demands on staff. Focused on safe patient care and staffing.
- CENNZ conference - Nicola Morgan received the Kirsty Morton Triage award for 2019. 2 nurses nominated for senior nurse of the year. Conference attended by 7 staff nurses.
- Celebrated Te Wiki o te Reo Māori with hints and encouragement for staff to use Te Reo in the workplace more confidently.
- Ongoing high presentation numbers with elevated VRM levels.
- Staff have worked very hard over the winter months and we are all looking forward to some sunshine soon!

NZDF

- Conducting ongoing clinical placements within EDs and DHBs around New Zealand. These continue to be well supported by DHB staff.
- RNs able to attend CENNZ conference which was well received.

Taranaki DHB

NIL report available.

Whanganui DHB

NIL report available.

Katie

Wellington Region

Kathryn Wadsworth
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Wairarapa District Health Board

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Good morning from the Wellington region. Thick frost on the ground this morning with a promise of a beautiful day ahead and although the Wellington region is spread across a huge area I think this is essentially what my colleagues over the Remutaka hill are experiencing also. The Tararuas are loaded with snow and the air is clean and fresh.

I wish I could capture something entirely different in this month's report but the same theme continues. All three Emergency Departments have and are experiencing either high numbers, high acuity or both. Flow out of our departments is particularly challenging with the shorter stays in ED measure as low as it has been in five years of capture for many of us now sitting in the 80's rather than the 90% region. The issue of vulnerable patients particularly mental health associated issues waiting for long hours before a management plan and appropriate transfer is established is an ongoing problem. Wellington ED takes the record on this` with a patient in the department from Friday afternoon until Monday afternoon. It is very frustrating having little control over this especially when we are all very aware of the researched evidence of patient harm when they stay in our departments for extended periods.

Mike in the Hutt referenced survival mode and this rings true with all hands on deck on many occasions. The acute nursing skills are called on regardless of existing positions held and the impact of this is starting to be felt with staff fatigue and any quality advancement initiatives on hold. Staff sickness again is a huge issue with the need for multiple days from staff following the general illnesses and injuries of this season.

The addition of a 1200-1800 hour shift in Wellington ED and the 1600-0030 hour shift in Wairarapa ED has helped manage the afternoon influx of patients. Hutt ED have employed a new CNS and another CNS in training from November. They also welcome a new position of Security Coordinator based in their ED with a focus on staff support and education and a driver for a safer hospital.

The Wairarapa is working on triage nurse initiated xray requests and are about to undertake the education required to achieve this. It is hoped that this will improve wait times and interruptions to the Clinical decision makers on the floor and potentially improve patient flow through the department.

It has been another round of challenging months but all three departments have coped admirably with a constant focus on safety and patient care. The busier we get the more examples of the unique skills we see amongst our teams. The organised chaos, the constant reprioritising of care and the overall empathy shown by our team when pushed beyond limits still amazes me and makes me feel proud to be part of it.

Kathryn

Top of the South Region

Jo King
Nurse Practitioner Intern
(CENNZ Chairperson)

Emergency Department, Nelson Hospital

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Greetings from the Top of the South where we are welcoming the arrival of spring.

Nelson Emergency Department

It is business as usual in our emergency departments and we are enjoying relatively stable and predictable presentation numbers and demand. We will shortly be looking to plan for our summer surge as our populations swell over the summer period and we host large events such as 'Bay Dreams' and 'Marlborough Food and Wine'.

Considerable work has taken place across the organisation to improve the emergency department care for people who present with mental health and addiction need. This project has involved collaboration and input across many sectors. We will shortly roll-out a Triage Initiated Mental Health Pathway that will formalise the standards required for assessment, observation and documentation. It will also include systems to improve the ED/Police interface and the exchange of information and the understanding of responsibilities between us.

Our hospital dental department has recently launched a new service. This is a twice weekly 'Relief of Dental Pain' clinic. The emergency department can refer any patient who has a community services card and at times they can be seen immediately. This is a fantastic initiative that really looks to improve access and equity for unmet community need.

The concept of frailty has been gaining global momentum. Many frailty studies have identified the need for collaborative and multi-disciplinary approaches, including emergency departments, to recognise frailty as a risk stratification tool and work to prioritise and optimise care. We have begun to think about our models of care for older patients with complex needs. This work is in the very early stages. It is interesting to consider if we can improve the journey and interface with the emergency department for frail older persons. And if we do this can we improve health outcomes for this population?

I will shortly be finishing my four-year term as the 'Top of The South' representative on the CENNZ national committee. It has been a great privilege to have had this opportunity to contribute to emergency nursing in Aotearoa / NZ. Louise Holland from Nelson ED has been the successful nominee to take over this role. She will bring significant expertise to the committee and I wish her well.

Jo

Canterbury/Westland Region

Dr Sandra Richardson
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Canterbury District Health Board

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Christchurch ED

The ongoing issues with high acuity and patient numbers remain, and staff continue to meet these challenges across the region. The ability of staff to step up and manage in times of capacity loading, overcrowding and challenging circumstances is one we should be proud of, and where we should recognise the resilience and commitment of our colleagues to provide quality patient care. This means recognising the need to support each other, and to offer encouragement and recognition of the good moments, as well as the difficult ones.

The passion for emergency nursing and the amazing innovation and development of skills and knowledge was highlighted at the CENNZ conference in Hamilton, with good attendance from Canterbury and the West Coast, and the additional support from CENNZ to provide assistance to members from Christchurch was much appreciated. The CDHB continuing programme of Sankalpa mindful meditation, together with consideration of the broader issues of compassion in healthcare, was presented at the conference by Christchurch ED nurse Sandy Richardson.

Attendance at these events allows us to share our stories, and re-connect with colleagues as well as forge new alliances which will strengthen areas into the future. Our region is pleased to be able to advise we will be hosting the 2021 conference in Christchurch – this will give us time to have settled into our new department, and to have many new and exciting aspects of the Christchurch rebuild to share.

Currently, the Christchurch Hospital ED continues to plan for the move to a new building, and while there is a delay in the staff and public open days, there was a brief opportunity for ED staff to visit the new area under controlled conditions. The need to look at changes to our models of care, to integrate effectively with adjacent services, and to consider the best way of managing the move continues to take up much of the planning and organisation time, and we will be looking to orientation programmes for staff in the near future.

If you want to see what the new build will be like, take a look at the following: https://vimeo.com/332904772

The development of a 'front of house' model, with care provided by CNS and NPs together with a senior doctor acts as a form of effective risk reduction and a means of improving patient flow and service delivery. These initiatives, together with the embedding of the overnight social work 'on-site' service and the 'front door' ED physio hours are creating a sense of innovation and an exciting professional work environment.

An educational seminar was hosted by the Trauma Network in Christchurch, bringing Professor Karim Brohi, the Clinical Director for the London Major Trauma System to talk about mass casualty events and responses. He was directly involved in the management of a number of significant mass casualty incidents. He was the surgical commander at the Royal London Hospital for the London Bridge attacks, and responsible for leading the medical response to the Westminster Bridge and Grenfell incidents. The session was well attended with a significant representation from the Christchurch ED and prehospital community as well as others interested in the topic. In addition to Professor Brohi's presentation, a panel session was held with representatives from Christchurch able to talk to the impact of our own mass casualty events, most notably the earthquakes and mass shooting

Sandy

Southern Region

Anne O'Gorman
ACNM

Southland District Health Board

Dunedin Hospital Emergency Department

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Dunedin

Hopefully that is the winter done and dusted. We are in great need of some reprieve from the high volumes and acuity we have been experiencing over the last 3 months. It's been exceptionally busy and all departments in the Southern region have experienced a record high number of presentations of patients.

We continues to have high acuity and an increasing number of days spent in access block. With the hospital at capacity patients are spending up to 24 hours in ED waiting for inpatient beds. Inpatient teams continue to utilise over 25% of the ED beds this sometimes running for 24 hours at a time. Patients are increasingly being cared for in inappropriate bed spaces such as corridors and triage which is not ideal but assists with the capacity to see waiting patients.

There has also been a significant increase in the patients who did not wait and left before treatment.

Acuity and complexity of the patients has increased although unable to measure it is reflective in the increased use of ICU and HDU demand. The variance response tool utilised also showing an increase in the number of hours spent in overload.

Dunedin has seen an increase in influenza like illness with many confirmed cases of both A and B putting pressure on the department to accommodate patients whom need appropriate isolation. Fortunately we have need seen any measles cases unlike Queentstown who have had confirmed cases.

Skill mix has been an issue at times with minimal skill evident on some shifts. This is mainly due to recruitment of junior staff and the movement of some RN's into some senior roles within the department and hospital. However a robust education plan has commenced for all skill levels and 3 RN's where successful on the last Triage course

Nursing Staff are certainly feeling the impact of this overload and demand. Care rationing is certainly evident and staff sickness has increased. Many nurses are working overtime and the loss of non clinical time has had an impact on the development of new projects and initiatives within the departments.

Projects

Ongoing projects in Dunedin include the OPAL (Older Persons Assessment Liaison) – this is a four bedded unit in the older persons care ward that admits directly from ED. which does run well when it has available capacity.

The "Fit to Sit" (ambulatory care in ED) project has gained significant traction and we are waiting for planning consent to expand this area. Recruitment for staffing has already begun.

We have also introduced a new Oral hydration pathway for paediatric patients.

Electronic handovers to all wards is in the process of being rolled out. We had been trailing this initiative for some time to one of the wards and it proved to be both safer and efficient medium of handover.

Education

We had a successful trauma conference here in Dunedin in September with many RN's in attendance from all over the South island. We are also sending RN's to both TNCC and Triage later in the year. We have an in house Mental Health study day planned for October.

Simulation teaching continues on a monthly basis and we have been able to facilitate insitu Sim training within the busy department

We have also introduced a weekly skills session which has been in place since July.

Anne

College Activities

Triage Courses 2020

Please see CENNZ Web page for details:

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

Region / City	Dates
Taranaki	22/23 February 2020 (Sat/Sun)
Christchurch	13/14 March 2020 (Fri/Sat)
Waikato	18/19 April 2020 (Sat/Sun)
Tauranga	9/10 May 2020 (Sat/Sun)
Rotorua	30/31 May 2020 (Sat/Sun)
Wellington	19/20 June 2020 (Fri/Sat)
Christchurch	25/26 September 2020 (Fri/Sat)
Hutt Valley	16/17 October 2020 (Fri/Sat)
Waikato	14/15 November 2020 (Sat/Sun)

Conferences and Events

Please see CENNZ web page for details:

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

Good Fellow Conference	
https://www.goodfellowunit.org/symposium	
Region / City	**Date**
Auckland	March 28-29 2020

Medico – Legal Forums NZNO +++ details to be announced +++	
Region / City	**Dates**
Christchurch	11 February 2020
Dunedin	12 February 2020
Palmerston North	18 February 2020
Auckland #1	26 February 2020
Auckland #2	27 February 2020
Wellington	4 March 2020
Hamilton	5 March 2020

28th College of Emergency
Nurses NZ Conference 2019

Kotahitanga
Compassion and Inclusion CENNZ Conference 2019

Hamilton 13-15 September

The concept of kotahitanga is one on unity, togetherness and collective action. This is both a goal we strive to attain and a challenge to achieve. The problem being the resource constraints we are working under. How do we maintain compassion and inclusion in the care of our patients when we might feel pretty stretched ourselves? This challenge was referred to by numerous speakers, in several contexts, giving the conference a sense of coherence and relevance.

The conference opened and centred our attention with a powhiri. Sandra Richardson (CDHB CENNZ National Committee) introduced the conference theme, placing it in a historical context of the development of ED nursing and CENNZ. Her plea for inclusion extended to growing the College by encouraging and nurturing our next generation - new nurses.

She concluded with a quote from Sir James Henare;

Kua tāwhiti ki to tātou haerenga, ki te kore e haere tonu
He tino nui rawa ā tātou mahi, kia kore e mahi nui tonu

We have come too far not to go further
We have done too much not to do more

28th College of Emergency Nurses NZ Conference 2019

Keynote Speaker

The keynote speaker was William Pike. William described his approach to life as a kid and young adult as "more enthusiasm than skill". This balance led him into plenty of adventures in the outdoors. In 2007 he found himself high on Mount Ruapehu, camping in the Dome Shelter with his mate James. Dome Shelter sits just above Ruapehu's volcanic crater lake. During the night, without warning, the crater lake exploded. The explosion pushed out a wall of water and 1.5 million tonnes of mud and rock. This debris filled wave inundated the hut, trapping his lower legs in volcanic ooze and ice which immediately set like concrete. William was in a bad way. He was battered, freezing cold, his legs awere smashed and he was unable to extricate himself. His mate James, a mountain novice, went for help in the darkness, not knowing if the eruption was going to continue. By the time William was rescued, he was profoundly hypothermic and in hypovolemic shock. His recorded temperature was 25 degrees with an arterial pH of 6.86. He was flown to Taumaranui, then Waikato. He paid credit for his survival to those initially involved in the difficult extraction and resus, which could have gone either way. At this point in the story, William moved off-script. He described how it felt to be a survivor and how small gestures of kindness meant so much. He began to slowly realize, in an opioid fog, that he had lost his lower leg. He described it as a "fork in the road" moment. He was a young man on the cusp of a teaching career, with a long list of adventures to tick off. He could accept the limits of his injury as a surgeon had advised him or choose the harder path and continue to follow his plan. After three months of recovery, he started applying for jobs and landed his first teaching position. He has since been back to Ruapehu, climbed in Antarctica and had numerous other adventures and has somehow found time also to have a family and inspire thousands of kids through the William Pike Adventure Challenge. He credits his recovery and success to three things, having a sense of purpose and passion, family and supportive relationships and stepping outside his comfort zone.

https://williampike.co.nz/

There was some serendipity in having John Bonning (Waikato SMO) follow William Pike. John Bonning, a Waikato ED SMO led William's resus in Taumaranui and Waikato ED's. His topic was Choosing Wisely, concerning testing and investigation. Sometimes less is more.

"The art of medicine consists of amusing the patient while nature cures the disease". (Voltaire)

This conservative approach is especially relevant in low-risk patients. In this group an incidental finding may lead to further investigation and treatment that may lead to harm being done. The Choosing Wisely campaign is now in over 20 countries.

https://choosingwisely.org.nz/

The concurrent morning sessions happily provided a dilemma: too many interesting speakers to choose from and the impossible task of being in two places at once. I opted to listen to Libby Haskell present her bronchiectasis research, part of her doctorate. Her study consists of an RCT, conducted in 26 sites across NZ and Australia. With tailored knowledge translation in terms of changing clinician behaviour concerning treatment and investigation to avoid unnecessary interventions. All of which linked to John Bonning's Choosing Wisely presentation.

Kay Sloan presented on challenges and tips to managing patients referred to ED from Corrections facilities. Corrections medical clinics are nurse-managed and nurse-led. Under the Corrections Act 2004, the standard of healthcare in prisons must be measured by the equivalent provided in the wider community. There are distinct challenges to achieving this in the penal environment. But there were surprises too. A nurse is more likely to be subject to assault in a hospital or A&M clinic than in prison. I commonly see prisoners referred by Corrections. They present unique challenges and opportunities for education and health care. I found this presentation gave me some useful insight and tips into how I can better tailor my plan for this group of patients. Particularly around ensuring the Corrections clinics can fill prescriptions; there is often no prescriber on-site in prison. Additionally, access to a dispensing pharmacy may be restricted over weekends and public holidays. Prisoners should not be discharged back to corrections if they need regular observation – they are often placed in a cell without nursing supervision overnight.

Julie Manning and Tanya Matthew, presented on innovations for managing frequent attenders to the Waikato ED. These included a nurse-led initiative which developed into an MDT to form care plans for the management of complex and regular ED attendees. The challenge is to achieve this while maintaining core values of caring and compassion.

Post-lunch I was ready for a wee lie down which was sort of provided by Sandy Richardson. Her presentation was on Sadkalpa, mindfulness, meditation and compassionate care. Mindfulness programmes are being employed in EDs to address stress and burnout and assist nurses to self-manage anxiety to prevent being overwhelmed by workload. We were taken

28th College of Emergency Nurses NZ Conference 2019

through a brief mindfulness exercise – and I had no problem slipping into a postprandial state of relaxation. I was so relaxed I narrowly avoided sliding off my chair.

Emergency Q, is a patient voucher system, trialled at Middelmore and Hawkes Bay for those who present with conditions that can be safely treated in an A&M or GP clinic. Patients are provided with a voucher via a down load to a smart phone app, that can be presented to a partnering clinic. This is an attempt to relieve ED crowding and prolonged wait times by allowing patients to access alternative care. The patient journey can be traced by the voucher provider to ensure they have been able to access treatment. This has been an interesting development in some of our DHBs. The presentation generated plenty of questions and comment on redirection from EDs and risk.

https://www.emergencyq.com/

Dr Ruth Large (SMO, Thames) followed this with a presentation that addressed further digital-based innovations. These may improve health care and better inform patients and their families. This is particularly relevant in rural locations. For example, current innovations are being applied to facilitate face to face consultation with specialists via web links without the need for patients to travel long distances.

The day wound-up with a debate. Conference debates are a bit like jelly wrestling. They are messy, hard to take seriously and not pretty to watch. In the end, nobody, participant, nor spectator, comes out covered in glory. It's just a hot sticky mess and this year was no exception. The topic was 'Primary Care is failing ED'. For the affirmative John Bonning railed against the "Dear Doctor" referrals to ED, he has collected over the years. He presented a stack of paper as evidence of primary care dumping patients on ED and blocking up hospital beds. The rest of his team took a slightly more reasoned stance suggesting the 'system' was at fault, that patients were let down by barriers such as cost and restricted GP hours.

The opposing team rose to the defence of primary care and valiantly fought their corner. Damian Tomic (Clinical Director of Primary Care, Waikato DHB) suggested: "Hungry Hospitals are gobbling our money". Ruth Large, (SMO ED, Thames) delivered the proverbial body slam that knocked the opposition out of the ring by quoting back to John Bonning (President Elect of ACEM), ACEM's own position statement. Which goes something like this, "....patients referred by primary care are not responsible for bed blocked hospitals". It was a slam dunk. At the very end of the day, both teams agreed, community primary care and ED need to talk more to do better for our patients.

I think a draw was declared - it was hard to tell how it wound up. The end was messy, noisy and confused, not unlike a typical day in ED. For my money, the primary care team was a clear winner. We retired, then re-grouped for dinner that included an Oscar's style prize giving and dancing.

The following day started with a presentation given by Marguerite Donaldson, from Positive Women, who has lived with HIV for 30 years. When diagnosed, she was given 5 years to live. Her story is one of perseverance over adversity, unwarranted prosecution and discrimination. Her life story is profoundly moving. Her message is that the smallest gestures of compassion and kindness from nurses can have significance far beyond what we may know at the time. Her family have been solid support against some destructive behaviour and attitudes. There are quiet heroes in our community. As her presentation wound-up, I felt humbled having heard from one of them.

"HIV does not discriminate – people do" Marguerite Donaldson

Positive Women:

https://positivewomen.co.nz/

Chronic pain can be challenging to address in the ED. Physio, Paul Hollaway posited that reflective listening is a very useful tool to apply for this patient group. He also briefly broke down the pathophysiology of three different groups of pain, suggesting that a single modality of treatment is therefore unlikely to be effective.

High-performance CPR was reviewed by Cameron Grylls, NZ Fire Service and NZ CPR guidelines and new innovations were discussed by Kevin Nation, NZ Resuscitation Council. Check out the high-performance CPR video and the "choreography of CPR" shot by St John, NZ Fire Service, Wellington Free Ambulance and AUT.

High-Performance CPR :

https://www.youtube.com/watch?v=7L45-AsO4bA

The conference closed with an address by Tusha Penny, the first Māori female District Commander in New Zealand Police. Her Iwi is Ngati Porou. She spoke on the privilege of leadership – but in doing so canvased a very wide series of anecdotes and observations to illustrate her point. We have to know our purpose to remain effective in a demanding professional role.

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Tusha Penny:

https://www.police.govt.nz/tusha-penny

We were taken on a wild and sometimes hilarious ride through childhood in Gisborne, early years in the Police, raising kids and later in leading high profile CIB investigations. Tusha hit her stride in the area of historical sex abuse and domestic violence, which just left me wondering how a mother remains in a professional mindset and not succumb to the horror that you can't possibly 'un-see'. And that's her point. To remain compassionate and caring we have to ask ourselves "What's my why?". Meaning, we need to regularly go back to the thing that made us want to go into nursing in the first place. Despite the terrible injustice she has seen she remains hopeful. She sustains this by working together with others. Simple really. And with that we closed the circle ... kotahitanga - unity, togetherness, collective action.

Mahi pai

Nga mihi Waikato

CENNZ Honorary Life Membership Award

CENNZ Honorary Life Membership Award – WENDY SINCLAIR

The CENNZ Honorary Life Membership Award is bestowed very occasionally to a past or present member of the College of Emergency Nurses New Zealand in recognition of their contribution to emergency nursing in Aotearoa / New Zealand.

The College presents this award to Wendy Sinclair, CNS Waikato Emergency Department, in acknowledgement of the major contributions she has made and continues to make to the specialty of emergency nursing.

Wendy Sinclair is recognised as having a strong and relentless commitment to emergency nursing and being influential locally, regionally and nationally.

Wendy is very much part of the College of Emergency Nursing's history having been part of the original Waikato team who founded the College.

She has been a member of the national committee and hugely influential in the development of the National Triage course in the 1990s.

Her involvement with Triage education has continued with her recent involvement in filming of new videos for the course.

Wendy was instrumental in the development of guidelines in her work with the New Zealand Guidelines group and she now advises to the HDC and consistently educates her workforce on relevant findings.

She is also recognised as having a major part in the development of advanced nursing roles at a regional level.

Wendy's colleagues talk of her outstanding professionalism and that she is the strongest advocate of Emergency Nursing and Emergency Nurses that the Midland region has ever had.

She upholds putting the patient at the centre and demands a high standard of evidence-based nursing from her colleagues. She is relentless in guiding emergency nurses on career paths and is always teaching.

Wendy is and remains one of the pillars of Emergency Nursing in New Zealand.

Snippets Summer 2019

Diagnostic accuracy of eFAST in the trauma patient: a systematic review and meta-analysis.

Canadian Journal of Emergency Medicine. 2019 July.

Performing an extended Focused Assessment with Sonography in Trauma (eFAST) exam is common practice in the initial assessment of trauma patients. The objective of this study was to systematically review the published literature on diagnostic accuracy of all components of the eFAST exam.

Systematic review and meta-analysis suggests that e-FAST is a useful bedside tool for ruling in pneumothorax, pericardial effusion, and intra-abdominal free fluid in the trauma setting. Its usefulness as a rule-out tool is not supported by these results.

https://www.ncbi.nlm.nih.gov/pubmed/31317856

Determination of the best early warning scores to predict clinical outcomes of patients in emergency department.

Emergency Medicine Journal. 2019 July.

Early warning scores (EWS) are used to predict patient outcomes. This study aimed to determine which of 13 EWS, based largely on emergency department (ED) vital sign data, best predict important clinical outcomes.

This is a prospective cohort study in a metropolitan, tertiary-referral ED in Melbourne, Australia (February-April 2018). Patient demographics, vital signs and management data were collected while the patients were in the ED and EWS were calculated using each EWS criteria. Outcome data were extracted from the medical record (2-day, 7-day and 28-day inhospital mortality, clinical deterioration within 2 days, intensive care unit (ICU) admission within 2 days, admission to hospital).

690 patients were admitted to the study hospital. Most EWS were good or excellent predictors of 2-day mortality. When considering the point estimates, the VitalPac EWS was the most strongly predictive (AUROC: 0.96; 95% CI: 0.92 to 0.99). However, when considering the 95% CIs, there was no significant difference between the highest performing EWS. The predictive ability for 7-day and 28-day mortality was generally less. No EWS was a good predictor for clinical deterioration, ICU admission or admission to hospital.

The study concluded that several EWS have excellent predictive ability for 2-day mortality and have the potential to risk stratify patients in ED. No EWS adequately predicted clinical deterioration, admission to either ICU or the hospital.

https://emj.bmj.com/content/early/2019/07/31/emermed-2019-208622

Oral Paracetamol Versus Combination Oral Analgesics for Acute Musculoskeletal Injuries. Annal of Emergency Medicine. 2019 Aug.

This was a prospective, double-blind, randomized, active-controlled, parallel-arm study at an urban tertiary hospital emergency department. Participants were aged 18 to 65 years and had acute (<48 hours) closed limb or trunk injuries with moderate pain (greater than 3/10). A single dose of 1 g of paracetamol, 400 mg of ibuprofen, and 60 mg of codeine was compared.

The study concludes combining oral paracetamol, ibuprofen, and codeine as the initial treatment for pain associated with acute musculoskeletal injuries was not superior to paracetamol alone for pain reduction at 60 minutes or need for rescue analgesia, with more adverse events in the combination group. with a single dose of 1 g of paracetamol, placebo ibuprofen, and placebo codeine. The minimum detectable difference in pain was taken as 1.3..

https://www.annemergmed.com/article/S0196-0644%2819%2930442-1/fulltext

Snippets Winter 2019 Cont.

Contamination in Adult Midstream Clean-Catch Urine Cultures in the Emergency Department: A Randomized Controlled Trial. Journal of Emergency Nursing. 2019 Sept.

A midstream clean-catch urine sample is recommended to obtain a urine culture in symptomatic adults with suspected urinary tract infection. The aim of this randomized controlled trial was to determine whether a novel funnel urine-collection system combined with a silver-colloidal cleaning wipe would decrease mixed flora contamination in midstream clean-catch urine cultures from ambulatory adults in the emergency department.

https://www.ncbi.nlm.nih.gov/pubmed/31445626

Comparison of Oral Ibuprofen at Three Single-Dose Regimens for Treating Acute Pain in the Emergency Department: A Randomized Controlled Trial. Annals of Emergency Medicine. 2019 Oct. Annals of Emergency Medicine . 2019

Nonsteroidal anti-inflammatory drugs (NSAIDs) are used extensively for the management of acute pain, with ibuprofen being one of the most frequently used oral analgesics in the emergency department (ED). We compare the analgesic efficacy of oral ibuprofen at 3 different doses for adult ED patients with acute pain.

This was a randomized, double-blind trial comparing analgesic efficacy of 3 doses of oral ibuprofen (400, 600, and 800 mg) in adult ED patients with acute painful conditions. Primary outcome included difference in pain scores between the 3 groups at 60 minutes.

The study concluded oral ibuprofen administered at doses of 400, 600, and 800 mg has similar analgesic efficacy for short-term pain relief in adult patients presenting to the ED with acute pain.

https://www.ncbi.nlm.nih.gov/pubmed/31383385

Emergency department recommendations for suicide prevention in adults: The ICAR(2) E mnemonic and a systematic review of the literature. American Journal of Emergency Medicine. 2019. Jun.

Caring for suicidal patients can be challenging, especially in emergency departments without easy access to mental health specialists. The American College of Emergency Physicians and the American Foundation for Suicide Prevention appointed a working group to create an easy-to-use suicide prevention tool for ED providers. The writing group created an easy-to-use mnemonic for the care of adult patients as a way of organizing sequential steps, accompanied by a systematic review of available ED-based suicide prevention literature.

The writing group created the mnemonic ICAR2E, which stands for Identify suicide risk; Communicate; Assess for life threats and ensure safety; Risk assessment (of suicide); Reduce the risk (of suicide); and Extend care beyond the ED. 31 articles were identified in the search, and were included in the systematic review.

The authors conclude the ICAR2E mnemonic may be a feasible way for practicing ED clinicians to provide evidence-based care to suicidal patients. However, further research is needed.

https://www.ncbi.nlm.nih.gov/pubmed/31493978

Precision and Solution for Pre-Determined Difficult Venous Access

Ultrasound-Guided Peripheral Intravenous Catheterisation – Knowledge-to-Action

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Background

Of all patients presenting to Emergency Departments worldwide, it is estimated that over half require PIVC[1] and over one third of these patients are reported to have difficult venous access[2]. After multiple attempts these patients commonly require ultrasound guided peripheral intravenous cannulation (USGPIVC). Current best practice guidelines stipulate two attempts at peripheral IVC by palpation prior to escalating to another colleague. If access remains unsuccessful an USGPIVC may be required causing delays if the physician is not available. Investigations, treatment delays and multiple attempts cause pain decreasing patient satisfaction.

USGPIVC has significant benefits for patients with higher success rates over the standard IVC palpation technique. Bahl and colleagues included a training programme for ED nurses and identified a 20% greater success rate with patient determinants for USGPIVC first time from their trial[3]. A systematic review completed in 2018, suggests no statistically significant difference in success rate between nurses or physicians and therefore training ED nurses would be feasible and invaluable[4]. Developing nursing practices to include USGPIVC within their scope will increase availability of qualified staff across each shift, improve patient satisfaction and decrease potential delays in treatment and investigations.

Evidence-based practice in healthcare is a fundamental concept that guides professional's decision making with the best available research and application of findings[5]. Translating evidence into practice is often challenging and to ensure evidence-based practice change is accepted, sustained and practices modified it is important to understand and manage human variables to gain support and acceptance[5]. The Knowledge-To-Action framework is a well cited tool that guides the dynamic change process of translating research into practice. Knowledge inquiry based on research evidence with an action cycle where evidence informs the cycle components is a great tool to consider for implementing change into the workplace. For the purpose of this submission, the Knowledge-to-Action framework was utilised to consider organisational readiness for change and to look at the barriers and enablers for implementation into practice.

Implementation

Does your patient fit the following criteria for USGPIVC?

- 18 years or older
- Identify themselves as having difficult access
- Had at least two attempts at PIVC palpation
- Have history of one of the following
  - Rescue access due to unsuccessful PIVC
  - ESRD
  - IVDA
  - Sickle cell disease

Please contact the ED CNS or RN extension staff

Any procedural change requires education and competency, it would be essential to discuss with key stakeholders ensuring awareness of the evidence and the benefits of ED nurses being trained in USGPIVC. A training programme should first be developed. The two Clinical Nurse Specialists at Waikato ED currently competent in USGPIVC completed an online learning package and a full study day. Ten successful cannulations were then required to gain competency. Research suggests a shorter training progamme with successful competency would be sufficient and therefore this would need to be considered and adapted to the needs of each department[3].

All staff should be aware of the pre-determined difficult venous access criteria. This could be printed in nursing assessment sheets or socialised at handovers. A reminder card would remind staff of the pre-determined criteria. This also provides staff with a physical prompt and helps guide the decision-making process. These cards identify pre-determined patient criteria as the evidence identifies these patients to have difficult venous access and assists with clinical decision making.

Consideration of the group of nurses would be organisation dependent. At Waikato, Clinical Nurse Specialists and those in RN extension roles are currently considered. This provides a trained USGPIVC nurse across all shifts and within these roles provides a more flexible workload than the primary nurses currently have. A specific group trained staff maximises enablers and eliminates barriers.

Evaluation

An important aspect of the Knowledge-To-Action cycle is evaluating a shift in knowledge and practice around implemented change. Evaluation of change towards the target behaviour, in this case nurses newly trained in USGPIVC being utilised and increased patient satisfaction. Outcome measures commonly used to measure implementation efforts include uptake of individual's performance, patient acceptability, fidelity and sustained use. If there is a gap where the pre-determined criteria or the trained nurses are not being utilised, it would be feasible to relook at barriers to resolve these. Measures to assess change include auditing of patient experience; staff experience; documentation including criteria consideration. If success rates or patient satisfaction are reduced, this may require modification at previous implementation cycle stages, further training, knowledge and credentialing. New knowledge or evidence may also be available which may modify the intervention. Further development beyond the scope of this implementation change could include a clinical pathway for the management of patients with difficult access. This pathway could include steps beyond USGPIVC to include central venous catheter devices, ED physician and anaesthetist guidance.

References

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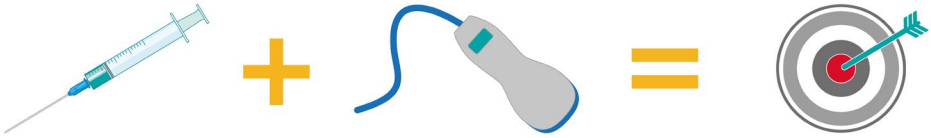


RCT assessing the use of ultrasound for nurse-performed IV placement in difficult access ED patients

Citation: Bahl A, Pandurangadu AV, Tucker J, Bagan M. A randomised control trial assessing the use of ultrasound for nurse-performed IV placement in difficult access ED patients. Am J Emerg Med 2016; 34(10):1950-1954.

Clinical Bottom Line

In patients with difficult venous access, USGPIVC is 20 per cent more successful in gaining venous access compared to the standard palpation technique. A moderate quality trial with clinical and statistical significance identified in successful venous access. With a robust training programme for ED nurses, USGPIVC should be considered for pre-determined difficult venous access patients.

Clinical Scenario

An increasing group of patients with difficult venous access are presenting to the ED. Multiple palpable PIVC attempts usually occur prior to escalation to a physician or certified CNS for USGPIVC. This causes delays in treatment and investigations being completed for these patients. ED length of stay is increased and pain from multiple attempts adds to decreased patient satisfaction. If all nurses in a CNS role were certified in USGPIVC you wonder if this would reduce attempts and time required for successful insertion over standard care (PIVC insertion).

Study Summary

Prospective, non-blinded, randomised control trial conducted at a single site tertiary care ED in Ireland from November 2014 to July 2015. This trial compared ED nurses trained in USGPIVC versus standard palpation PIVC in patients with difficult venous access. The trial was divided into two phases. Phase one involved an education programme for ED nurses. All ED nurses were offered to participate who had good clinical skills and a minimum two years of experience. Those willing to participate were randomly assigned to either the USGPIVC or standard care methods with ten nurses in each group. Two didactic education sessions with a PowerPoint presentation took place prior to patient enrolment outlining techniques required to obtain intravenous (IV) access with each method. The USGPIVC group also watched a short video demonstrating the ultrasound (US) guidance technique and completed a practical session. Nurses were required to complete ten successful USGPIVC under supervision prior to being certified.

Phase two involved a randomised prospective cohort study of patients presenting to the ED. Enrolment, consent and random assignment occurred in 124 patients. Two patients were excluded after consenting due to lack of availability of the study-trained nurse in the control group. Inclusion criteria were patients over 18 years of age, prior history of difficult access or had experienced at least one prior episode where two or more attempts occurred to obtain a PIVC and had at least one of the following four conditions: prior history of a rescue catheter with previous failed attempts, previous IV drug use, end-stage renal disease or sickle cell disease. Patients were excluded if they had PIVC insertion attempts prior to enrolment, were a previous study participant or the enrolment process had potential to delay care. Participation was voluntary and once consent was obtained participants were randomly assigned to the intervention or control groups. After randomisation the appropriate study-trained nurse was attained, and a research nurse recorded time. A functional IV was confirmed by withdrawal of 5ml of blood or infusion of 5ml normal saline flush without extravasation. Time commenced when the tourniquet was applied and stopped when the tegaderm was secured. If unsuccessful, the patient remained in the study with time continuing until successful insertion occurred.

- Intervention group (n=63): The study-trained nurse gathered required equipment prior to applying tourniquet. A Sonosite M-turbo US machine linear transducer was used for the trial.
- Control group (n=59): Study-trained nurses gathered required equipment for palpable peripheral IVC insertion.

Outcomes

Primary outcome was success rate for IV placement. The secondary outcome measure was tourniquet to tegaderm time where total time interval to achieve a functional IV including time to obtain a rescue IV if required was recorded.

Results

Analysis completed on 122 participants; 63 in the USGPIVC group and 59 in the control group. Success rate for functional PIVC was higher in the USGPIVC group (76% versus 56%). Of the 15 unsuccessful attempts in the intervention group, 4 had a second successful attempt with USGPIVC, 3 had PICC lines placed, 8 had palpable IV insertion. Of the 26 unsuccessful in the control group, 3 had a second successful attempt, 21 then received the USGPIVC method successfully, 1 participant had a failed femoral access attempt, and 1 participant left the department after the first attempt. The odds ratio for USGPIVC success was 2.52 (95% CI, 1.09 – 5.92) greater than the standard technique. The mean tourniquet to tegaderm time was 20.7 minutes in the intervention group compared to 15.8 minutes in the control group. Extrapolating data to the 75th percentile showed significant reduction in USGPIVC (17.8 minutes versus 36.6 minutes). Upper limit analysis of placement time above 33 minutes identified only 10% of cases in the intervention group and 27% in the control group. Safety and adverse events not reported.

	USGPIVC	Palpable PIVC	Absolute Difference
Primary Outcome Success Rate	48/63 (76%)	33/59 (56%)	20.3% (95%CI, 3.8%-36.7%)^
Tourniquet-tegaderm time*	17.8min (95%CI, 13.2-23.5)	36.6min (95%CI, 23.1-45.6)	18.8min
IV placement time over 33 minutes	10%	27%	17%

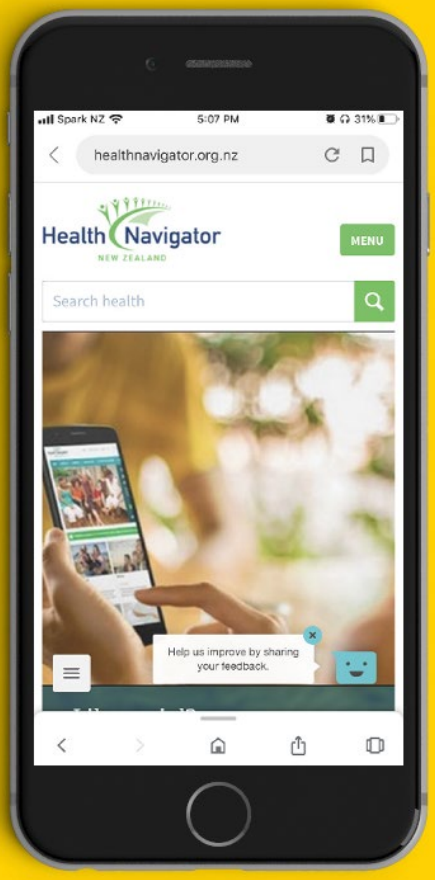
*CI - Confidence interval; NNT – number needed to treat; *- 75th percentile; min – minutes; ^ - calculated by student*

Comments

- Confounding variables eliminated with training programme and ED nurse selection criteria.
- Strict inclusion criteria for patients pre-determined as having difficult venous access prior to attempting access. Previous studies have not included pre-determined criteria.
- Control group nurses also encouraged to but not standardised to complete two attempts prior to moving to a rescue IV. Patients with unsuccessful access in the control group then received a functional line by an USGPIVC trained nurse (83% 20/24 cases). Usual practice would be to wait for an available physician. These factors likely led to shorter tourniquet-tegaderm times in the control group.
- Upper limit analysis of PIVC over 33 minutes shows statistical significance favouring USGPIVC

What are you looking at?

Health Navigator Website: A Review.



My first question in reviewing this web page is "How come I have not been using this?" I was under the mistaken impression that Health Navigator was a dry list of services and outpatient clinics to refer to. In contrast to my mistaken impression, the site is an extensive repository of information for both clinical and non-clinical users. The subject range is extensive and covers just about any question I can imagine a patient might ask me in a primary care setting. And patients are always asking me stuff I don't know the answers to.

The home page is arranged in a top bar that includes an A-Z of topics and a more general breakdown of videos, apps, services and support amongst others. A quick and dirty search on the search bar for "Is vaping safe?" brought up a range of pages and a helpful NZ-made youtube file. Just about everything I needed to know on the subject is there and easily accessed. Topical issues such as social media and mental health, recent medication changes, measles and palliative care – the stuff that's in the news this week are highlighted on the home page.

I particularly like the apps section. There is a whole raft of peer-reviewed, evidence-based apps that are reviewed with the pros and cons clearly listed.

The page works a lot better on a PC screen than my phone – but that aside, it is rapidly becoming my go-to for patient education. Especially the information sheets on medications and presenting conditions which are way better than some I have been using recently.

https://www.healthnavigator.org.nz/

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EMERGENCY NURSE NEW ZEALAND

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