Volume 22 | Issue 02

EMERGENCY NURSE NEW ZEALAND

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

Spring blossoms in Hagley Park (Central Christchurch)

In this issue

Editorial Information

Subscription:

The journal is available on the CENNZ NZNO College website: www.cennz.co.nz/journal

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Editorial

Dr Sandra Richardson
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Working in an environment that enables violence and aggression

The issues facing New Zealand EDs and the staff who work in these are neither new, nor unique. As we move forward, and away from the immediate focus on Covid-19, we are dealing with the impact of high patient volumes and staffing shortages. Whether we call it a healthcare crisis or not, the facts remain the same. Our EDs are overcrowded, with long waiting times resulting, and patients becoming frustrated while staff are often left feeling unable to cope. The focus of this edition of the journal is on violence and aggression, and the ability to provide safe environments for our workers. The context within which we are currently working to provide care is one that has the potential to exacerbate the risk of violence, to aggravate those who are already stressed, anxious or angry due to circumstances they cannot control. So, we need to be mindful of the environment, and to acknowledge the impact this can have. We need to recognise that the circumstances we have observed occurring overseas, and have long deplored (albeit sympathetically), are now occurring in our own EDs. The outrage that we expressed at the thought of patients being cared for in corridors has been tempered by recognition this is now 'business as usual' and factored into our capacity response plans. Our horror at the thought that a patient might wait in the ED for more than 8 hours to be admitted has dissipated, and we now struggle to provide care under the new norm that sees us having to prioritise back to the basics. No nurse, or doctor, comes to work and wants to provide less than the best possible care for their patients. Yet it is becoming harder and harder to rationalise the cut-backs in care we are asked to make – the need to prioritise so that the life-saving and essential services are maintained, as this may be all that we can provide. The sense of risk associated with managing a workload which feels unsafe, of offering only the essential cares, and of working with a reduced workload as a result of sickness and low base numbers creates a tense and reactive workforce. It is harder to provide the calming, respectful response that works to defuse an atmosphere of anger, agitation or entitlement. Within such an environment, we have exhausted, stressed, and fearful workers who are unsure whether they can continue to provide effective, safe care. It is within this environment, that even when we are given permission to increase our staff numbers, we are struggling to recruit more staff.

Increasingly, patients and even more so their whanau and friends, become angry at prolonged waits, distressed at the perceived inequity as they see other patients being called through from the waiting room ahead of them, or increasingly edgy as they lose perspective and the ability to manage their circumstances. This can result in a combination of staff with a lowered threshold for management of aggressive patients, and a heightened level of verbal and psychological abuse spilling over into higher levels of physical threat and intimidation. The risks become those of both over response and under recognition – of reacting to situations in a more forceful or escalating manner than is needed, or of failing to recognise warning signs because of the frequency and normalisation of the constant low-level violence. While various forms of management are being trialled both internationally and nationally to manage violence in health care settings, most of these require resourcing – both in terms of personnel and education. Whether this is through education in de-escalation, the use of early warning checklists, MAPA training or similar, this requires the capacity to access such education, release staff for training and importantly for refresher courses. It also requires the maintenance of a baseline level of sufficiently trained staff. In other words, it is not enough to have systems in place to provide training if the staff turnover remains high; the constant cost of re-training and working to achieve effective team responses becomes prohibitive at worst, and reduced in terms of effectiveness at best. If the resource is in terms of security systems or services, the input in terms of cost, staff numbers, and training to achieve meaningful improvement is again a significant consideration, and one that under our new health system should be addressed at a national level, to ensure equity across services. If we intend to ensure a safe workplace, and to provide a safe service to patients, we need to look at the policies, guidelines and protocols that are in place. Are these unified, consensus based, and equal across the health system? Do we have an agreed response to actions that are violent and aggressive, and targeted towards health workers? Currently, there is no single,

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national position on the recognition, response and remediation for health worker occupational violence, and therefore an absence of accountability or mechanism to achieve this.

This also means there is no national process or standard of care for those affected by violence or aggression, or standardised set of goals in terms of support or well-being.

No one issue facing EDs can or should be managed in isolation. All impact each other. While covid-19 is no longer the dominant concern, it continues to impact us in terms of staff sickness, welfare and even recruitment and retention as more nurses look at wider employment opportunities. Hospital crowding and access block impact on staffing, and the need to identify effective means of maintain staff well-being are paramount. If we continue to lose nurses through exhaustion, burnout and resignations, in a global environment of healthcare crisis and competition to hire those who are available, then our circumstances risk becoming even more challenging. We need to continue to advocate for the well-being of our patients and our workforce, to identify not only the problems, but also the solutions. As we work in each of out EDs, finding mechanisms and tools to address the problems of violence and aggression, we also need to share these across the motu – learn from each other, and build on our strengths. So think about proactive rather than reactive responses – Cath Allwood provides insight into the management and response to suicidal patients, a difficult population that can often cause anxiety for nurses who struggle to find the 'right' words. Chris Thomas and Lucy Benjamin-Mitchell outline the journey within Whangarei ED, identifying both issues and successes, building on a quality initiative and acknowledging the importance of staff education, and efforts to mitigate the physical limitations present in the environment. The Christchurch ED group, WAVE, is outlined by Polly Grainger who identifies the significance of team work, improving reporting and interdisciplinary responses. The role of security services and their interaction with the ED alongside the use of code responses are outlined in the cases for Middlemore and Taranaki Base hospital EDs – all providing additional ideas and opportunities to consider. Of most significance, perhaps, is the need to focus on each individual nurse, working with the team, and trying to make sense of an increasingly chaotic health system. Stacey Smart reminds us of the importance of self-care and self-compassion, key elements in our tool-box for wellness in her regular feature section on mental health, in this edition focussed on looking after yourself.

There is a lot of food for thought in this edition, and information to help strengthen the ED workforce,

I orea te tuatara ka patu ki waho

A problem is solved by continuing to find solutions.

This whakatauki refers to the need for creative thinking, adaptability and perseverance. In order to solve the problems we face, all of these are needed.

Kia kaha.

Sandy

Guest Editorial

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Violence and Abuse Protection and Prevention mechanisms in the workplace (ED) – why aren't they working?

As an ED nurse myself, I see violence and abuse every day I work on the floor. A mixed methods research project in my department (yet to be published) was undertaken in late 2021 which attracted a 45.8% response rate (93/203 potential participants) on the subject. The prevalence of violence and abuse was much higher than we had anticipated (96.6% of all staff had experienced violence and abuse in some form in the last year/70% of staff had experienced physical violence). It prompted me to ask what protection mechanisms were in place and why they were not working?

Nurses live and work in a world that uses rules, often in the form of legislation. The law is a system of rules that regulate the actions of its members and which may be enforced by the use of penalties. Tensions between nursing practice and legislation that is required to provide measures of safety are apparent as they don't seem to be doing the job. I looked at a web of current protection mechanisms including the International ILO C190 convention; New Zealand legislation namely the Health and Safety in Work Act, 2015; the First Responders Bill; the Health Practitioners Competency Assurance Act (2003) and the inherent Nursing Council of New Zealand (NCNZ) competencies; and finally the NZNO Maranga Mai campaign in an attempt to answer that question.

The International Labour Organisation (ILO) promotes jobs and works to protect people in those jobs (ILO, 2019). In June 2019 the ILO developed the C190 convention which primarily recognised the "right of everyone to a world of work free from violence and harassment, including gender-based violence and harrassment"....as violence and harassment disproportionately affects women and girls. It also recognised that an inclusive, integrated and gender-responsive approach, which tackles underlying causes and risk factors, including gender stereotypes, multiple and intersecting forms of discrimination (including racism), and unequal gender-based power relations, is essential to ending violence and harassment in the world of work. Governments were asked to "adopt laws and regulations to define and prohibit violence and harassment in the world of work, including gender-based violence and harassment" but the New Zealand government has yet to ratify the convention. That is a real concern as current NZ legislation appears to be ineffective. If it was effective, violence and harassment in the workplace would no longer be part of our ED nurse experience. However, the New Zealand Council of Trade Unions (NZCTU) is currently working to influence the government to reconsider ratification (Ratify C190 - Together).

In New Zealand, healthcare organisations are required to provide a safe environment by the Health and Safety in Work Act (2015) for all healthcare workers, patients and members of the public (Richardson, Grainger, Ardagh & Morrison, 2018). Under the Act, Worksafe is New Zealand's primary health and safety regulator and has published control measures that include implementing a zero-tolerance policy against all forms of violence. However, the World Health Organisation (WHO, 2021) suggests optimal staffing levels, working time, supportive work teams and improved work conditions can reduce violence, but most Worksafe controls focus on how to manage the perpetrator of violence rather than prevention.

Under the Health and Safety in Work Act (2015) nurses also have a responsbility to report unsafe work environments to the employer. Understaffing, combined with increasingly high workloads, lack of time, perpetual exhaustion, time consuming reporting mechanisms, the acceptance by many that violence and abuse is part of the job, and the perceived lack of change in the health work environment in response to reporting, are reflected in low reporting rates (Richardson et al, 2018). Health and safety representatives (HSRs) working in ED's in NZ are placing increasing numbers of Provisional Improvement Notices (PINS) on their employers or PCBUs (Person Conducting Business of Undertaking) regarding unsafe work environments with little significant effect to date.

Another piece of legislation that is in the making is the Protection for First Responders Bill, which was first read in parliament in 2018 (New Zealand Parliament, 2022). NZNO advocated for nurses to be included in the bill but cautioned that it was more important for employers to do their part to make the workplace safe (Devlin, 2020). NZNO professional nurse advisor, Suzanne Rolls, stated that nurses also wanted "the triggers of violence to be removed...and called for Worksafe to do more than just provide guidelines" (Devlin, 2020). This perspective is echoed by others who criticised the bills intent, that a suitable punishment will deter perpetrators of violence and abuse towards First Responders (Hendry, 2020). Critics of the bill rightly stated that we should be looking for solutions that prevent victims of violence from being created in

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the first place by improving the conditions in which they work (Hendry, 2020). This means taking colonisation seriously and its impact on the underfunded and under supported mental health and addiction services, the impact of poverty and the current justice system that is seen by many to traumatise those who interact with it (Hendry, 2020).

Prevention is a key ideal in the Health Practitioners Competence Assurance Act (2003) as it provides a framework for the regulation of health practitioners in order to protect the public. The role of the NCNZ is to set standards to ensure that nurses are competent to practice under the Act. Nurses are expected to produce a professional portfolio every 3 years to demonstrate competence in order to obtain an Annual Practising Certificate. Competency 1.4 requires that Nurses promote an environment that enables health consumer safety. Specifically, nurses are required to "identify and report situations that affect health consumers or staff members' health or safety". Furthermore nurses are required to demonstrate that they can recognise and manage risks so they can provide care that best meets the needs and interests of health consumers and the public.

The HPAC and NCNZ however are silent on the obligations and responsibilities of those who enact the laws guiding the practice of nurses or how they will protect and prevent harm that occurs as a result of violence and abuse towards nurses. As a portfolio assessor, I have never seen any evidence provided by a nurse that suggests that they have adequate control and decision making authority, over their workplace, that supports them to meet the ideals of Convention 190, nor the legislation as described above. Disempowerment and continued gender discrimination of nurses, punishment rather than prevention of so-called perpetrators, are strategies that rule our workplaces.

Violence and aggression towards healthcare workers has been estimated to affect up to 90% of Nurses working in the Emergency Department (Jacob, van Vuuren, Kinsman, & Spelten, 2022; Richardson, Grainger, Ardagh, &Morrison, 2018). Overwhelmingly, most research points to environmental issues (such as nurse shortages, long patient wait times, drug and alcohol intoxication) as ED violence and abuse triggers. It seems to me that the government, Worksafe, and nurse employers are all failing collectively to protect and prevent violence and abuse, particularly in the Emergency Departments and Mental Health settings, wherein lies the highest prevalence. Nor are they being held accountable for their inaction under the current legislation. So, how do we, as nurses, hold government and regulatory bodies such as Worksafe and NCNZ to account?

NZNOs position on violence and abuse towards nurses is clear (CENNZ, 2018; NZNO, 2019). NZNO calls for a strengthening in accountability of government and employers through transparency and strong accountability mechanisms. These mechanisms need to be built into legislation such as mandatory reporting and penalties applied to employers under the Health and Safety in Work Act (2015). To date, these calls for action have not been implemented. However, I have to question whether transparent, mandatory reporting by government and nurse employers would help in the current context. Reporting requires data. Nurses are not being enabled to report violence and abuse in their workplace. Reporting mechanisms are time consuming and not user friendly. While this is a problem, it is also an opportunity.

Working collectively through our Maranga Mai campaign focusing on Health and Safety, has the potential to improve safety in Emergency Departments. The opportunity to challenge nurse employers (Te Whata Ora) to enable easy and meaningful reporting as discussed previously, of violence and abuse that occur in the workplace, will be a start. Negotiating a collaborative way forward with Te Whata Ora will require good data. Nurses, as noted above, do have an obligation to report. The lack of reporting makes the realities of violence and abuse in EDs invisible, and difficult to change. NZNO members must also work collectively to enforce health and safety legislation to be used to its fullest extent, and lobby for strengthened provisions and/or penalties that incentivise nurse employers to keep our members safe.

Making visible the unequal gender-based power relations and racism that contribute to violence and abuse on a female dominated profession such as nursing is also a must in this kōrero, as I believe it is one of the main reasons there is little impetus from government and regulatory bodies to get serious about reducing nurse shortages and inherent patient wait times in the short and long term. Maranga Mai requires that every NZNO Member, everywhere is active in our campaign. We are not alone in our fight for safety in our workplace, we have the power of 55,000 and counting, to create change for ourselves and those we care for. Let's do it.

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Clinical Issues Article:

When a patient says they're suicidal - what do I do?

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Category: Opinion piece:

Abstract:

Emergency Departments across Aotearoa New Zealand are often the first place that those experiencing suicidal crises present. This piece discusses how can ED staff feel more comfortable responding to suicidal distress given the already overwhelming demands on their time. ED Mental Health & Addiction (Acute Support) Educators, funded by the Ministry of Health, have been rolled out across Aotearoa New Zealand as a way of building workforce capability. 'Guidance for emergency departments' and the Australasian Triage Scale (ATS) are discussed and the need for sustainable education in EDs to safely support tangata whaiora (consumers) presenting with suicidal distress or mental health and addiction needs.

Acknowledgements:

Alicia Blacker, Annette Beautrais, Debora Anderson, Greg Davies, Jenny Smith, John Carson, Marguerite Watt, Maureen Treston, Renee Marsters, Simon Smith, Stacey Smart.

Emergency Departments across Aotearoa New Zealand are often the first place that those experiencing suicidal crises present. This may be due to the need for medical assistance following a suicide attempt or because emergency services have been contacted and have brought the person to 'a place of safety'. The desire to provide appropriate support and care for tangata whaiora (consumers) is clear, however ED staff often voice concern that they are unprepared to respond in a meaningful way when someone is acutely distressed.

Clinical Issues Article:

When a patient says they're suicidal - what do I do? Cont.

There can be a fear of accountability – "If I let them leave and they kill themselves or hurt someone else, is it my fault?" Staff also don't want to say the wrong thing – "What if I upset them more? What if that increases their risk?" Use of the word suicide itself can invoke concerns – "What if I ask them about suicide and it makes them think about it for the first time?" And there can be the fear of being assaulted – "What if this person gets angry when I try to treat them; what if they try to attack me?"

So how can ED staff feel more comfortable responding to suicidal distress given the already overwhelming demands on their time? Having some clear direction about how to support tangata whaiora and their whanau in a suicidal crisis will have a positive impact on patient experience, improve ED flow by reducing wait times and freeing up resources. The idea of having ED staff feeling comfortable and confident in conducting suicide risk assessments in not new.

There is a wealth of resources available to support learning, however competing pressures often means that mental health education is put on a back burner. The ongoing Covid-19 situation and continuing pressure on ED to manage over-capacity departments, staff sickness and never-ending roster gaps, are significant constraints.

ED Mental Health & Addiction (Acute Support) Educators, funded by the Ministry of Health, have been rolled out across Aotearoa New Zealand over the past 18 months as a way of building workforce capability. The roles were initiated in response to the Ministry of Health's framework 'Let's get real'. Whilst the job description for the role varies across the country, the goal is shared and simple – to support tangata whaiora by providing all ED staff with knowledge and skills to feel competent.

The ED Mental Health & Addiction Educator is responsible for building the capability and confidence of frontline clinical and non-clinical staff, when people present in crisis or distress. The role includes clinical teaching and orientation, being available for consultation for tangata whaiora presenting with any mental health or addiction need, supporting staff working with tangata whaiora, particularly Māori and their whānau, challenging discrimination, and supporting staff to effectively work with non-government organisation (NGO) communities. A network to provide support and further development for educators is facilitated by South Island Alliance.

These educator roles provide an opportunity to make sure that education around suicide risk assessment is readily available to the ED workforce on a more regular and sustained basis. There are a wide range of ways in which this can be embedded in the ED education schedules, whether through didactic teaching / simulation sessions or just having a mental health voice in team discussions and planning. This is an opportunity to change practice ensuring that not only is the journey through ED a more streamlined experience, but staff also feel comfortable to 'speak the language' of suicide and safety planning. Staff are therefore less likely to resort to taking safety measures which feel punitive and stigmatising. Evidence supports potential benefits of training for improving staff knowledge, attitudes, and skills, and of safety planning and follow-up contact for reducing repeat suicide attempts. (Zarska et. al. 2022)

'Every Life Matters' is the most recent suicide prevention and action plan that expresses the need for a system that allows those in need to access appropriate supports no matter where they present in the health system. "At every point, people should be able to expect and receive co-ordinated care." (Ministry of Health, 2019)

The reality is somewhat different to this aspirational goal. The geography and demographic diversity across the country means each ED has differing levels of access to mental health and crisis services with some rural services having lengthy waits for specialist review.

'Preventing suicide: Guidance for emergency departments' (Ministry of Health, 2016)

formalised the use of a standardised triage tool (figure 1). This tool allows nurses working at front-of-house in triage roles to conduct a brief (under 3 minutes) assessment and allocate an appropriate triage code which then directs the patient journey through the department. This tool is taught as part of the National Triage Training Programme run by CENNZ and is embedded within the expected career progression pathway for all emergency nurses, and many private sector RNs in urgent care roles.

This initial triage provides a starting point. Some EDs have built on this and created a pathway and mental health assessment tool for their staff to follow; others refer tangata whaiora directly to the local Mental Health Crisis or Psychiatric Liaison

Clinical Issues Article:

When a patient says they're suicidal - what do I do? Cont.

Team where those services are closely linked. Some EDs find themselves having to provide the support and 'manage' the safety of their patients for many hours until a specialist mental health assessment can occur.

The language in the triage tool requires the triaging nurse to assess risk of violence and aggression as well as differentiating between levels of suicidality and risk. The importance of effective communication in nursing care is widely recognised with good communication leading to better patient outcomes. (Lang. 2012)

This can pose a significant challenge for ED triage nurses working in busy departments with limited or no private space to conduct the conversation. Even once this obstacle is overcome, the average ED has few truly private spaces in which to hold such a conversation. Additionally, the triage nurse will be handing over the care to another nurse and is therefore unlikely to be the person with whom the distressed person has the most interaction with.

The Ministry of Health guidance document suggests a number of possible tools that ED staff might also use to follow up on the initial triage, including the ED Suicide Risk Assessment (EDSRA) and its brief subset (B-EDSRA), the Personal Health Questionnaire (PHQ-2) and acknowledges that staff should have access to training in specific suicide risk assessment as well as access to clinical supervision in order to support their ongoing wellbeing. (Ministry of Health. 2016)

Successfully implementing suicide prevention guidance in EDs requires that:

- a recovery-focused service is already in place
- access to the relevant ED and mental health services for people presenting with suicidal thinking and/or suicide ideation or attempt is in line with suicide prevention guidance
- the appropriate service configuration, clinical pathways and service linkages are in place to manage people with suicidal thinking and risk
- suicide prevention guidance is available in different formats for emergency staff (e.g. summaries, posters and decision support tools)
- the ED workforce is appropriately trained and/or upskilled in suicide assessment, management, treatment, referral and discharge planning
- the ED workforce has completed cultural training to increase skills in effectively managing people with suicidal thinking or risk, and their family/whānau
- emergency staff working with people who are suicidal have regular professional support/supervision to mitigate any personal negative impacts of this work, which may also affect the quality of their work
- a range of resources on suicide prevention are available in emergency departments for people accessing services, and for their families/whānau.

(Ministry of Health. 2016. p27)

For most EDs the environment, staffing levels and the demands on the services mean that some of these ideals are hard to meet. Many EDs will have the usual posters advertising services such as '1737' and maybe some leaflets about where to access support in a suicidal crisis. However, many have poorly designed overcrowded waiting rooms and limited access to quieter or more private spaces where distressed people can wait or be assessed in a less frantic setting. So how can we get from here to a better place?

Education on the principles of suicide risk and assessment is only a starting place. Moreover, the art of risk assessment is imprecise, and a lot of clinicians rely upon their gut instinct (Melin-Johansson et. al. 2017) when deciding about whether someone is safe to go home. This gut instinct is a combination of unconscious knowledge and skills honed over years of practice. In the same way as an experienced ED nurse will be able to determine if a patient is at risk of deteriorating even when they appear well, so does a mental health nurse have a sense of whether someone's safety is more at risk than they might have indicated in conversation.

The less experienced nurses in any area are likely to feel less confident in their clinical reasoning skills and will seek guidance from more experienced colleagues as they continue to develop their skills and knowledge. One of the issues faced by EDs is that even very experienced ED nurses may have had limited training in suicide risk assessment and therefore the tendency to err on the side of caution persists. This means tangata whaiora are kept waiting for specialist mental health services for long periods when this may have been avoidable.

Postscript – CENNZ are currently undertaking a project to review mental health triage assessment tools for use in EDs.

Clinical Issues Article:

When a patient says they're suicidal - what do I do? Cont.

AUSTRALASIAN TRIAGE SCALE (ATS)

Altered behaviour due to the use of Methamphetamine = Triage 1 or 2

ATS category 1 Immediate	ATS category 2 Emergency	ATS category 3 Urgent	ATS Category 4 Semi-urgent	ATS category 5 Non-urgent
□ Severe behavioural disorder with immediate threat of dangerous violence □ Possession of a weapon	□ Violent □ Aggressive □ Immediate threat to self or others □ Acutely psychotic □ Suicidal □ Homicidal threat □ Self-Harm with suicidal intent □ Requires restraint or □ Has required restraint □ Severe agitation	□ Very distressed □ Risk of self-harm □ Thought disordered □ Situational crisis □ Deliberate self-harm □ NO suicidal intent □ Agitated □ Withdrawn □ Potentially aggressive	□ Semi urgent mental health problem □ Under observation and or no immediate risk to self or others □ No agitation □ Irritable without aggression □ Cooperative □ Coherent history □ Reports anxiety or depression	□ Known patient with enduring symptoms □ Social crisis, clinically well patient □ Restless without aggression □ Cooperative □ Communicative □ Compliant
Observation				
Continuous visual observation 1:1 ratio	Continuous visual observation 1:1 ratio	Close observation minimum 10 min intervals Patient must have a support person present	Intermittent observation	Intermittent observation

Figure1: Australasian Triage Scale (ATS)

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Tackling workplace violence and aggression: Our journey so far, Whangarei ED

Author:

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One of the first projects that landed on my desk when I became ACNM 3 years ago three years ago was to address the concerns of ED nurses working at Whangarei Hospital about the perceived rise in workplace encountered violence and aggression.

I began the process by conducting a staff survey to identify specific concerns and the survey yielded the following results (*which from talking with colleagues nationwide appear to hold some commonality*):

Workplace violence Quality Initiative (July 2019)

Whangarei ED staff have raised concerns about being increasingly exposed to violence at work in particular:

- Aggression from patients and family including verbal abuse
- Aggression from intoxicated and "high" patients
- Aggression and violence from psychiatric patients
- Bullying or perceived bullying from peers

A voluntary survey of nursing staff has raised the following issues:

- No secure room for patients who are agitated and exposure of events to other patients and children.
- Minimal Training to deal with de-escalation and personal safety
- Minimal training around psychiatric crises
- Duress alarms currently go through operator to security which causes a delay for their response
- Poor control over access to department – anyone can gain entry by waiting at the exit door for it to open and no swipe control in back corridor
- No access to information on JADE
- Police need to leave and so often leave violent/aggressive patients before security are present
- Minimal security presence currently visible in ED
- Reporting episodes of aggression and violence on DATIX is problematic as the format is quite prescriptive and episodes often do not fit category boxes. Many staff do not use for this reason therefore DATIX is a poor reflection of actual frequency of occurrences.
- Perceived soft approach to tolerance by management, in the past not been allowed to put up posters saying we do not accept aggression or violence in ED. (MELT directive)

This survey coincided with the establishment of a Workplace Violence Prevention programme within Northland DHB whose appointed manager was very proactive in the development of a Workplace Violence Prevention Framework after initial consultation with staff members across the Board. The concerns of ED nurses were acknowledged and ED became the pilot program for the roll out of plans to identify and tackle the issues across the Northland DHB.

The WVP manager and I met regularly to tease out and progress issues and ideas with the full support of the CNM, CD and service manager. We looked at assessment and analysis tools used in other DHBs and a Workplace Violence Event Review document to provide some structure to our planning and implementation of ideas.

With the aid of these tools and direct problem responses to the issues raised in the survey have had a positive effect for the ED team.

Tackling workplace violence and aggression: Our journey so far, Whangarei ED cont.

Our successes so far have been:

- Raised awareness of the issue for both staff and patients/ visitors with signage. Increased support from management with a low tolerance for aggressive and abusive patients and visitors in the form of letters to offenders and trespass notices where appropriate. Police involvement where appropriate.
- Addressed some of the physical issues with our environment and the response capability from security and police. eg duress alarms, regular police liaison meetings, security presence in the waiting room and within department as soon as needed, extra security presence within ED over Christmas/New Year
- Support and encouragement for staff to report (Datix) episodes of violence and aggression to assist with quantifying issue and identifying hot spots and precipitating factors.
- Establishment of a mental health link nurse position within ED to assist with disturbed or distressed patients more effectively and support nursing staff with little or no psychiatric experience.
- Increased staff training. Initially this was delivered by an outside company but as part of the wider DHB WVP programme an in-house, high risk specific programme has been developed and tailored to the ED environment and is delivered to all ED staff.
- Identification and mitigation of aggression triggers eg Using EQ for the deflection of appropriate patients away from ED to take the pressure off wait times which was one of the identified triggers of aggression.

The areas that continue to be difficult for staff to manage are:

- Physical environment. Like many hospitals we have been screening, triaging and waiting patients in an open tent with the elements to deal with. These far from ideal conditions have resulted in an uptick in patient/whanau aggression as has the limit to visitors allowed into the department. Support in the form of increased security, dissemination of public information (local radio and papers, social media) and now the arrival of a port-a-com to replace the tent have helped.
- Aggressive patients with diminished mental capacity. We have noticed anecdotally that ED has become the go to place when patients are too difficult to manage in rest homes and dementia units. While in our situation these patients come to ED to be admitted medically they end up dwelling with us for extended periods of time as patient watches are often not available or ward placement is an issue.
- Our hospital often has problems with bed capacity for mentally unwell patients, who at times have aggressive tendencies. Currently there is no suitable secure physical space for such patients within our department so holding them for extended periods of time can be very taxing on both staff and the patient.

Overall the project has been successful with staff reporting increased confidence in managing aggression and feeling they are better supported around this. Further work is on-going but there has been a substantial foundation established to build on. We remain engaged with the WVP program and monitor datix reports for areas of concern, trends or developing situations. The physical environment of ED is also being tweaked with the addition of sliding doors on cubicles replacing the existing curtains. While this was done for COVID and infection control reasons it does promote a quieter/calmer environment and allows a modicum of privacy for patients.

Lucy Benjamin-Mitchell, ED RN

In Whangarei ED we have security guards dotted around the department. They are there to assist with de-escalation, or just make their presence known if a patient or whanau member is starting to get agitated.

We have one security guard at the main entrance of ED who supports the triage nurses in the COVID screening area.

Another guard is stationed just outside the waiting room, keeping an eye on our non-respiratory patients and supporting our waiting room RN and ward clerk.

A security guard does hourly rounds in the department, although with short staffing this is the role that seems to be missed of late.

The security office is stationed right at the main entrance of ED, and guards are readily available if we need them. They carry a cell phone with a direct line, and we also have the ability to call a “code orange” if we need security in a hurry. The code goes out all over the hospital speakers in case security guards

Tackling workplace violence and aggression: Our journey so far, Whangarei ED cont.

are elsewhere in the hospital. The code gets us a few security guards and the duty manager who are all geared up to help support our nurses, doctors and HCAs when needed.

In our screening area we also have personal alarms the nurses can wear out the front. When these are pushed, alarms go off on the ED floor, and in the security office. This alerts the need for assistance so the CNC, security, and other available staff can attend and help as needed.

All clinical staff in ED attend CALM+ study days, which teach both de-escalation techniques and break-away skills. This is part of the mandatory training provided in our ED. When an incident of violence or aggression occurs, we debrief as a team, and put in incident reports, which go to our Wellness Team. The Wellness Team contacts the reporter directly to ask if they require any additional support, or just want to debrief further.

Our CNM is also very good at following these things up with staff, and leaves her door open for debriefs. Although we are seeing an increase in aggression towards ED nursing staff, we are generally well supported in these instances by security, the CNC, our medical colleagues, HCAs and our CNM.

CENNZ Members

If you would like to highlight a colleague, we invite you to write to the editor at editor.cennzjournal@gmail.com.

We can provide you with a set of interview questions or you can create your own.

The WAVE Committee: Committed to Working Against Violence in Emergency

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Like every emergency department (ED) and urgent care provider, violence, aggression, threats and inappropriate behaviour are extremely common. Likewise, our culture often says it is ok to be subject to this abuse, that this is just part of the job, and not worth reporting. Of course, these issues are not unique to ED – they occur throughout healthcare (Geraghty, 2014; NZNO, 2019; Forbes, 2022). We also know that not everyone reports it, after all what actually happens? Does anyone do anything? It is reasonable to wonder if it's worthwhile.

A call to action

Under-valuing reporting was our culture here in Christchurch, and then in 2013 we got a shock. We discovered that our Board was receiving reports of falling rates of violence and aggression (V&A). Our team were naturally surprised to hear that we were being congratulated on this – our perceptions were that levels of V&A experienced by staff remained high, and if not actually increasing they were certainly not falling. This gave rise to the question of why there was this mismatch in understanding, and whose perception was correct? We found the Board's belief was founded on a fall in the reported incidents via the Health and Safety reporting system. The rates had fallen from 78 in 2011 to only 29 for all of 2013 (Richardson, Grainger, Ardagh & Morrison, 2018). We decided that we needed to identify the true picture, so, we carried out a focussed snap-shot audit in May 2014, called "May it's not ok", in conjunction with a targeted campaign encouraging all staff (from ED staff to staff visiting ED, such as orderlies, inpatient teams, and relief staff) to report all incidents of V&A. A total of 107 reports were received during that single month – a clear discrepancy.

As a result, we established the WAVE group (Working Against Violence in the Emergency department). WAVE is an advisory and monitoring group for the ED that supports the zero-tolerance approach to all forms of V&A. We meet every two months. We aim to promote safety for all ED employees, as well as patients and other bystanders, by reducing risks and to manage and monitor exposure to workplace verbal and physical abuse. We raise the issue to the highest levels in the organisation, of the prevalence and significance of exposure to V&A on a daily basis. Within the department, we highlight the importance of recognising, reporting and responding to V&A and are working towards local practice improvements and a broader quality and policy involvement focus.

While this group was initially a nursing led and nursing driven initiative, it rapidly became an ED multidisciplinary clinical and non-clinical group. WAVE now works with others outside of ED to promote a system-wide response to V&A and pursue initiatives that reduce the risks of exposure to and impact from V&A. Our membership includes the emergency team; Security; Specialist Mental Health, (who have already undertaken some of the steps we're beginning); Occupational Health, who reveal the reported toll it is taking and to learn what they are missing; Health and Safety (H&S) including the corporate H&S team, our ED H&S chairperson, and often an ED Health and Safety Representative (HSR); and members from the Wellbeing, Health and Safety – People and Capability team.

Ongoing work

The *'May, it's not ok'* campaign was intended to be repeated annually. One notable point was to see what impact the introduction of the digital reporting system had. The campaign

The WAVE Committee: Committed to Working Against Violence in Emergency cont.

identified that the initial increase in incident reporting achieved from the focus on V&A was subsequently reduced, with a much lower number of reports being submitted. A survey of staff perceptions regarding V&A included feedback that the digital tool was too complicated and time-consuming. This information contributed to the redevelopment and simplification of the tool. To improve uptake, one of our administrators volunteered to enter the data into the digital system, on behalf of staff. To facilitate this, a paper version of the tool was created and now the information is entered for the clinical staff. This has been well received and increased the reporting rate, however, with the ongoing increasing workloads for all staff including this administrator, data entry is still delayed at times. We continue to run the ED campaign annually, to encourage reporting of V&A towards staff and other patients and gather a snap-shot of real life. May is a good month as we have reasonably high numbers of presentations and no significant causes of happiness or unhappiness among the population. The data is reported back to service and operations managers, up to the Executive Board level. Any recommendations for improvement in processes are discussed within the committee before implementation.

Periodically we review a random selection of the V&A reports. We attempt to identify trends and then to take suitable actions. Reviewing them individually gives us a sense of what the reporter is experiencing and has helped form arguments for change based on true stories.

We support the Health and Safety Representative (HSR), in 2020 they worked with our CENNZ representatives to submit a Provisional Improvement Notice (PIN) to our DHB. A PIN is a written notice issued by an HSR to their employer asking them to address a health and safety concern in the workplace. Along with this PIN the CENNZ representatives presented a large number of incidents to the Executive Board, ensuring that they read them in a meeting, to drive home what our staff are experiencing each day.

Outcomes

One of the first things we identified was that there was no existing DHB-wide policy regarding response to V&A, in other words our presumption of an existing Zero Violence Policy was a myth, it was simply a poster on the wall with no substance behind it. Our questioning led to a corporate-level sub group being established to look at how this policy might be developed. This is ongoing work, and one which that is now producing a higher-level policy under which other initiatives are being developed.

Through our May it's not Ok campaigns we identified that there are multiple international studies linking this constant exposure to verbal violence with loss of job satisfaction, compassion fatigue amongst clinicians, and ultimately burnout. Burnout is increasingly in the media these days and cannot be underestimated with more and more healthcare providers leaving to find an improved work-life balance. This information was sought to support the report-writing to publish our campaign data, and our reports on the now annual campaign findings have contributed to various emergency conferences in Aotearoa NZ, as well as national print, radio, and TV media. We have published in academic journals and contributed in national governmental submissions (Richardson, 2017; Richardson et al., 2018; Richardson et al., 2019; Richardson, Grainger & Joyce, 2022). The WAVE group are also advocating for a national publicity campaign, similar to that in NSW Australia; however, this is currently out of our hands, but we continue to raise this in national forums as a viable response.

In addition to influencing change at the wider national and organisational level, we want to introduce systems within ED to help with the specific issues staff have identified. A number of initiatives have been introduced.

At the time that WAVE began the corporate orientation package around reporting, management of mental health patients, communication, de-escalation and restraint was already in place – although sessions were only brief. Over one year we focussed the annual ED team days on communication skills, with sessions from the police on de escalation and the role of the police in the removal, and potential arrest and prosecution of violent patients. We undertook a review of locally accessible training courses, to enhance the recognition of contributing factors to V&A, and opportunities to address possible trigger issues. Funding to support education and skills training for our large staff (approx. 130 FTE) remains a barrier.

For a while in the late 2000's we had an increased police presence within the ED in the form of randomly timed evening 'walk-throughs', sometimes with an accompanying police dog. This certainly had a positive impact with a quick settling down of perpetrators. Sadly, their capacity to continue this has diminished and it can now be difficult to gain a police presence, even when in the midst of a significant incident.

A funded role developing interdisciplinary management plans for patients designated frequent attendees, a proportion of whom were identified as having a tendency towards V&A, was introduced in 2008. Having these plans, that include input from mental health and the social workers, has helped avoid triggering of some patients, and enabled rapid assessment and disposition of others.

In the last few years we have also begun a process where letters are sent to patients or visitors who deliberately exhibit V&A. We describe the incident, provide an explanation as to why

The WAVE Committee: Committed to Working Against Violence in Emergency cont.

this is unacceptable behaviour, and notify them that the police will support staff should they wish to formally report such incidents, with a view to charges being laid. These letters are sent via the corporate lawyer's office. In some cases, the letters have resulted in apologies from the aggressor.

For our department use alone, we developed in 2016 the Aggressive Patient Pathway – a clinical document for managing challenging patients. We also developed another clinical pathway: Assessing competence in non-consenting patients, this pathway is used in multiple adult locations in the hospital. Together they give clinicians confidence to detain a patient or to allow (or enable) a person to leave the department. At present we are also developing an online Hospital HealthPathways Aggressive Patient pathway, which will improve access to the information.

In association with the Aggressive Patient Pathway, we introduced the BET (Behavioural Management Team). The team comprised of the on-duty senior clinical staff (SMO and ACNM), two security officers (including the team leader), and a psychiatric consult liaison team member to ensure additional support in crisis situation when patients become unmanageable. The BET call was triggered by a 777 call to switchboard. Initially this BET process was under consideration for a potential wider hospital roll out, however questions about clinical decision-makers were never resolved and it was not extended. We can still see that there would be great benefit for areas that receive undifferentiated patients such as medical admitting areas. To support the BET response, we created a 'BET box' consisting of various crisis medications ready for rapid use in ED with a copy of the Aggressive Patient Pathway. Six years later, the BET call is rarely made via switchboard as all the ED team wear voice-activated communication badges and the team is called using that. The BET box is still in regular use.

The most recent action, the 2020 PIN resulted in two improvement notices given to the CDHB for contravening a provision of the Health and Safety at Work Act 2015 and notifying the Executive Board of the need to provide support to address them. The recommended prevention or remedial measures were: Section 61 (1), to review procedures to ensure workers are provided adequate time to participate effectively in improving health and safety; and Section 58, to review and implement procedures for engagement with workers, to review and implement procedures to ensure workers have opportunities to express their views and raise health and safety issues, and to ensure workers can contribute to the decision-making processes. From this we have been able to contribute to a national working group that is looking at V&A in the broader health system. We are using the lessons learnt in the pilot actions of our mental health colleagues to assist in this. We also now have dedicated HSR time to undertake their activities.

A significant number of outcomes have occurred since WAVE began, but the difficulties in encouraging staff to report, and to do so consistently, remain. Overall, WAVE has been very productive. Yet we're still facing increasing frequency and level of V&A. WAVE has given us a voice to make change, to make us visible. That said, it is unlikely that our team will become redundant. We believe that it is important that nurses take V&A seriously and recognise the impact of it on themselves and their families, their colleagues and their families, their patients and witnesses. It is critical that we stop the culture of acceptance of V&A as the 'norm' within healthcare. We can make changes, and the first step is to make it visible; this requires reporting it, measuring it and elevating it to senior management – the people who hold the purse-strings. If we don't inform the leadership of the true picture, they cannot help.

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Security services and responses: Taranaki hospital Emergency Department

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The 200-bed Taranaki Base Hospital, Te Whatu Ora Taranaki, is the main regional hospital for the New Plymouth district. The current Emergency Department is a 23 bedded facility which includes two Resuscitation Bays and six isolation beds (with negative pressure capacity). The department see's on average 100 patients a day, which is approximately 35,000 annually. Staffing is currently 48 FTE with an approved additional 7.5 FTE to assist with capacity coverage as a result of the surge from COVID. However, recent TrendCare data has identified that the recommended minimum staff needed currently is an FTE of 56 as a baseline. While able to achieve the existing minimum 48 FTE, it is proving more difficult to move towards the 56.

Recent focus has shown that the ED, in line with others around the country, is facing the impact of staff shortages, long waiting times and rising numbers of patient presentations. It was reported that more than 1:5 people are waiting at least 6 hours for treatment, and 2021 saw annual patient numbers through the ED of 34,583. This equates to around 710 patients per week, with 200 coming in on weekends (Harvey, 2022).

Violence and aggression have been noted to be problematic in ED settings nationally. In the Taranaki Base Hospital (TBH), the most common form of violence experienced has been that of verbal abuse, often at the triage area. This is a common occurrence, being present within the ED on a daily basis. Fortunately, this rarely escalates to physical violence, with reporting of a physical assault estimated to occur around once a year. The more serious incidence of violence or aggression are currently reported through the electronic incident reporting system, Datix. These vary in nature, although estimates suggest an average on one security incident a month.

Security presence has been stepped up across the TBH since the beginning of the year. This is partly due to COVID, but also due to increasing incidences requiring security presence. Within the ED specifically, we now have two security guards 24/7. These two guards are exclusively focused on the ED environment, with all our security staff contracted through a local service provider. The development of a healthcare Security Operations Manager role, to provide overall co-ordination of the security service has further enhanced the ability to respond effectively to incidents. As part of the on-going focus on providing a safer environment additional recognition of the need for developing and reviewing policies, governance structures and acknowledging the standards of practice for security personal in accordance with NZ protective security requirements.

Additional developments have included the introduction of a hospital wide Personal Security Safety course (2 days), and this has been supported by the ED with the aim to upskill security within the depart, by raising the level of security awareness for all staff. This course is provided through an external provider (CERT). A Pilot course was run mid-year in ED, with a mixture of staff from a variety of roles including RNs, Doctors, Security guards, orderlies, and reception staff. The decision is currently with the executive leadership team to determine whether this course should be made compulsory/mandatory.

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Mental Health and Looking after Yourself: part one

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Here we are! We have made it to the pointy end of yet another year. In many circles 2022 has been crowned "The Worst Year Ever" snatching the dubious title off the former worst year ever, Miss 2021. Perhaps that is a bit dramatic. But it is undeniable that we are in the thick of challenging times, no matter where you look. Spring is well and truly in the air, summer is just around the corner and we are a nation of summer enthusiasts, looking forward to beach days, BBQ's and long summer nights on decks. The "winter flu's and virus's" are slinking off into the distance, making way for hay fever, sunburn and festival injuries. The hum of a new season and summer holidays does a lot to pretty up a scruffy year. So why would I choose to write about depression now?? I was intending to write about violence in the workplace, a not irrelevant topic given the summer boozing that is around the corner. Well, the change resulted because one of the things I started thinking about was how much I have heard the words "coping, stress, crisis, burn out, challenging" mentioned in professional groups, by nurses, managers, teachers, by members of the public, by friends, and in the media, over recent times. And when I look around, I see people who are tired. It has been a long, hard year.

I recall my ED manager quite rightly saying, that despite COVID 19 being in our world and part of our vocabulary and having caused trouble for a couple of years already, that "this year has been OUR pandemic". There's so much research being done now on the impacts of COVID 19 psychosocially, in terms of mental health , politically, and economically. But we don't really need to look at the research to know what we can see with our own eyes. It's had a significant impact on everyone, directly or indirectly, no one is unaffected.

On top of that, our nursing workforce is not healthy. We have a nursing crisis, one that has been a good many years in the making. Many nurses have warned this exact situation was inevitable if things kept going the way they were going. I remember hearing the forecast staffing crisis being talked about more than 15 years ago. The writing has been on the wall, and nurses have been hitting the panic button about it for a LONG time, only to be ignored and left feeling unheard and patronized by "experts" with inadequate solutions. The absolute pressure nurses are under is unthinkable really. I was lucky when I was a NESP (New Entry to Specialist Practice) in that I had many senior nurses and middle year nurses who taught me so much and imparted their philosophies, and pragmatism. They role modelled real-life skills and how to have fun at work. These days nurses are all in the deep end, there are seemingly endless nurse vacancies with no one to fill them, high staff turn-over, and huge demands on services. The sick are sicker, budgets are tighter, stays are shorter, and the list goes on. And it's not going to be changing any time soon, despite recruitment campaigns.

So, that is why, instead of managing violence in the waiting room, I'm going to talk about recognising signs of stress/distress/depression in ourselves. This is a broad overview, and not an exhaustive list. I think all nurses could identify the check list of symptoms for depression. But in reality, symptoms of depression can be more nuanced. And how do you know when a normal dip or stressful time becomes something of clinical significance? Because the tricky part of depression, is once you're in it, it can be a lot harder to self-identify. Good one Depression!

You may read this and feel it doesn't apply to you right now. Be that as it may, it could be useful to file this away into your brain bank for future reference. Or you may read it and think it applies to someone you know or work with and could give you a starting point in having 'that conversation'. So please, read along with an open mind. Some of this talk references my own experience of post-natal depression (PND), which snuck up on me after the birth of my second child. I knew all the mental

Mental Health and Looking after Yourself: part one cont.

health screening stuff, and yet it still took me by surprise. That experience gave a me a whole new perspective on sneaky nature of depression, that's for sure!

Let's start with thoughts. Across the day, we all have a gazillion different thoughts. Some of them we are aware of, some of them we don't even really notice. We often don't notice how noisy and thought-filled our heads are until we try to sleep at night or try some sort of meditation or mindfulness activity.

Then suddenly, we become aware of how busy our brains are. Of all these thoughts, some are boring, some task orientated things, some are funny quirky things, memories or random ideas. Out of all these thoughts and images, some are dark, strange or even violent. These are normal fleeting thoughts we all have. In good health, we don't really give these thoughts a second go. They're in, they're out. We might think "that was dark" or "that was odd". But EVERYONE has them. It is normal. It's when the scales tip and we are getting more stressed, anxious or low in mood, that the strange thoughts can be more frequent and darker. The thing about these thoughts is that they are thoughts you are never going to act on. They are just thoughts without intention. They can be strange, confusing or random and quite ego dystonic, (that is, thoughts that are vile or unacceptable to who you are as person), but they are just mind junk and have no meaning or chance of being acted on. I was actually a mental health nurse with a couple of years practice up my sleeve before I remember being taught about thoughts and when they are or aren't a concern. And in the years since, in many conversations, a lot of other people identified they also didn't know such thoughts are normal. So, you might not have known that too. All those weird and wonderful thoughts, even the fleeting death thoughts, are normal. You have them, I have them, he has them, they have them. We all have them. To a point.

The thoughts become a warning sign that all is not well in your mood or anxiety-scape when they become more persistent, and dark. When ideas of (*insert random intrusive death fantasy here*) are becoming a regular theme, not an occasional background thing you don't really notice, then it is time to take note. You may notice that your thoughts in general become a bit slower, or your thinking feels a bit foggier. The variety of thoughts may seem less, as more repetitive and worry inducing thoughts creep in. You can feel like you need more effort or concentration for regular thoughts and memory. Anxious, worrying, negative, morbid thoughts easily meander in and seem to be getting more comfortable roaming around the forefront of your mind. This is when you might start to take note, something might not be going well in the mood or anxiety department. You, the owner of the brain, can observe your thoughts: watch these thoughts, trying not to attach too much (or any) value to them. Just observe: are there times when they are worse? How often are they occurring? How do you feel about them? These are going be good clues in the bigger picture.

That reminds me of another 'funny' quirk in the slow unravel of depression... Your memory and concentration hold hands and skip off together into the sunset, leaving you constantly chasing your tail looking for keys, forgetting appointments and generally wondering what the heck you just came into this room for. You can feel like you're losing your mind, and just hope no one notices! This is one of things that can be put down to a lot of other things, especially in older folk. We can easily dismiss fogginess, memory and concentration lapses as part of old age, menopause, grief, parenthood or any other number of things (such as post Covid 'brain fog'). But it's important to not dismiss depression or anxiety as a cause. I have often thought about how it must be to be very old, when friends and family are passing away, and certain independences start getting lost. We tend to expect that older age can be a time of many griefs, and perhaps there can be a non-intentional, non-malicious kind of overlooking of the impact depression can have on this age group. Which is an injustice, when you think that in many cases, assertive treatment of aggression can really restore so much quality of life. Food for thought.

Next stop, we might look at your thinking style now, since we are here on thoughts. One of the things to notice is the more under stress we feel, the closer to burn out we get, the less flexible we are in our attitudes and thinking styles. Its like we have spent all the energy doing what needs to be done, we run out of energy to fuel our mind to be able to be flexible. You know how it looks! someone who is usually adaptable and flexible is suddenly short fused, and small changes become huge inconveniences. You might feel like you are walking on eggshells around this very irritable and grumpy person, and they radiate a vibe that everyone around them is a flaming idiot. Or it could manifest as feeling easily overwhelmed, unable to pivot or change track once starting on a course of action or clinging to the outcome even when it's obviously unachievable. It can be impossible to make decisions and hard to act if something happens outside of the plan. These symptoms can be a stress response, but it's a stress response that seems to make stress worse (how silly)!

We can all get to this state. Sometimes there's so much going on, at work, at home, not enough sleep, too many things to do, juggling all of the things, then we have a bit of a mental melt down and suddenly can't make even a simple decision without really overthinking it, or we sort of combust when something doesn't go to plan. Sometimes we are so busy and stressed We. Just. Need. Everything. To. Go. As. It. Is. Supposed. To! And sometimes that includes not being yelled at by family members in the waiting room or having the IT system suddenly run at snail speed when we are getting information for the yelling family member, and we need all the medications to arrive when they are supposed to and the meeting to actually run to time... and BIG BREATH sometimes, (and often), that is not the case. When we are in good health, and good coping we can just accept those things for what they are. They are challenges, a

Mental Health and Looking after Yourself: part one cont.

run of bad luck, annoying for sure, but certainly not a personal attack or set up. When the anxiety is high and a low mood is throwing negativity hooks into the mind, it can start to seem like part of some larger conspiracy, trying to make life harder or show how little you are valued. When we are not in optimal mental health, and anxiety and low mood is creeping in, then we have much less humor or mental flexibility, and we start to think everyone, and everything is a hassle or not on our side. If this sort of thinking is creeping in, then we need to take note.

More clues that depression and anxiety might be setting up residence in your mind is the constant exhaustion or tiredness despite rest. Low mood and anxiety both have the ability to make someone feel very tired. Like bone tired. Low energy and easily drained. Obviously sometimes we are very busy times with hectic schedules, extra shifts, long trips, a weekend of renovations ... But a rest, a good sleep, a wee holiday and we feel restored. Depression tiredness does not really respond to this. Depression tiredness can take away the desire to do thing that you would usually find enjoyable. AND, as if that's not bad enough, if you do muster the energy to do the thing, joy is harder to access, less intense, shorter in duration or worst of all, no longer there! Depression tiredness sits there no matter what you do. It does not recover with a nap. It's another one of those insidious symptoms we can push under the rug and soldier on through to a certain extent. But it takes SO MUCH EFFORT to do it. So much effort, that we are quickly exhausted again. If you are finding yourself very tired, easily tired, not enjoying activities you usually like or consistently have no energy for things, take note. And don't forget changes in sleep pattern too, either over sleeping (the untreatable exhaustion), or under sleeping or frequent waking (which we then attribute all the other symptoms to). Changes in sleep patterns can be a symptom of many things, so in and of itself is not enough. But if you are experiencing changes in sleep pattern and any of the other things mentioned, keep an open mind to it being a side effect of depression.

Feelings of saddens, hopelessness, "what is the point-ness", irritability, angry outbursts can be part of the picture. Feeling guilty, a failure, not good enough, or a fake are very common and uncomfortable feelings (the nursing imposter syndrome comes to mind). Sometimes the low self esteem and worthless feeling that are part of depression can tell people that they don't deserve help, or they'd be wasting someone's time. the depressed and anxious mind can spin a yarn out any interaction, turning small things into giant mental chew bones to ruminate over and feel worthless about. The cycle of difficulty functioning, feeling crappy, thinking crappy becomes a concentric circle that just reinforces itself if left to its own ill-devices. Some people can putter along, in this state of getting by, but not really happy for weeks, months or years. For other people it keeps spiraling until the guilt and shame and worthlessness and hopelessness are all that remains or makes sense, so that suicide seems to be the only solution. Depression isn't terminal, but it can be lethal.

Some people (a whole lot actually) adopt alcohol or other drugs or addictions as a sort of buffer. Booze and other drugs dull out the low mood and anxiety and drown the thoughts. Sometimes alcohol and other drugs can allow a sense of feeling something through the fogginess. But they also compound the low self-esteem, impaired sleep, and anxiety that contribute to a depression. This is one of those home-made solutions that eventually does more harm than good but does a reasonable job of publicly masking the depression to those not in the know.

Some people (again, a lot of people) do nothing and wait and hope for it to pass and that no one will notice, or even just accept this is just how they feel, and this is just life. Maybe the depression has their self-esteem so low they believe that. Or think it's not bad "enough" or a waste of someone's time to seek help. These are things we only say about ourselves, which makes me think this is the bastion of mental health shame/stigma we are facing as a culture. Why do I say this?? Because with all that being said, if it was your best friend telling you they felt like that, and it was your best friend confiding that they are struggling to concentrate, to sleep, to feel rested, and that they had intrusive thoughts about death or running away or whatever, then you would NOT say *"yeah you're right, waste of time trying feel better like you used to, definitely just put up with this subpar quality of life because you don't want to waste anyone's time getting treatment for a treatable disorder"*. I MEAN, COME ON!! We save that brutal judgement for ourselves.

So, if any of this sounds like a bit of you, or a bit of your mate or colleagues, have the conversation about it with someone you trust. Do see your GP or EAP or have a look at the Mental Health Foundation website, or have a look at depression.org.nz, call lifeline or your local Mental health crisis team immediately if you are feeling like you may have to end your own life. There is so much help and support out there, and groups and services that can help get you over the line on the path of wellness again. Unfortunately, I have used up way too many words, and have no more space to talk about resilience today, but I will next time, because that is a big part of the solution. In the meantime, be well! Be mindful! And keep going! 😀

An overview of security at Middlemore Hospital Emergency Department

Authors:

Wendy Sundgren and Sandy Richardson

The Emergency Department at Middlemore Hospital has 27 adult assessment rooms, two adult procedure rooms, a dedicated plastering room and an ENT (Ear, Nose & Throat) room. There are also 24 beds in the adult short stay area for patients with an 'expected' discharge period within 24 hours from arrival that are utilised by all teams providing acute care. The Emergency Department also has a separate area for paediatric services (Kidz First Emergency Care). This includes two resuscitation rooms, 14 acute assessment rooms and a procedure room. There are also 13 beds in the paediatric short stay area (Te Whatu Ora Counties Manakau, 2022).

The ED is facing many of the same issues as other departments across the country, include high patient presentations and the need to manage the associated delays and increased waiting times. Reporting on the situation at Middlemore in June of this year, Anderson (2022) identified record numbers of patients presenting to ED, with one staff member quoted as saying that staff are under enormous pressure, with an all time high of 213 patients being seen on one day in May. As the patient numbers increase, and staff sickness continues, the level of stress and exhaustion is an ongoing problem. Against this background, the continuing issues of violence and aggression towards healthcare staff need to be remembered, and the security responses available identified.

Wendy Sundgren, Associate Charge Nurse Manager (ACNM), outlines the security response available at Middlemore ED:

In the Middlemore Hospital Emergency Department, we have a security pod based at the triage doors. This is usually (wo) manned by approximately 4-6 guards; while they may be stationed here they are also responsible for responding to other areas within the wider hospital. There are at least four other security stations based within the hospital, however, the resourcing of these fluctuates throughout the day. Our security team, like most others, has not been exempt from the staffing/ resourcing challenges faced across the globe.

We also utilise Health Care Assistants who work in the role of patient 'care partners' (previously known as 'watches'), who are assigned to work with patients, in order to facilitate patient safety. Again, the demand for patient care partners almost always exceeds the supply. In some circumstances, we do order external security guards to support patient and staff safety in this instance. Where possible, Health Care Assistants carry a personal alarm, which they activate if they identify a threat to patient or staff safety.

When a threat to staff or patient safety is identified, we have an emergency activation system known as 'Code Orange'. As per the CMH Paanui site, "Code orange is defined as any situation in which staff may feel threatened or are subject to aggressive, verbal or unusual behaviour" (para. 1). When this is activated, security, the ED ACNM and the supervising ED Senior Medical Officer (SMO) attend the location where the incident is taking place.

It was acknowledged that incidents of violence and aggression were being underreported in our department. The reporting process itself was identified as a barrier to staff reporting; in particular the process was described by staff as confusing and described as taking too long. Middlemore ED has since implemented a simplified 'Code Orange' incident form. These forms are not just used for incidents where a 'Code Orange' emergency call has been activated, but for all incidents of patient/whānau aggression and violence (including verbal abuse) in the ED. The forms are quick and easy to fill out. Introducing such reporting processes has encouraged an increase in reporting. There were 49 Emergency Department

An overview of security at Middlemore Hospital Emergency Department cont.

Code Orange security calls in the month of September 2022. This only identifies the incidents involving aggression from patients where a staff member activated the 777 call out and is not likely to represent all of the violence and aggression that occurred that month. A final move towards addressing the issue of violence and aggression in the ED that has occurred more recently, is that the ED has also started rotating staff through MAPA® (Management of Actual or Potential Aggression) training.

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Anderson, R. (June 09, 2022). 'Frightening' to work at Middlemore Hospital as ED sees 400 patients a day. Stuff Health News. Retrieved from: https://www.stuff.co.nz/national/health/300608861/frightening-to-work-at-middlemore-hospital-as-ed-sees-400-patients-a-day

Crisis Prevention Institute. MAPA® (Management of Actual or Potential Aggression). https://www.crisisprevention.com/en-NZ/Our-Programs/MAPA-Management-of-Actual-or-Potential-Aggression

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Children's Emergency Care opens in Waipapa

Reprinted with permission from Te Whatu Ora Waitaha Canterbury Pānui 12th Sept 2022

Our Children's Emergency Care (CEC) area opened today to children requiring emergency care.

This new space means that children and their families presenting for emergency and acute care are now treated in an environment designed to meet their needs, separate from adult patients and adult activity in a busy Emergency Department (ED). A child-friendly and specific environment is considered international best practice.

"It has been a long-term aspiration of Child Health and Emergency staff to provide children of Canterbury with a dedicated space," says Clare Doocey, Chief of Child Health.

"We worked collaboratively with our ED colleagues to design a space specifically for children so that we can reduce the stress that coming to hospital causes and streamline care for children. I am really excited that this area has become fully operational."

The space was constructed when Waipapa was initially built, with a plan to co-locate services for children requiring emergency and acute care. Along with children who are currently being treated in the main ED, Children's Acute Assessment is also a part of CEC and provides a high-quality assessment service for children and young people referred with acute medical and some surgical conditions. Consultation has been ongoing since 2019 on how to adequately fund and resource this area. Knowing it is the best thing to do for children and young people, funding was approved in 2022.

Tracy Jackson, Nursing Director Women's and Children's Health, and Anne Esson, Nurse Manager Emergency Department, have been working together with their nursing teams to develop a model of care for this area which consists of one joined up team providing nursing care focussed on the needs of children, young people and their whānau.

The space has 23 beds and additional nursing and support staff have been employed to create the team working in CEC. Medical and Allied Health staff from the Emergency Department and Child Health will work in the CEC.

We would like to thank all people across many services who have worked towards the opening of this space.


1.


2.


3.

Image Captions;

1. *The warm and bright waiting area of Children's Emergency Care*
2. *The consult bays in CEC are decorated and child-friendly.*
3. *Registered Nurse Michael Streeter and Acting Charge Nurse Manager Emma Payne check equipment in the Children's Emergency Care Area.*

Paediatric Pearls - Scratching the itch on scabies

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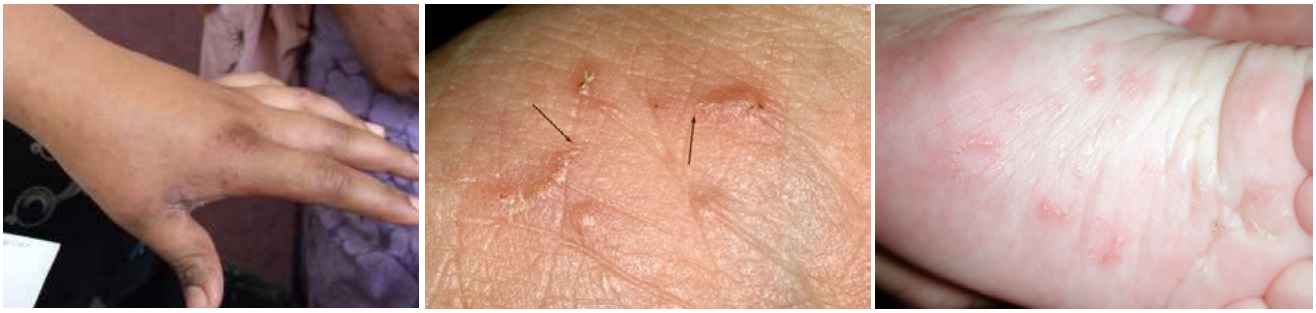

Images: Dermnet

Scabies (mate māngeongeo riha) is a common, highly infectious skin condition spread through close bodily contact. It is caused by a tiny mite *(Sarcoptes scabiei var. hominis)* that burrows into the skin and lays eggs. The hatched eggs cause an allergic reaction via a TH1-mediated hypersensitivity reaction which causes the classic itchy erythematous rash (Maguire, 2022).

Scabies is seen across the life span but is highly prevalent in New Zealand children (Thornley et al., 2022). It is crucial that emergency department staff are able to recognise scabies as correct recognition and timely treatment will help prevent transmission and reduce the burden of more serious illnesses linked to scabies - including cellulitis, post-streptococcal glomerulonephritis and rheumatic fever (Thornley et al., 2022). In addition, recognition and appropriate treatment will reduce the inequitable burden of scabies and its sequelae on Maori and Pacific children, and those living in socioeconomically deprived areas and overcrowded living conditions (Maguire, 2022; Thornley et al., 2022)

Is it scabies?

Diagnosis is a clinical one and is made based on lesion history and distribution and is made easier if another family member has a similar itchy rash (Hong et al., 2010). It can be difficult to differentiate scabies from other common paediatric rashes such as eczema and itchy bites, or it may be complicated by impetigo (Thornley et al., 2022). Scabies can be classified as classic, nodular or crusted (bpac, 2022). Classic is the most common and will be discussed here. Below are a few pearls to aid in recognising classic scabies:

- The rash appears as erythematous papules (raised red, symmetrical lesions) associated with excoriations and linear scratch marks.
- The rash is associated with widespread itching that is worse at night or worse after a hot bath/shower.
- The rash is distributed in an acral way- commonly around hands and feet and in web spaces. Children may also have a rash over the face, scalp, palms, and soles of the feet and nappy area. While most children will have the head and neck spared, this is not usually the case in infants.

- Search the skin for burrow marks. They may be seen but are very subtle and appear as thin, browny-silvery wavy lines about 5-10mm in length (Maguire, 2022). They may not always be present.

Treating scabies:

Scabies must be treated. However, the typical treatment can be awkward for a family/whanau to navigate. Good robust nursing education can make all the difference to ensuring scabies is treated adequately.

- Treatment is as per the prescriber, but topical 5% permethrin remains first-line therapy for classic scabies (Maguire, 2022).
- It should be applied to cool dry skin (not immediately after a bath or shower) and over the entire body (avoiding the eyes and broken skin), not just the itchy areas including under the nails
- Leave Permethrin on for 8-12 hours. Applying it before bed works well. If an area is washed during that time i.e. hands, it should be re-applied.
- All members of the household must be treated at the same time even if asymptomatic to reduce re-infestation
- Scabies should improve within a few days and resolve within a month of treatment (Swinburn, 2022).
- Symptomatic children should be treated twice, one week apart as the original treatment will not have covered any recently hatched larvae
- A post scabetic itch may last for weeks after infection- antihistamines or mild topical corticosteroids may be helpful (bpac, 2022; Maguire, 2022). However, if symptoms are not improving or are worsening the clinician needs to consider incorrect diagnosis, secondary infection, inadequate treatment or reinfestation and other specialist input.

General measures:

- It is important to reassure families it is not associated with poor personal hygiene.
- Encourage the family to launder sheets, towels, and clothes worn recently in hot water. Outer garments, duvets, and blankets should be aired for 72 hours. Vacuum soft furnishings where possible.
- Keep nails clipped and short.

Key points:

- **Scabies is more prevalent in New Zealand than previously realised.**
- **It is highly infectious and easily spread in our community.**
- **Given the accumulating evidence of association between scabies and serious complications the need to control scabies is growing.**
- **Emergency nurses are well positioned to assist in the recognition of scabies and provide education about treatment of scabies to patients and whanau.**

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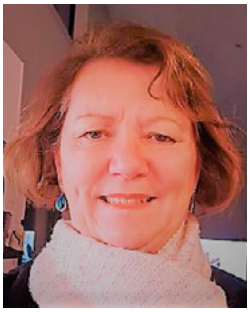
NP tips, tricks and trips



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Eyes – Foreign bodies in particular

Aim; triage and acute care nurses, a wee introduction ☺

Groan, I hear, "I hate eyes, don't know what to do...." but actually there's lots you can do.

Let's set the scene: a recent case I had. A lady presents, history of sewing five days ago, felt a sharp pain in her eye, thinks a bit of the needle somehow popped into her eye. She couldn't see it and couldn't find any broken needle either, hmmm. She rinsed her eye and went to see her GP who treated her for FB eye with appropriate eye ointment. When the pain didn't get better she went back, no rust ring was visible, so she was referred to ED for a slit lamp examination. The triage nurse wanting to give an appropriate triage from GP to ED asks me what I would do as it was now a 5-day old injury. Still a bit sore but thinks she is losing her vision.....hmmm FB? *Interesting.....*

RED FLAGS

History of penetrating injury – high velocity

Consider

- Take a really good history
- Visual acuity – in all eye patients.
- Analgesia

History

- Where/when is it sore? Is it all the time, when they blink, when they look into the light, when they move their eye?
- What they were doing at the time?
- What sort of equipment or tools?
- Velocity or speed involved?
- Eye protection?
- Did they rinse/irrigate?
- Previous injury or trauma?
- Is it itchy, red, does it discharge, and if so is it watery or pus?

What do you think it is?

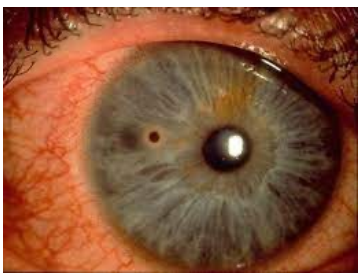
What can you see, wounds, shape of pupil, discharge, colour, swelling?

Tell the NP or MO what you think it could be, it's about you learning.

Pain

Most often, when it is a FB, the patient will be able to tell you the area that feels most painful, and sometimes this is because it has scratched the cornea or is still there.

If the object is still there you can often see it, use your ophthalmoscope (or a torch) and look.



Obvious FB - this you will easily see with a torch

Analgesia; Pop some anesthetic drops in; (if you have the standing orders to do so).

This will assist you to be able to do the visual acuity and open the eye to have a look.

Anesthetic eye drops; nzf

Oxybuprocaine; Ocular anaesthetic; Eye drop (0.4%)

Adult 1 drop in the eyes(s) according to procedure; or corneal foreign body removal 3 drops at 90 second intervals

Tetracaine; Ocular anaesthetic; Eye drop (0.5% or 1%)

Adult 1 drop in the eye(s) as required

Simple analgesia paracetamol and or ibuprofen as per local guidelines. Often we forget this, but once we have the FB sorted we should send them home with good advice around pain relief.

Visual Acuity;

I am often surprised at the number of nurses who are quietly confused at the process for measuring visual acuity– and I was too initially.

Visual acuity (VA) is a measure of the ability of the eye to distinguish shapes and the details of objects at a given distance. It is important to assess VA in a consistent way in order to detect any changes in vision. One eye is tested at a time.

Use an eye chart, most commonly a Snellen but there are many different types, so consider particular needs including those of children, or those who can't read the alphabet.

The patient stands a stated distance, usually 6 meters sometimes 4m. This distance is the first number when you are writing down the results.

One eye is assessed at a time.

Ask the patient to use their glasses if they have them for distance.

Cover one eye and ask them to read from top and then record the lowest line number they are able to read. Write this as 6/the line number.

Repeat with the other eye.

If they have not bought their glasses or the result is decreased use the pin hole and do both eyes again.

Record as VA Left 6/6 – corrected if glasses, or pinhole.

This chart has feet on left and meters on right, so is a 6m or 20ft chart.

If the patient can see some of the line, not all you can write e.g. Left eye 6/12+2 corrected, which means they can read all of line 12 plus 2 from the next line with their glasses on.

Taking the history, sorting out the pain and doing the visual acuity is incredibly helpful to the MO's, NP's and ophthalmology folk when attending these patients.

As for my lady, she had a curtain of decreased vison on that eye, no pain, no red conjunctiva or discharge. She had a retinal detachment visible on direct ophthalmoscopy and was sent to the eye doctors ☺ See, its all in the history and the nurses at the front door had already suspected it was more than a foreign body. Excellent.

Anyway that's what I like to do and I love it when the nurses at the first point of call come and ask me, what do you think? And can I? *Yes you can*

Lots of extra reading;

The eye emergency manual,
https://aci.health.nsw.gov.au/__data/assets/pdf_file/0013/155011/eye_manual.pdf#page=36

Canterbury health pathways,
https://canterbury.communityhealthpathways.org/25459.htm
http://kellogg.umich.edu/theeyeshaveit/common/foreign_body_sensation.html

oxybupicaine, tertaracaine, NZF
https://www.nzf.org.nz/nzf_5961

Life in the fast lane;
https://litfl.com/eyes-wide-split/

Reviewer: S.Richardson, RGON, PhD

Journal and Publication Reviews'

Review

Ministry of Health. 2022. Evolution of Racism and Anti-racism Literature Review & Summary Document – Whiria Te Muka Tangata. Wellington: Ministry of Health.

Published online: 25 August 2022. Available as a full text pdf or a summary document from https://www.health.govt.nz/publication/evolution-racism-and-anti-racism-literature-review-summary-document-whiria-te-muka-tangata

This literature review is the first of a series of intended works, forming phase one of Ao Mai te Rā: the Anti:Racism Kaupapa, commissioned by the Ministry of Health. It provides an overview of the history and presence of racism within health and disability services, identifying how it has been perpetuated together with the implications and associated concepts. It is relevant, readable and recommended for anyone working in health. For nurses, the inclusion and discussion of cultural safety within the wider context adds to its relevance for our profession. The inclusion of a glossary of terms provides a useful orientation at the beginning of the work, and its intention is given as being to "trace the evolution of the philosophical and ethical underpinnings of racism and anti-racism for Aotearoa | New Zealand" (p.6).

A timeline of key events within Aotearoa/NZ history in relation to racism/antiracism is presented, and the concepts of racial categorisation, shifts from biological to scientific racism and the role of colonisation are considered. The consideration of cultural racism, the shift from purely race based ideas of superiority to cultural justifications for prejudice and racism provides a thoughtful platform for discussing the wider implications of institutional and systemic racism. Having introduced the broad concepts and defined the associated processes, the authors then look more closely at health inequities and race, and the role of the health system and opens the way to identifying health responses.

The topic is one that can be confronting but remains an essential issue to engage with in relation to health care and in any response to improving health outcomes. This is work is written in way that allows the reader to reach an understanding of potentially difficult material, and which offers opportunities for self-reflection. This is a recommended read.

Recent articles of interest:

Calder, S., Tomczyk, B., Cussen, M.E., Hansen, G.J., Hansen, T.J., Jensen, J., Mossin, P., Andersen, B., Rasmussen, C.O., & Schliemann, P. (2022). A Framework for Standardizing Emergency Nursing Education and Training Across a Regional Health Care System: Programming, Planning, and Development via International Collaboration. *Journal of Emergency Nursing, 48*(1) 104-116 https://doi.org/10.1016/j.jen.2021.08.006.

This paper identifies the challenges related to providing continuing education and competence management for emergency nurses, and reports on an international collaboration between emergency nurse leaders in Region Zealand, Denmark, and nurse leaders and educators from Boston, Massachusetts. Working in collaboration they designed a competency-based education framework to support high-quality emergency nursing care in Region Zealand.

Heufel, M., Kourouche, S., Lo, W-S. A., Thomas, B., Hood, L., & Curtis, K. (2022). End of life care pathways in the Emergency Department and their effects on patient and health service outcomes: An integrative review. *International Emergency Nursing, 61* https://doi.org/10.1016/j.ienj.2022.101153

This integrative review focussed on primary research relating to end-of-life (EOL) care in the ED. Findings included that while there were some commonalities in criteria used to identify patients who may be EOL, there was no standardisation for screening or treating EOL needs and recommended further work on EOL pathways.

Journal and Publication Reviews' Cont.

Schablon, A., Kersten, J.F., Nienhaus, A., Kottkamp, H.W., Schnieder, W., Ullrich, G., Schäfer, K., Ritzenhöfer, L., Peters, C. & Wirth, T. (2022). Risk of Burnout among Emergency Department Staff as a Result of Violence and Aggression from Patients and Their Relatives, *International Journal of Environmental Research and Public Health, 19,* 9, (4945), 1 https://doi.org/10.3390/ijerph19094945

This paper reports on the frequency of violence by patients and accompanying relatives in the ED setting and the correlation between experienced aggression, a possible risk of burnout and a high sense of stress. The effect of prevention and preparation initiatives was assessed and shown to have a protective effect. The study determined that management staff play a major role in preventing violence and its impact on employees.

Timmins, F., Catania, G., Zanini, M., Ottonello, G., Napolitano, F., Musio, M.E., Aleo, G., Sasso, L., & Bagnasco, A. (2022). Nursing management of emergency department violence—Can we do more? *Journal of Clinical Nursing.*1-8. https://doi.org/10.1111/jocn.16211

This is a position paper underpinned by experiences and evidence reported in the literature. It acknowledges that while risk factors for ED violence can be identified, these are often over emphasized. The main risk factors identified are related to presentations associated with mental illness and the impact of overcrowding and long waiting times.

Walsh, A., Bodaghkhani, E., Etchegary, H. et al. (2022). Patient-centered care in the emergency department: a systematic review and meta-ethnographic synthesis. *Int J Emerg Med 15,* 36. https://doi.org/10.1186/s12245-022-00438-0

The intention of this review was to explore Patient Centred Care (PCC)in the Emergency Department and to better understand how this is undertaken, by means of a systematic review. The objectives were to identify the components of PCC, and the challenges and benefits as perceived by staff. Findings identified a lack of consistently used definition for PCC in the ED, but also that PCC had high value in the ED setting and was recommended as being standardised in practice.

Snippets: Spring 2022

Snippets: Violence and Aggression.

A snippet is a "small part, piece, or thing, especially a brief quotable passage."

If you know of any items suitable for inclusion in 'Snippets', please e-mail these through to: editor.cennzjournal@gmail.com.

We all need help, especially in our pressured workplaces, and all of us have challenges at home to some degree or another. As such, the following are a range of resources, in addition to those from our workplaces.

If you know of any items suitable for inclusion in 'Health and Wellbeing Snippets', please e-mail these through to: editor.cennzjournal@gmail.com.

Useful Links and Resources;

Check out the following resources, if you haven't already:

New Zealand Resources

Worksafe NZ: Violence at Work

- https://www.worksafe.govt.nz/topic-and-industry/work-related-health/violence-at-work/

Check out the MY Health Hub Webinars:

- Violence and Aggression in ED: https://myhealthhub.co.nz/coming-soon/cennz/
- Violence and Aggression in the Workplace: https://myhealthhub.co.nz/violence-and-aggression-in-the-workplace-2/

Guidelines, Standards and Policies:

NICE National Institute for Health and Care Excellence

Violence and aggression: short-term management in mental health, health and community settings. NICE guideline [NG10] Published: 28 May 2015 https://www.nice.org.uk/guidance/ng10

This guideline covers the short-term management of violence and aggression in adults (aged 18 and over), young people (aged 13 to 17) and children (aged 12 and under). It is relevant for mental health, health and community settings. The guideline aims to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur.

Violent and aggressive behaviours in people with mental health problems. Quality standard [QS154] Published: 29 June 2017. https://www.nice.org.uk/guidance/qs154

This quality standard covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem. It applies to settings where mental health, health and social care services are provided. This includes community settings and care received at home. It describes high-quality care in priority areas for improvement.

Australian Guidelines

Guidelines for behavioural assessment rooms in emergency departments (May 2017). Health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/b/behavioural-assessment-rooms-emergency-depts-guide-june-2017-pdf.pdf

These guidelines were developed to assist with the procedures and policies related to the use and design of behavioural assessment rooms - a specifically designed room for assessing and managing emergency department patients exhibiting aggression that places themselves or others (including staff) at risk of harm. Such rooms are seen as an effective intervention, where agitated and aggressive patients are removed from the main ED area. The intention is to provide a separate space, privacy for patients while the situation is assessed and appropriately managed. These rooms can reduce the risk of injury for the patient and staff, facilitate a more positive patient experience, and reduce distress to other patients and visitors in the ED.

Snippets: Spring 2022 Cont.

Helplines:

- He Waka Tapu 0800 439 276 (0800 HEYBRO) – for men who feel they are going to harm a loved one or whanau member
- Vaka Tautua 0800 652 535 (0800 OLA LELEI) – free national Pacific helpline. Mon-Fri 8.30am - 5pm
- Anxiety Helpline 0800 269 4389 (0800 ANXIETY)
- Aoake te Rā 0800 000 053 – free counselling for people bereaved by suicide. See www.aoaketera.org.nz
- Rural Support 0800 787 254 – for people in rural communities dealing with financial or personal challenges
- Shakti Crisis Line 0800 742 584 (0800 SHAKTI) – for migrant or refugee women living with family violence
- Rape Crisis 0800 883 300 – for support after rape or sexual assault
- 24/7 HELPline 0800 623 1700 www.helpauckland.org.nz – support for sexual abuse survivors
- Asian Family Services 0800 862 342 help@asianfamilyservices.nz – provides professional, confidential support in multiple languages to Asians living in New Zealand, Monday to Friday 9am – 8pm

Cultural Safety and Te Ao Māori

Cultural Safety and Te Ao Māori Snippets

Incorporating aspects of culture and operationalising Cultural Safety are key elements with New Zealand nursing, that have the potential to make our practice unique. Within Emergency Nursing, we can impact health care, raise awareness around issues of equity and access, and challenge aspects of power and its misuse.

The Health System has specific responsibility and accountability to Māori, and as representatives of the wider health system, emergency service providers need to understand the implications of their actions (and inactions). One way of developing our responsiveness to Māori is the wider understanding of Te Ao Māori – the Māori world view - and use of Te Reo – Maori language.

If you know of any items suitable for inclusion in 'Cultural Safety and Te Ao Māori Snippets', please e-mail these through to: editor.cennzjournal@gmail.com.

Te Reo Māori

We have been celebrating Te wiki o te Reo, the use of language – Te Reo Māori – continues to grow in Aotearoa/New Zealand. If you want to practice or learn how to create a mihi or pepeha, there are on line resources including Kia Kaha Te Reo Māori.

https://www.reomaori.co.nz/learn_your_mihi

- Also check out the general website with ideas for Te Reo: https://ReoMaori.co.nz/
- The online Māori dictionary is also a useful resource: https://maoridictionary.co.nz/
- Build your vocabulary, with the word of the day (Kupu o te Rā) or word of the week (Kupu o te Wiki) available on https://kupu.maori.nz/

Kia nui ake te ako ka korero ai
Learn more, and use what you know.

- *Whakatauhia te reo Māori ki te mahi me te hapori.* Make te reo welcome at work and in the community
- *Tōku reo, tōku ohooho, tōku reo, tōku māpihi maurea, tōku reo, tōku whakakai marihi.* Language is the key to understanding.

Te Ao Māori

There have been a number of frameworks introduced within healthcare that aim to improve our understanding of and responsiveness to Māori. A brief review of these will be presented over the coming editions, introducing you to some that you will be familiar with, and some that may be less well known. We are beginning the series with an introduction to the Health Quality & Safety Commission New Zealand (HQSC) Te Ao Māori framework, with information and images reproduced here with permission from HQSC. The symbol representing the framework is designed for and copyright to the Commission.

The Commission is working on the implementation of the framework, which has emerged as a result of the ongoing disparities in Māori experiences within health care access, provision and outcomes within Aotearoa New Zealand. In their background document, the HSQC identify decades long reports of such deficits, and the evidence that inequities continue to exist (HQSC, 2021). Work began on the framework in 2019, with the stated aim of improving the quality of care afforded to whanau Māori across Aotearoa New Zealand. An associated intent is identified as being to provide "avenues to address the inequity that exists in the current health system" (p.1) with this being achieved through the use of the framework and associated resources as a means to advance the uptake of te ao Māori and mātaruranga Māori concepts into general health system design and health practice.

The framework in represented in the design below:

Figure 1: HQSC model

Cultural Safety and Te Ao Māori Cont.

Concept	Definition	Description
Wairuatanga	Provides the connection between the physical and spiritual. Wairua weaves through all elements of Māori culture.	Wairuatanga will be the centre of this framework as it makes culture key.
Pātuitanga	Serves to describe a relationship where one party is not subordinate to the other but where each must respect the other's status and authority in all walks of life.	Grow and foster strong partnerships in a shared power relationship.
Rangatiratanga	The capacity for Māori to exercise authority over their own affairs as far as practicable within the confines of the modern State.	This is a Crown obligation under Te Tiriti o Waitangi – the right to autonomy (the right to choose and decision making power over our own affairs).
Whānau	Service is provided based on need as identified by whānau.	Whānau need is at the forefront of service design and delivery.

Table 1: HQSC model: core concepts

Each of the outer sections have two koru representing tapu and noa. The haehae lines bind each section together and connect and interact with each other.

The inside koru of each concept opens into wairuatanga, which allows wairuatanga to flow seamlessly throughout the entire framework.

The outside koru opens into te ao Mārama. The pītau design on the edge of the outer sections represents new beginnings and is the interconnection between te ao Māori and te ao Mārama (HQSC, 2022)

The core concepts presented in the model are shown in table 1 (reproduced with permission of HQSC).

The framework draws on Te Tiriti o Waitangi, which is a central element to all HQSC work. In addition, both Māori and non-Māori understandings of quality in health care were incorporated into the model, with recognition of the significance of holism and Māori cultural values as fundamental principles to enable action in the provision of quality health care.

Wairuatanga

A starting point is the acknowledment that Māori epistemology (knowledge) and ontology (truth, reality) are valid as ways of making sense of the world. Wairua is described as the one element of Māori culture that sits within all others, that is free flowing and connected to all things. There is no single definition, but it provides the link that weaves culture together, and is therefore central to the function of all elements in the framework.

Pātuitanga

Within the framework, the concept of strong leadership is one where the relationship is such that one party does not subordinate another, but each must show respect for the others status and authority in all walks of life. In this way, Pātuitanga is about creating strong partnerships based on shared power, which is critical to enabling improved outcomes.

Rangitiratanga

This refers t the capacity for Māori to exercise authority over their own affairs as far as practicable, it supports Māori autonomy that

Cultural Safety and Te Ao Māori Cont.

is dispersed regionally through whanau, hāpu and iwi leadership models.

Whānau

The basic driver behind the framework is the recognition of whanau needs, and the importance of developing a whanau-centred approach to service delivery, and recognising that this is inherently values based. HSQC describes this as an approach that allows whanau "to lead and be led, through confidence and assertion" (HSQC, 2021, p.6).

Resources to support the implementation of the framework are in the process of being developed, and once completed will be added to the HQSC web site.

References

HQSC (2022). Te ao Māori framework. https://www.hqsc.govt.nz/resources/resource-library/te-ao-maori-framework/

HQSC (2021). Background on te ao Māori framework document. https://www.hqsc.govt.nz/assets/Misc/te-ao-maori-framework_backgrounder_final2.pdf

CENNZ Reports

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

Vacancy

There is a position representing Top of the South on the CENNZ National Committee currently vacant.

Please see application information on page 52

Committee Roles

CENNZ Mission Statement

We believe that emergency nursing is a speciality within a profession. We aim to promote excellence in Emergency Nursing within New Zealand / Aotearoa, through the development of frameworks for clinical practice, education and research.

CENNZ Committee Roles

Role / portfolio	Portfolio holder	Location and Link
Chairperson	Sue Stebbeings	cennzchair@gmail.com
Secretary	Amy Button	cennzsecretary@gmail.com
Treasurer	Keziah Jones	cennztreasurer@gmail.com
Membership	Lyn Logan	cennzmembership@gmail.com
Grants and Awards	Lyn Logan	cennzawards@gmail.com
Staffing Repository	Anna-Marie Grace	cennzrepository@gmail.com
NZ Triage courses	Tanya Meldrum	cennztriage@gmail.com
Professional Nursing Advisor (NZNO)	Suzanne Rolls	suzanne.rolls@nzno.org.nz
Te Rūnanga Representative	Tina Konia	
Knowledge and Skills Framework	Lauren Miller	
Website and Social Media	Dr Natalie Anderson	
Networks	Networks	
Clinical Nurse Educator Network	Anna-Marie Grace	
Charge Nurse Managers Network	Anna-Marie Grace	
Advanced Emergency Nurses Network	**Vacancy**	
Emergency Nurse Practitioner Network	Sue Stebbeings	

Committee Regional Representatives

Committee Regional Representatives

Region	Name	Daily Role
Te Rūnanga	Tina Konia	Registered Nurse – Hawkes Bay Fallen Soldiers' Memorial Hospital
Northland / Te Tai Tokerau	Sue Stebbeings	Nurse Practitioner – Whangarei Hospital
Auckland	Anna-Marie Grace	Nurse Unit Manager – Starship Children's Health
Auckland	Natalie Anderson	Registered Nurse, Professional Teaching Fellow – Auckland City Hospital
Midlands / Bay of Plenty	Lyn Logan	Nurse Manager – Rotorua Hospital
Hawkes Bay / Tairawhiti	Amy Button	Registered Nurse – Hawkes Bay Fallen Soldiers' Memorial Hospital
Mid Central Region	Lauren Miller	Clinical Nurse Educator - Taranaki Emergency Department
Wellington	Shannon Gibbs	Nurse Practitioner - Wairarapa Emergency Department
Top of South	VACANT	
Canterbury / Westland	Keziah Jones	Registered Nurse – Christchurch Hospital
Otago / Southland	Michelle Scully	Associate Charge Nurse Manager – Southland Hospital Emergency Department

Chairperson's Report

Sue Stebbeings
CENNZ Chairperson

Contact: cennzchair@gmail.com

Kia ora koutou katoa
Hello everyone

I am putting this report together as we prepare for the CENNZ AGM in November, so it is a good opportunity to look at the progress that has been made over the last year, and outline current projects.

Our key priorities of achieving safe staffing, improving equity, and supporting professional development for emergency nurses easily align with goals of the Maranga Mai NZNO campaign that include:

- Patient outcomes that are culturally safe and equitable across the whole health sector
- Every nurse has the power and resources to do their job

We hope that the changes unfolding in the health system under Pae Ora will bring about healthy futures for all, and we will continue to add our collective voice to ensure the realities of clinical practice are addressed. This relies on your input. While this is not easy with the marathon challenges we continue to face at work and the need to prioritise well being, working together makes it possible to keep moving forward, even if the steps are small.

We are in the early stages of exploring ways to increase support for Māori emergency nurses and equity in Emergency Departments. A survey inviting feedback around this will be sent out shortly. The feedback will inform kōrero to develop connections and strategies.

Since my last report, the national committee has welcomed Shannon Gibbs as regional representative for Greater Wellington, Michelle Scully as regional representative for Te Tai Tonga /Southern, and Wendy Sundgren as regional representative for Tamaki Makaurau / Auckland. Nominations are currently open for Te Tai Tokerau, a further Tamaki Makaurau / Auckland, and Top of the South regional representatives. It's vital to have representation from all areas to ensure the committee can be a strong advocate and remain up to date on members' issues and concerns.

Following the 2021 AGM, the revised position statement on registered nursing staff requirements in emergency departments was approved by members through electronic voting and has been added to the CENNZ website. (Link to CENNZ Position Statement RN Staff Requirements in ED)

Revised position statements on triaging away and redirection of patients presenting to an emergency department have been circulated for feedback prior to being presented for endorsement at the AGM. Triage is an area under even more pressure at

Chairperson's Report Cont.

the moment and with staff changes, many triage nurses have limited experience in the role.

The initial stage of revising the triage course workbook is almost complete. This has involved updating the formatting and reference links, plus correcting some typo issues. The next stage will be a content refresh and planning for this will begin shortly.

Several CENNZ national committee representatives will be joining the Safe Staffing Healthy Workplace Unit national advisory group to continue the committee's work to address safe staffing in Emergency Departments. This group developed from the recommendations of the Nursing Advsiory Group Safe Staffing Review.

Plans for our CENNZ Clinical Nurse Manager and Nurse Practitioner networks to meet are underway. Unfortunately, there have not been any AENN study days this year and a webinar or zoom meeting is yet to be organised. Hopefully things will be more feasible next year for a department to host a study day and for people to access professional development leave. Please contact me if you are considering hosting a study day or have a webinar topic or speaker to nominate.

CENNZ webinars began in July as attending professional development opportunities remains challenging with roster gaps and FTE deficits. Unfortunately, our scheduled speaker was unwell in August. We are planning future webinars. Information and the registration link to attend live sessions will be forwarded to members when available. The opportunity to ask questions is one benefit of being part of the webinar, however, the recordings are available on the My Health Hub website CENNZ page a couple of weeks following the live presentation.

We hope to see as many members as possible at the zoom AGM on the 4th November to provide further updates. Remits are being developed for circulation at the end of September with the agenda. Spot prizes will again be a feature of the meeting.

Ngā mihi nui tatou katoa,

Sue

Northland/Te Taitokerau Region

Sue Stebbeings
Nurse Practitioner

Whangarei Emergency Department

Whangārei ED

Although there continues to be mention of a new department, the reality is that we continue to adapt our small department in the meantime.

After the challenges of the recent renovation process, we are enjoying the space and improved layout of the new medication room, and slowly finding our way around the shelves and drawers. Every time I pick the wrong drawer, it reminds me how much time it takes to learn new habits.

Another benefit is that we have stacker doors on four more patient cubicles, which gives better privacy and infection control precautions. It's much quieter for patients, and unsurprisingly most people prefer to have them at least partly closed.

There is a new staff station with improved computer access. Much better visibility and no more narrow, cramped doctors' office to navigate.

The waiting room extension is still a work in progress as the best way to deal with concrete load-bearing walls is explored.

The ED staff room refresh surveys showed it has made a positive difference. Thanks to all those focusing on improving wellbeing.

The arrival of a portacom to replace the main screening/triage tents has been a welcome change. Drier feet and less wind turbulence is great for any time of the year here. One small separate tent has been kept for further assessment when appropriate. As Covid funding comes to an end, there will be further changes to triage and front-of-department processes.

We appreciate the support from colleagues outside of ED to fill some of our many roster gaps - a mixture of FTE vacancies and sickness. There has been a lot of discussion and effort to ensure that the pressure to pick up overtime and additional shifts is reduced, and that there is recognition of the need for short and long-term solutions to address the worsening staffing crisis. A two-week period of not picking up any additional shifts helped make the issue more visible to those outside the department. Rachel Thorn has represented our concerns to managers and the media, including Kaitiaki. As NZNO emails have outlined, the payments for additional shifts are now being discussed at a national level.

My time as Tai Tokerau regional rep is almost completed. Nominations are now open to join the national committee. Many worthwhile projects are underway and opportunities to add the unique perspectives and challenges of emergency nursing in this region. I'd encourage people to consider being the next representative.

Sue

Northland/Te Taitokerau Region cont.

Bay of Islands ED

The Bay of Islands hospital provides care for approximately 47 000 people in the Mid North and Bay of Islands area. Like most popular summer destinations, visitors increase the demand over the warmer months, and cruise ships in pre-covid times were a regular visit to the shores of Opua.

The Emergency Department has nine cubicles – including two resus rooms, four bays, one isolation, and two consult rooms. There is a 20-bed mixed medical and paediatric ward. As this is a smaller hospital, access to after-hours radiology and lab services is limited, but staff are always on call. Medical cover is provided by rural hospital specialists. BOI hospital is run by a small team of rural nurses, doctors and allied health staff who can deal with any situation and cope with extreme workloads and surges.

The after-hours GP service in the area operates from the same building as the emergency department, from 1700 hrs to 2200hrs on weekdays and from 0830 to 2200 on weekends.

In July next year, we are opening a new building, and the staff are looking forward to these ongoing improvements. This will see us with primary care practice on site, an increase in renal dialysis beds, an increase in OPD capacity, and an Oncology service.

A regular staffing challenge is finding escort nurses when patients need to travel to Whāngarei by road – one way is approximately 45 minutes. Whilst we are closer than our other colleagues, such as Kaitaia, it is still challenging to take a nurse off the floor and operate with decreased numbers. One alternative currently being considered is the option of utilising paramedics when appropriate. St John staff already support the hospital staff when time permits, making the most of the community resources and teamwork. Often people fill multiple roles in the community, such as HCAs who are also paramedics.

Recent flooding events have made it difficult for people to access their GPs leading to increased acuity when they present for emergency care.

Yasmeen Singh, Clinical Nurse Manager

Greater Auckland Region

Anna-Marie Grace
Nurse Unit Manager

Children's Emergency Department

Starship Children's Health

Auckland City Hospital

Starship Children's ED

CED has undergone major building works across the department over the last six months and over winter!

The team have managed this really well, adapting to rooms being recycled through the build and using the outside tent for overflow.

We are about to finish and have gone from two negative pressure rooms (AIIR) without access to toilets to two negative pressure rooms with individual toilets and a shared ante-room, 2 Negative pressure resus rooms and ten further negative pressure rooms.

We are well kitted out for further pandemic management and looking at the predicted measles outbreak, probably just in time.

Access block has added pressure to CED over the last eight weeks, but our numbers have been reasonable for a winter. We have welcomed a lot of new staff to CED, coming to us from within Starship, as well as Ireland, England, Singapore and the mighty Waikato.

Anna Marie Grace

Vacancies within New Zealand

If you would like to advertise for staff to join your ED team, we invite you to write to the editor at; editor.cennzjournal@gmail.com.

Auckland Region cont.

Natalie Anderson
Registered Nurse & Senior Lecturer

Auckland Emergency Department & The University of Auckland

Auckland Adult ED

The face of Auckland Emergency Department is changing in more ways than one. This year, the built environment and patient flow processes have been transformed to improve the isolation of those with COVID and other respiratory infections. We now have dedicated monitored, acutes and resuscitation isolation areas. However, there is still work to be done to ensure patients can be triaged, allocated to a suitable space and assessed in a safe and timely way. Well into spring, our hospital continues to admit patients in record numbers and is almost constantly full beyond capacity.

A lot of energy is going into the recruitment, orientation and precepting of the 73 new RNs who have started in our ED and Clinical Decision Unit this year. As is the case globally, we have seen high staff turnover with over 50 RN resignations. Around half of the nurses who have resigned this year have moved on to senior roles at Te Toka Tumai Auckland or taken up overseas postings. In combination with record sick leave, this loss of senior staff often reduces daily staffing well below budgeted nursing FTE, making for some challenging shifts and staffing decisions.

As we continue to work through challenging times, I feel proud of my colleagues' rapid adaptation to constant change and uncertainty associated with the pandemic. Every week, there are new faces and processes, and our built environment has undergone massive changes. I am also deeply concerned about the unrelenting pressure on the extraordinary humans who make up our health services in NZ. I see the overwhelming fatigue on faces and keenly feel the disappointment and dissatisfaction with providing compromised and rationed care. The increasing scarcity of experienced nurses must be met with a much greater investment in nurses as valued employees. Across the country, we must prioritise and fund adequate professional development, compensation and support as well as the safe staffing and wellbeing of nurses and all health professionals.

Natalie

Auckland Region cont.

Middlemore ED

Middlemore ED is no exception to Aotearoa's current staffing challenges, which are further exacerbated by deteriorating access block. We are incredibly grateful to all of those team members who go above and beyond and pick up a bit extra where they can but are mindful that self-care also needs to be prioritised. Recently an ED Nursing Retention Group was developed in order to enhance our current workforce, and a Health Psychologist has come on board to support staff wellbeing.

August saw the commencement of Middlemore ED's annual Kia Kaha challenge. An annual event whereby the entire ED (clerks, orderlies, nurses, doctors, cleaners, radiographers etc.) is split into teams that work to earn points based on exercise and challenges. It's a way of boosting team spirit and creating friendly competition among colleagues.

Regarding initiatives: The rollout of electronic ward handovers is coming to an end. While it has taken some time to get this up and running across the organisation, it is pleasing to see that it is mostly running smoothly and saving precious nursing time. We've also seen the introduction of Safety Intervention Training to better equip staff for managing violence and aggression in the ED.

Several staffing changes have taken place over recent months. We have welcomed a new interim Service Manager to the ED, and there have been several new Associate Charge Nurse Manager and Clinical Coach appointments. We would like to welcome Dr Matthew Clarke into his role as the Clinical Head of Middlemore ED. Matt has worked at Middlemore for many years, and we look forward to working alongside him in his new capacity as we strive to provide optimal emergency care to the population of South Auckland. .

Wendy Sundgren, Associate Charge Nurse Manager

Midland Region

Linda (Lyn) Logan
Associate Clinical Nurse Manager (ACNM)
Emergency Department
Rotorua Hospital

Rotorua ED

Similar to other EDs from around the country, Rotorua has struggled over the winter period with long waits and patient flow issues due to bed capacity and staffing issues. We have had a peak of paediatric presentations with respiratory issues recently, so the introduction of our paediatric liaison nurses has helped support some of our newer staff members with their invaluable knowledge and skills.

Our team are seeking every avenue for education, including the use of the CENNZ webinars, which have been well received. We also have more staff to undertake the triage course coming to Rotorua in 2023. Our MHCNE has also been busy with a new dedicated mental health room within the dept as well as further education on the mental health process to improve the quality of care given.

The CNS team has increased to four, with a further CNS coming aboard in 2023. This team has also been providing a satellite service for minor injury and illness at the Rotorua Police Custodial facility, improving care and decreasing admissions to ED from the police cells.

Finally, we are assessing risks of violence and aggression in our workplace with work being done in this space with policy, procedures and training in progess. We continue to support our H&S team in ensuring correct procedures and support are given if any staff members have been verbally or physically abused or assaulted.

Lyn

Tauranga ED

Tauranga ED is full of many challenges but has so many things to celebrate this quarter. Like every other ED, we are experiencing long waits for inpatient beds and inpatient reviews. We are juggling staff, trying to cover covid-related staff illnesses and roster gaps. Our recruitment has been highly successful. Our team is building amazingly with a mixture of experienced and less experienced RNs. Each comes to us with a unique skill set to add to our team. We are now working on recruiting into the extra FTE granted to us care of Trend Care. We continue to be proactive in upskilling and advancing through the department. Even though staffing can be tight, we do our very best to keep training and orientation afloat. We have two fixed-term clinical coaches who are giving amazing support to our team at the bedside. We have employed a NP intern and a new CNS into our advanced nursing team. We have also recruited two further ACNM roles in the department, adding to our existing ACNM team..

Lynette Finlayson

Associate Clinical Nurse Manager

Midland Region cont.

Middlemore ED

Kia ora koutou,

Our department is undergoing a lot of growth and development. Our COVID response over two years has evolved like most departments. Previous pathways involved external triage and a GP after-hours service that included a GP COVID surge response in pods. We have removed all services from the pods and are working within the department again, which for many, is a relief. As a department, we are taking the covid experience, good and bad, and have modified processes and flows adapting to the current climate.

As a team, we continue to grow. We have completed three years of Trend care and CCDM. Trend Care has allowed us to show our RN deficit that was not acknowledged in the same way prior to the implementation. Our experience is that the resulting CCDM business cases, once completed, have been approved quickly, enabling Colleen, our CNM, to recruit into the RN FTE deficit. She said,"*We were so far behind in FTE that our implementation of Trend care and CCDM, and the resulting FTE (although a challenge) is considered both a starting point and a success. And now that CCDM has identified EDs as a priority, it is an opportunity to ensure the tool can cater for all ED models and departments to meet NZ(s) needs.*"

As a clinical team, we are also growing. A point of difference with Whakātane is that growth is at all levels. We are advertising for a second Nurse Practitioner for a model where NPs see all ED presentations. We have one CNS and one CNS/NP Intern, five CNCs, and myself, a new Nurse Educator for Whakatāne Emergency. Training occurs through the Resuscitation rooms for Intermediate RNs. We have three New Graduates, and four HCAs due to commence training in their extended scope of practice roles. Support for PDRP development at all levels commenced. For our medical colleagues, we have had the approval of the ACEM training programme with a position for one registrar, and a Rural specialist programme has led to the appointment of one Rural specialist working in ED as one of three specialities. Also, the addition of Flo, our department physiotherapist.

In my new role as Nurse Educator, I have commenced training within the resuscitation rooms for an initial eleven RNs, and increased training at the CORE Advanced level. I am also the Resuscitation Coordinator for Whakatane, which has enabled the blended roles to complement the training within Emergency. We are also in the process of reforming a Māori ED nurses group, focused on Whanaungatanga and facilitating ideas that support addressing inequities in the emergency department.

Our CNC group have also had opportunities to refresh and focus on portfolios that support departmental growth, such as Triage and Trauma Training, Trend Care, Whanau Ora, Health and Safety, Mental Health, and Wellbeing. We also have 24-hour security in place, given the increasing violence and aggression in emergency departments nationally, a kaupapa discussed in many departments and the CENNZ hui. Like other emergency departments, we are also focused on the recruitment and retention of nursing staff, so if you are looking for a change come over to Whakātane. Nau mai Haere mai.

Natasha Kemp

Clinical Nurse Educator

Hawkes Bay/Tarawhiti

Amy Button
Nurse Manager (ACNM)

Emergency Department, Hawke's Bay Fallen Soldiers' Memorial Hospital

Hawkes Bay ED

It's hard to believe that the year is almost over. So much has happened this year, but I feel our department as a whole is heading towards the end of the year in a much better place than when 2022 started.

We have a new nursing management team that has come on board permanently in the last three months. The nursing staff have really stepped up and become one united team under new management. Despite the high number of daily presentations, the team is staying positive and working tirelessly.

Hospital flow and capacity are a never-ending battle, and we constantly start our day in ED with between 5 and 20 inpatients occupying ED bed spaces. This constant struggle for acute space in ED has meant that we are working closely with inpatient teams to improve patient flow from ED through the rest of the hospital. This includes the review of current ED pathways and designing new ones. We have just updated our #NOF pathway, allowing for a more streamlined progression from ED to the ward for this patient group.

We have a passionate team working on a waiting room revamp. This project includes better signage outside the department to welcome people into the ED, a more welcoming interior in collaboration with local artists, and a 'Welcome to ED' video to be played for people in our waiting room.

We are looking forward to welcoming back our volunteers (Friends of the Emergency Department - FEDS) into ED. Our number of Covid presentations has dropped off significantly, and so we have been given the green light to allow our volunteers back. This is of great support to the department and the contribution they have will be substantial to staff and patients alike.

We are excited to have our department's first Clinical Nurse Specialists join the team in November. We have a well-established Nurse Practitioner team in our department and are really looking forward to having some CNS's join the team. Our biggest hurdle moving forward is finding the right area for this team to work out of. Our current Fast Track service is being run out of an external prefab building in our car park. However, much to our disappointment, this building is being removed before the end of the year, leaving us with the need to find another suitable Fast Track space within an already overcrowded ED. Ongoing work in this space is going to require lots of creativity and flexibility until we can find a feasible solution.

Recruitment is an ongoing campaign. We are ending the year with a much larger staff base, but there is still a significant FTE to recruit into. The current nursing team are working above and beyond to pick up extra shifts to help cover the daily staffing gaps due to unrecruited FTE.

2022 has been a long hard year all around, but we are definitely beginning to see some positivity heading into 2023.

Amy

Mid Central Region

Lauren Miller

Clinical Nurse Educator

Emergency Department

Taranaki Base Hospital

Whanganui Emergency Department

Thinking creatively, the hospital has employed ward assistants (different to HCAs) that stock and do tasks that are non-patient-facing; this then releases HCAs to provide direct patient care. Additionally, upskilled HCAs can complete phlebotomy rounds at weekends. We have been utilising staff from non-clinical roles, working with smart 5 tasking in clinical areas working in Patient safety/quality roles.

We have been experiencing more unwell and higher acuity presentations. One of our biggest challenges has been overcrowding from holding 10+ patients per shift that need admission into inpatient beds, as well as sick staff, covid illness, and sick families (children). We have also had trouble recruiting to FTE that is signed off and ready and waiting.

On a brighter note, we have been trialling a new drive-through respiratory clinic on hospital campus, run by our primary regional health network. It is open seven days per week and consists of a RMO and/or NP, plus 2 RNs. It is open 1000-1830 weekdays, 0800-1630 on weekends - and it's Free!

Carla OKeeffe

Clinical Nurse Manager

Taranaki DHB ED

Taranaki Base hospital ED has had both a challenging and optimistic last quarter. We have gone through the process of decommissioning our tent and replacing it with a three-cubicle portacom, which is a more permanent and weather-appropriate alternative. This portacom will help us to manage capacity and streaming of minor's type patients. The much larger construction of the new ED is ongoing and scheduled for completion in 2024... we can't wait!

Patient presentations have remained steady - with a few challenging weeks through viral winter illnesses. We have also had some challenging trauma and resuscitation presentations that have tested our resources and systems, and created space for discussion and learning.

As a department, we have implemented RN access electronic medication charting; this brings us in line with the wider hospital and aims to prevent delays in medication administration. We are still getting used to the implementation of TrendCare. We have recently had a cohort of nurses complete IRR training in preparation for all the nurses to be IRR tested and for the official launch of TrendCare to go live.

On a positive note, we have had a good period of recruitment and have a number of new people starting over the coming months. We also have an RN who has recently commenced on the CNS pathway. Additionally, we are busy supporting four transition students and some CAP placements, which is positive for the workforce going forward.

Therese Manning

Clinical Nurse Manager

MidCentral DHB – Emergency Department

Construction continues to expand our ED footprint and bring MAPU alongside ED. The completion date remains December 2022. Conversations have been had about what to do with the existing ED Observation Area (EDOA), which is part of the new construction, and plans have been drawn up to move forward with a dedicated paediatric assessment and procedural area. This is very exciting! The launch of the Foundation and the request to fundraise went really well with the entire target pledged, so we are full steam ahead on this! Completion date TBC.

We continue to see high acuity presentations in ED - this isn't necessarily something that has changed; however, we are holding on to these patients for a long time

Mid Central Region cont.

due to hospital capacity.

In the last few months, we have rolled out TrendCare in ED. Staff have adapted really well, and even though we knew as a department that we were under resourced and over capacity, it was comforting to see the negative variance - I just don't think we were expecting to see such a negative variance. Our TrendCare team has been so supportive in the rollout - staying all hours to help us make this successful.

Staff sickness is a current challenge - the winter illnesses are well and truly in force among the nursing workforce in ED. Recruitment is ongoing, and we have seen a nice little influx of new staff into the department. With the changeover to HealthNZ, this has put a spanner in the works with Immigration as work visas have been inaccessible for the last month.

Last month we celebrated Matariki with the blessing of our Emergency Department. With a very challenging last 12 months, it was a way we could bring some calming energy into the department, remember the last 12 months, give thanks, celebrate the present and look positively to the future.

Kellie Stickney

Associate Director of Nursing/Operations
Lead Surgical Wards

Clinical articles – case-studies and reflections

We are always looking for clinical articles. These could be written entirely for the journal or as a part of a post-graduate course.

If you are willing to share a piece of work: write to the editor at editor.cennzjournal@gmail.com. Articles will be peer reviewed and the editor will provide editorial support.

Wellington Region

Shannon Gibbs
Nurse Practitioner
Masterton Emergency Department
Masterton Hospital

Masterton Hospital ED

We are subject to the same pressures as EDs across the country, with recruitment difficulties, staff sickness and an increasing cohort of new Mums on maternity leave. While COVID and influenza have settled, we are still seeing high presentation rates driven partly by difficulty accessing primary care. The team is tired, and this has been highlighted in the media thanks to the efforts of our NZNO rep and our ED medical lead.

We have had some recruitment and staffing wins with four NPs now working out of ED, although sadly, we are losing one to primary care very soon. Growing our own nurses via NETP employees has proven fruitful. With these team members going from strength to strength, we anticipate employing graduates again at the end of the year. The recruitment of several experienced ED nurses has reduced some of the pressure by improving the skill mix of our team (sorry Palmy ED!). We are grateful for the addition of HCAs to our base staffing, which has been transformative.

While the initial Trend Care learning curve was steep, it is now firmly embedded in department processes. IRR testing is near completion, with the data speaking for itself in terms of negative variance. The data has been so convincing that six months of data has been enough to begin FTE calculations, rather than waiting for the full year that was originally proposed.

We appreciate the recent addition of a Mental Health Educator to the department, developing a database of resources and supporting staff to streamline the pathway for our patients presenting with mental health concerns.

Our ED is attached to a High Dependency Unit, enabling us to access a Critical Care funding stream. This funding is being used to support a Clinical Coach FTE on the senior RN scale (utilising preexisting advanced knowledge in the department and successful recruitment) and an increased educator FTE. The focus is on the care of the ventilated patient and on developing our MET response capability, which is met by ED nurses on the floor.

Hutt Hospital ED

Hutt ED has gained 32 FTE from calculations out of the Trend Care implementation but is struggling to recruit, both into the new FTE and into 10 FTE of resignations and 8 FTE of nurses moving into senior roles across the hospital. Many applicants do not yet have NZ registration which has proven frustrating.

ED is feeling the pressure after losing one of two Hutt Valley after-hours and the continuing Primary Care strategy of separating respiratory cases, which reduces the availability of acute appointments. This winter has seen the minors unit functioning as an overflow inpatient space with the management team in scrubs and taking a patient load.

While the ED is not affected by the earthquake risk building situation at Hutt Hospital, there are concerns around ambulance and transport availability as inpatient units move out of at-risk buildings and into the community.

Positively, however, new Mind Ray monitors are transforming practice, and there is excitement at the growth and advancement potential for nurses in the team. The department now includes five CNS's, NPs and an anticipated NPTP position in the new year. They are also celebrating the return of the Flow Nurse Specialist role to the ED from elsewhere within the hospital.

Charley Gibson

Clinical Nurse Manager

Top of the South Region

Vacancy

Regional Representative

The committee invites nominations for a regional representative from the Top of South CENNZ members to join the national committee.

See page 43 for details of the role and how to nominate for the position.

Canterbury/Westland Region

Keziah Jones
Registered Nurse

Christchurch Emergency Department

Christchurch Waipapa ED

The new Children's Emergency Care area opened in September. We are excited to have this great service for the children in Canterbury, working collaboratively with Child Health and emergency nurses to provide outstanding care in a new purpose-built environment.

In August, we had our Trendcare FTE calculations, and we look forward to hearing from the CCDM governance group for final approval of additional FTE for Christchurch ED. It is very timely as our patient numbers have again seen an increase. Patient numbers averaged around 321 patients per day in June, down slightly in July to 300, and back to around 320 patients per day for August. ED Delegates and the Health and Safety team continue to highlight safety issues and acknowledge key stressors to help facilitate positive change going forward.

We are working toward opening our Emergency Observation area, which will allow the department to be fully operational. ED nurses have formally highlighted their concerns over the winter and strongly advocated for staffing resources to open this area. We have received confirmation from the District leader (Peter Bramley) that opening the Emergency Observation area is their highest priority.

We continue to work hard together as a team and occasionally get the opportunity to let our hair down. The Ministry of Fun organised a great 'Stars in their Eyes' evening; Doctors, Nurses and Paramedics stars for the night. Adele stole the show with other great acts and plenty of laughter and fun for all.

Kez

Southern Region

Michelle Scully
Nurse Educator/Registered Nurse

Southland Hospital Emergency Department

Southland Hospital

Hi all,

I am your Southern Regional Representative, new and keen to learn the workings of the College and the committee. I am the Clinical Nurse Educator 0.6 FTE and 0.3 RN on the floor at Southland hospital, Invercargill. Presently the region is blanketed in snow bringing a cold spring and winter.

The Southern Region is 62,356km² and covers the largest geographical area in New Zealand.

This region has;

- 348,868 residents.
- 65,240 are 65 years and older (18.7%)
- 39,158 Māori (9.8%)
- 10,481 Pacific (2.6%)
- 34,604 Asian (8.7%)

Invercargill has 37,000-38,000 presentations per year. Southland Hospital (Invercargill) has 188 resourced beds (with some in ATR that have not opened and some flex in Children's and NNU. This includes mental health beds but not day surgery).

Southern ED

Barriers and challenges: Experiencing complex presentations, high acuity, and large numbers coupled with a lack of space to accommodate patients has been challenging. A lack of a clearly defined escalation plan is proving problematic. We often seem to be in access block and have had many staff off unwell with Covid. Some of our young staff are heading off to Australia or other regions of New Zealand. Invercargill would love to have ACNMs, but we are categorised as service level four, so we have shift coordinators while scoped at this level. Invercargill has had some incidents of violence. Our security team is based very close to ED, but should they be over at the Mental Health Unit when ED needs them, then we have to call the Police.

What's new? Staff are being recruited in an attempt to provide improved staffing levels. We are not fully recruited for nursing or medical staff. Our CNM has introduced a new room allocation model, streamlining nurse allocation to patients and eliminating those unfortunate surprises of patients not having a nurse for a period of time. This team approach can be helpful with covering meal breaks. Feedback has been mainly positive when there are enough staff to make this system work. He is also reintroducing and reinforcing old lapsed initiatives such as the bedside handover, which formalises the transfer of accountability, improves patient safety, the accuracy of information and a patient-centred approach.

CNS's have had increased hours, education formalised, and a valuable study day held. The Nurse Practitioner pathway is being reintroduced in the department. Emergency Q has been introduced where appropriate patients being offered the opportunity to attend available GP clinics.

Our CNM has been seconded into a role that looks at improving flow

Southern Region cont.

from ED to CCU, and interhospital flow. Leigh-Anne Fearn is our acting CNM while Matt is in this new role.

Our Mental Health Educator, Cath Allwood, who is 0.7 FTE in Queenstown, Invercargill and Dunedin, is providing clinical supervision opportunities and education sessions to upskill us in mental health assessment tools and legislation. We are extremely grateful for her calm, caring and knowledgeable input.

We are investigating trialling some protected education time for nurses in our department. Hopefully, I will be able to report on this in a future Journal edition. Invercargill does not have Trendcare.

As the Southern Regional Rep, I would like to see increased membership in the College, promoting its benefits of education, advocacy, courses and networking. We have a committed team going the extra mile in extraordinary times and circumstances. I just want to finish with a thought that one of our wise consultants said, which is that we, the staff in ED, are a family. Like a family, we need to remain strong and support each other in these turbulent times.

Michelle Scully, contributed to by **Matt Flutey,** Clinical Nurse Manager

Queenstown ED

Skill mix has not been ideal and the Covid budget has been used to staff up to cover high volumes of patients. Patient presentations have increased with covid and influenza patients and increased numbers of tourists. A new initiative of having monthly topics and champions to provide brief education sessions has often had to be cancelled due to the busyness of the department.

HCAs have been upskilled to take Vital signs, covid swabs and other useful tasks such as applying tubi grip and fitting crutches. Ward nurses have been upskilled to help in ED.

The challenges are similar to other EDs such as lack of bed spaces, high numbers of covid presentations, staff illness and now staff moving off to Australia. Being overworked and underpaid, having education cancelled and being under resourced is stressful.

Lisa Friesen

Clinical Nurse Manager

College Activities

College Vacancies

Vacancy for Top of South Region Representative on CENNZ National Committee

The committee invites nominations for a regional representative from the Top of South CENNZ members to join the national committee.

This is a rewarding, challenging role representing your region, promoting emergency nursing nationally, and meeting like-minded emergency nurses. A strong commitment and interest in the development of emergency nursing is essential.

By becoming a committee member for CENNZ you will be involved in:

- strategic planning
- governmental dialogue
- collaboration with national agencies
- development of education for emergency nurses, and
- networking with other emergency nurses nationally and internationally

Each committee member writes a short journal report four times per year. The role also involves other committee and portfolio responsibilities between meetings as well as disseminating information back to your region.

The term of office is for 2 years (maximum of 4 years) and requires a moderate time commitment. There are four face-to-face meetings per year (2-day meetings) and a monthly zoom (or teleconference).

The nomination form is available at on the CENNZ website and should be sent to: emergency@nzno.org.nz.

Both nominees and nominators must be current CENNZ members according to college rules.

Any questions or enquiries welcome to: cennzchair@gmail.com

Ngā mihi nui

Sue Stebbeings

Chairperson

DATE: 04/11/2022

CENNZ-NZNO Position Statement

Redirection of patients presenting to an emergency department

SUMMARY

The College of Emergency Nurses New Zealand – NZNO is committed to providing equitable quality emergency care. This revised position statement outlines the requirements for safe redirection process to occur when deemed appropriate.

Redirection is not triaging away which is defined as a refusal to provide further care in the ED or advice to the patient that they do not need care in the emergency department, based solely on the outcome of the triage interview.

Redirection is a process of referring a patient from an Emergency Department to another health care facility. The redirection of patients to alternative healthcare providers has been proposed to provide care in the most appropriate context, to support patient engagement with their primary health care providers, and to clarify understanding of emergency department level of care.

CENNZ POSITION: KEY RECOMMENDATIONS

It is the position of the College of Emergency Nurses - NZNO that offering referral to other health care providers from ED must:

- Be facilitatory and not against the patient's wishes or constitute denial of care
- Be based on a high level of comfort from the assessing clinician that the referral is best for the patient with particular consideration for persons from vulnerable groups
- Occur in the context of there being an available and responsive health care service
- Be supported by a documented departmental referral process that ensures seamless continuity of care, and that documentation is completed. To be eligible for redirection, the patient must be a registered patient of ED that they presented to.
- Ensure that the extent of the assessment and care provided prior to redirection must be sufficient for a health professional to be satisfied that redirection is safe for patient and any urgent intervention has been completed.
- That a full set of vital signs is completed
- Be audited to ensure safe outcomes for redirected patients
- The medical and nursing team in the ED should address appropriate follow up with patients: where and in what time frame this is appropriate.
- Any barriers to gaining primary health care should be identified and addressed.

BACKGROUND: THE CURRENT STATUS OF THE ISSUE:

Emergency Departments provide episodic crisis care for people who perceive the need for acute or urgent care. The Ministry of Health (2011) provides guidance regarding referral of people from the Emergency Department (ED) to primary health care for ongoing management. Primary health care facilities provide both routine and urgent care to the New Zealand population, and provide continuity and co-ordination of health care for individuals (Ministry of Health, 2011). There is no clear boundary between the services each provides and this can vary between healthcare providers and regions (Ministry of Health, 2011).

The Australasian Triage Scale is used in emergency departments to calculate safe waiting time for further assessment and is not a validated tool for triage to alternative care providers outside of the emergency department (Australasian College for Emergency Medicine, 2019; Feral-Pierssons, et al. 2022; Ministry of Health, 2011).

Consideration of potential for redirection of patients should occur following further advanced assessment (Feral-Pierssons, et al., 2022; Minstry of Health, 2011) as additional history and assessment are required to support the critical thinking and clinical judgment to safely offer redirection. There has been considerable debate over many years regarding which patients can be safely redirected. A recent proposed tool (Gilbert, et al., 2021) found 200 out of 1999 people met the tools' criteria for redirection yet acknowledged that an error rate of 7% remained.

Knowledge of local primary and urgent care health facilities, availability and their capability are required as well as advanced clinical assessment skills, and established documentation processes. Primary health care must be available in an appropriate timeframe. Clinical and professional accountability for offering redirection from ED remains with the health care practitioner, however organisations may not place pressure on assessing clinicians to redirect patients.

Emergency Departments are required to have a robust process in place that ensures it is clinically safe following sufficient diagnostic workup and that acute distress has been resolved prior to offering alternative care options or redirection (Ministry of Health, 2011). EDs should undertake regular review and audit of the 'redirected 'population to verify safety and seamless continuity of care. Unnecessary delays to care or the requirement to return to hospital for acute care are important indicators to assess the safety of redirection decisions.

Redirection is not a mandate to deny care (Ministry of Health, 2021, Ministry of Health, 2011; Australasian College for Emergency Medicine, 2019), and consideration of the needs of vulnerable people is essential to ensure safe and equitable care provision (Australasian College for Emergency Medicine, 2019). Consideration of available patient resources to attend and engage with alternative health care provider is required.

It is also important to note that there is no evidence that redirection changes ED overcrowding (Kirkland, et al., 2019; Morin, 2018, College of Emergency Nurses New Zealand, 2009).

RATIONALE FOR CENNZ RECOMMENDATIONS

- Emergency departments are required to assess all patients who present for care
- Appropriate and clinically necessary care will be provided to all patients.
- Appropriate assessment following triage is required to ensure redirection is safe and available
- Robust documentation and regular audit ensure any poor outcomes or lack of access to care is identified and addressed.

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POSITION STATEMENT DUE FOR REVIEW: 04/11/2026

DATE: 04/11/2022

CENNZ-NZNO Position Statement

Triaging Away

SUMMARY

The College of Emergency Nurses New Zealand - NZNO does not support the practice of triaging away. The College of Emergency Nurses New Zealand - NZNO believes that health care should not be denied to any patient requesting care from an emergency department.

Triaging away refers either to a refusal to provide further care in the emergency department, or advice to the patient that they do not need care in the emergency department, based solely on the outcome of the triage interview. This is an update of previous position statement (College of Emergency Nurses New Zealand-New Zealand Nurses Organisation, 2009).

Redirection is a process of referring a patient from an Emergency Department to another health care facility (College of Emergency Nurses New Zealand – New Zealand Nurses Organisation, 2015).

CENNZ POSITION: KEY RECOMMENDATIONS

It is the position of the College of Emergency Nurses - NZNO that:

- Emergency department care should not be denied to anyone who seeks it
- Lower acuity triage scale category does not directly correlate with need for emergency department care
- The provision of equitable and culturally safe care is a priority for NZ emergency departments.

BACKGROUND:

People present to emergency departments for care due to their urgent health concerns. While the role of the emergency department is primarily to provide emergency care, the Ministry of Health states that care should not be denied to anyone who seeks it (Ministry of Health, 2011).

Patients presenting to an emergency department require triage at time of arrival by a trained and experienced registered nurse or medical practitioner (Ministry of Health, 2021). Triage is an advanced assessment skill requiring skilled questioning and clinical judgment.

The triage interview is a brief assessment of clinical urgency (Australasian College for Emergency Medicine, 2013) and is not intended as a tool to deny treatment (Australasian College for Emergency Medicine, 2019). The potential for patient condition to change following triage, while waiting for further assessment and treatment is clearly acknowledged by both the Ministry of Health and the Australasian College for Emergency Medicine (2013). Any intent to deny care on the basis of the triage interview creates a risk for the patient, the triage nurse, the emergency department, and the organisation.

The supposition for triaging away is based on the assumption that there are easily determined reasons directly correlated to a lower triage scale category, that indicate emergency department care is not required. A percentage of patients in the lower acuity triage scale are known to require hospital level care and specialist inpatient admission. Lower acuity patients or perceived GP type patients are not significant contributors to emergency department overcrowding and access block (Australasian College for Emergency Medicine, 2022).

New Zealand studies demonstrate a lack of health professional consensus regarding which ED presentations could be managed in primary care (Elley, Randall, Bratt & Freeman, 2007: Richardson, Ardagh, & Hider, 2006). The study by Elley et al noted that consensus was not reliable despite providing results of investigations and discharge diagnosis, therefore determining need for emergency level care at triage with only the presenting complaint has even greater variability.

There are complex intertwined factors relating to choosing to attend emergency departments (Cummins, et al, 2022; Parkinson, Meacock, Checkland, Sutton; 2021). Six distinct reasons were identified in a review by Coster et al. (2017) to explain why patients choose to access emergency and urgent care services including patient perceived urgency, views of other health professionals, and limited access to primary care. These findings echo those elicited from patients presenting to Middlemore ED in 2011 (Thornton, Fogarty, Jones, Ragaban, & Simpson, 2014).

A New Zealand equity patient-centred approach also offers the contrasting concept that presentation to ED may be very appropriate for a particular patient, with a particular problem at a particular time (Curtis, Paine, Jiang, Jones, Tomash, Raumati, Healey, Reid, 2020).

Lack of acute care resources and capacity within the emergency department are not adequate or equitable rationale to decline care and redirect to other health services who are equally overwhelmed.

RATIONALE FOR CENNZ RECOMMENDATIONS

- Triage is a brief assessment to gauge urgency of further assessment and treatment.
- The need for emergency department level of care is not correlated to triage scale category
- Patient condition can change following triage, and additional information or results of investigations can demonstrate patient need for emergency level care
- Denial of care at triage increases risk for poor patient outcomes and potentially exacerbates existing health care inequity.

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POSITION STATEMENT DUE FOR REVIEW: 04/11/2026

Publications

- A list of all the current college position statements are on the CENNZ website at https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/publications.
- Previous copies (where digitised) of Emergency Nurse NZ are available on the CENNZ website at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal.

College Activities: Courses

The CENNZ webpage keeps ongoing updates and details of courses that are administered by CENNZ and others that are run externally. *These include:*

- Triage Course
- Trauma Nursing Core Course (TNCC)
- Emergency Nurse Paediatric Course (ENPC)
- International Trauma Life Support Course (ITLS)
- Paediatric Trauma Life Support Course (PTLS)
- Course in Applied Physiology in Emergency Nursing (CAPEN)
- AENN training days

For the details see the CENNZ websites at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/courses and https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/resources/advanced_emergency_nurses_network_aenn

- Any questions on triage course, content or holding a course in your area, contact your nurse educator where available then the Triage Course Director – Tanya Meldrum, email: cennztriage@gmail.com
- For any enquiries or bookings for TNCC, ITLS, PTLS, ENPC or CAPEN contact the Programme Coordinator – Sharon Payne, email: sharon.acen2014@gmail.com, Phone: 027 245 7031

Education: Conferences and Seminars

Please continue to check the CENNZ web page for ongoing updates / details:

The NZNO offers members a range of scholarships and grants. These grants are funded from various trusts. NZNO also administers a range of other NZNO local and national grants. See the NZNO Scholarships and Grants page at https://www.nzno.org.nz/support/scholarships_and_grants for the details and application processes.

Some upcoming conferences in the coming year are as follows:

Conferences and Seminars

Dates	Conference Name	Location and link
27-29 October 2022	Emergency and Ambulatory Care Nursing – Nursing World Conference	Hybrid event: online and Florida https://nursingworldconference.com/program/scientific-sessions/emergency-and-ambulatory-care-nursing
10-12 November 2022	Global Conference on Emergency Nursing and Trauma Care	Gothenburg, Sweden https://www.elsevier.com/events/conferences/global-conference-on-emergency-nursing-and-trauma-care/location
6-9 December 2022	The London Trauma Conference 2022	London https://www.londontraumaconference.co.uk/Programme
6-7th March 2023	Frontline Mental Health Conference	Gold Coast, Australia https://anzmh.asn.au/fmhc-2023

Submissions Guidelines - (Brief)

Journal Submissions

***Emergency Nurse New Zealand* welcomes submission of projects and research, case studies, literature review papers, viewpoint / opinion pieces, reflections, short reports, reviews and letters.**

Manuscripts submitted to Emergency Nurse New Zealand are expected to conform to the journal style and not to have been previously published or currently submitted elsewhere. See the CENNZ Journal website for full details including the submission checklist at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal

Category of manuscripts

Research papers – These should describe improvement projects and research undertaken: up to **4000** words (including references but excluding title page, abstract and tables, figures and graphs).

Format:
Title page: title, authors, abstract and keywords
Body: introduction, methods, results, discussion
References: limited to 30

Review articles – These should describe the current literature on a given topic: up to **5000** words (excluding title page, abstract, references and tables, figures and graphs)

Format:
Integrative, scoping or systematic literature reviews are preferred
Use of JBI for integrative or scoping reviews recommended
Use of PRISMA for systematic reviews recommended

Case studies – These should describe a detailed examination of a patient case or cases, within a real-world context: approximately **2000** words

Format:
Introduction: brief overview context / problem
Case: patient description, case history, examination, investigations, treatment plan, outcome
Discussion: summarises existing literature, identifies sources of confusion or challenges in present case.
Conclusion: summary of key points or recommendations
Acknowledgement that consent has been obtained from the patient plus any ethical issues identified
References: limited to 20

Opinion/Viewpoint – These should be on a topic of interest to emergency and acute care nurses

Approximately **2000-3000** words
Format: free-text
References: limited to 20

Profiles – These should be on a role within emergency or acute care that makes a difference to patients and staff activities:
Approximately **600-1000** words

Format: free-text, may include describing a typical day or arrange as a question/answer interview.

Reference style

Emergency Nurse New Zealand uses APA 7th edition. It is the authors responsibility to ensure that references are accurate.

EMERGENCY NURSE NEW ZEALAND

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