

# Emergency Nurse New Zealand



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**College of Emergency  
Nurses New Zealand**  
Ngā Ringa Ringa Aroha NZNO



**NEW ZEALAND  
NURSES  
ORGANISATION**  
TŌPŪTANGA  
TAPUHI  
KAITIAKI Ō AOTEAROA

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# Editorial Information

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All articles should be submitted electronically in Microsoft Word, and emailed to: [editor.cennzjournal@gmail.com](mailto:editor.cennzjournal@gmail.com). Articles are peer reviewed and we aim to advise authors of the outcome of their submission within six weeks of our receipt of the article. Brief guidelines for manuscript submission are included on the last page of the journal, and more detailed guidelines are available from the editors: [editor.cennzjournal@gmail.com](mailto:editor.cennzjournal@gmail.com).

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# Editorial



**Dr Sandra Richardson**  
Editor | Emergency Nurse NZ

**Kia kaha, kia mataara.**

As we enter 2024 with a new government and changes to the health system, we can look back to the end of the 2023 and the successful return of the CENNZ conference, a rejuvenation of the College in the opportunity to meet together, to share our ideas and passion for this specialty and to launch the new logo. So many great memories from this event to sustain us as we move forward, in what we hope will prove to be a fruitful partnership with a new government coalition of political parties, who although taking very different approaches, we need to trust will have the best interests of both patients and staff at the forefront. As with all

those establishing new pathways, there will be aspects that are challenging, and areas where input and expert advice from those at the heart of the system is vital. We are the ones who can offer that advice, with the confidence of experience and knowledge embedded in the practice realities and often damaging outcomes from ill-informed or under-resourced policies. Nurses, as we so often hear, are the largest health care group. We are told this when we are a burden on the health purse, or when are somehow expected to achieve even more outcomes because of our sheer presence, even when any cohesion has been systematically disrupted and our voices marginalised. We are constantly being asked to achieve more with less, and when we challenge this, are castigated for putting patients at risk. We know that we have no choice but to speak out, and to identify the pressures facing the health system. This edition of the journal celebrates the encounters and reflections of nurses who have been involved in natural disasters, who dealt with mass casualty situations, and who have considered how better to respond in these events. New Zealand has been exposed to significant weather related adverse events including cyclones, hurricanes, flooding, as well as other natural occurrences such as earthquakes, fires and volcanic eruptions. Additional trauma related mass casualty occurrences continue to present, whether related to transport incidents, infectious diseases or toxic exposures. As we read the experiences of nurses responding in the face of devastating emergencies and crisis situations, we also know that this is only the 'public face' of the everyday workload.

Emergency and urgent care nurses face challenges in their everyday work of equal importance, if less media significance, with cumulative impact and which can create an ongoing sense either of satisfaction and teamwork or exhaustion and demoralisation. We are entering a time of further change, recognising the existing pressures and impact of continuing resource constraints and sense of undervaluing. For many, this is managed through the balance of seeing the positive impact we can have for our patients, the support we give to our colleagues as we work together in these difficult situations, and the aroha we show to new nurses coming into the profession. Our mahi has meaning – it has the capacity to change lives, for better or for worse, and it has the possibility of making changes at national as well as local levels. As we think back on the shared knowledge and the amazing sense of whanaungatanga that is present when any group of emergency nurses comes together, it is clear we can continue to thrive no matter the circumstances. Take forward the experiences from the 2023 conference and its theme of Ready to Respond, Kia Mataara, and be prepared no matter what is ahead. Be willing to speak out on the things that matter – to recognise your values and your beliefs and to reflect on what matters in health and emergency care.

**Kia Kaha, Kia Mataara.**

**Mā te wā**

**Sandy**

# Launch of the new College of Emergency Nurses NZ Logo



## Introduction

The College is pleased to be able to introduce the new tohu/logo, formally launched at the 2023 CENNZ Conference in Christchurch. The process surrounding the re-development is necessarily complex, and involves many stages, including seeking consultation and approvals. We are pleased to have been able to have the introduction formalised with appropriate karakia and waiata, and generous korero from Ruru Harepeka Nako Hona.

The history of the previous imagery and its significance to CENNZ, as well as the influences underpinning its new presentation, are significant and important for the membership to recognise.

*"Kia whakatōmuri te haere whakamua."*

*"I walk backwards into the future with my eyes fixed firmly on the past."*

This whakataukī or proverb speaks to Māori perspectives of time, where the past, the present and the future are viewed as intertwined. This conceptualisation of time does not leave the past behind, rather the past is carried into the future.

## The new Tohu / Logo

# College of Emergency Nurses NZ



Ngā Ringa Ringa Aroha NZNO



# Launch of the new College of Emergency Nurses NZ Logo cont.

## 2023 – current

The logo was refreshed to enable greater flexibility and improved clarity in print and digital media, but with a focus on retaining the elements and essence of the CENNZ core values:

**Caring – Atawhai | Knowledge basket – Kete matauranga | Knowledge – Matauranga | Emergency Care – Tiaki ohotata | Community – Hapori | Land & People – Whenua me te iwi | Compassion – Arohanui**

An important element of the new logo is enhancing the visibility of Ngā Ringa Ringa Aroha, the caring hands. The original depiction of the literal hands has shifted to a symbolic interpretation. The koru, portrayed in blue, represents embracing, caring and healing as a contemporary design evolution of the hands in our new logo. This represents the work of emergency nurses, providing skilled critical physical and emotional emergency care in often highly traumatic and stressful situations. The change in colour palette reflects our relationship to NZNO, highlighted with the purple colour of the cross. The style of the cross illustrates the dynamic energy of emergency nurses.

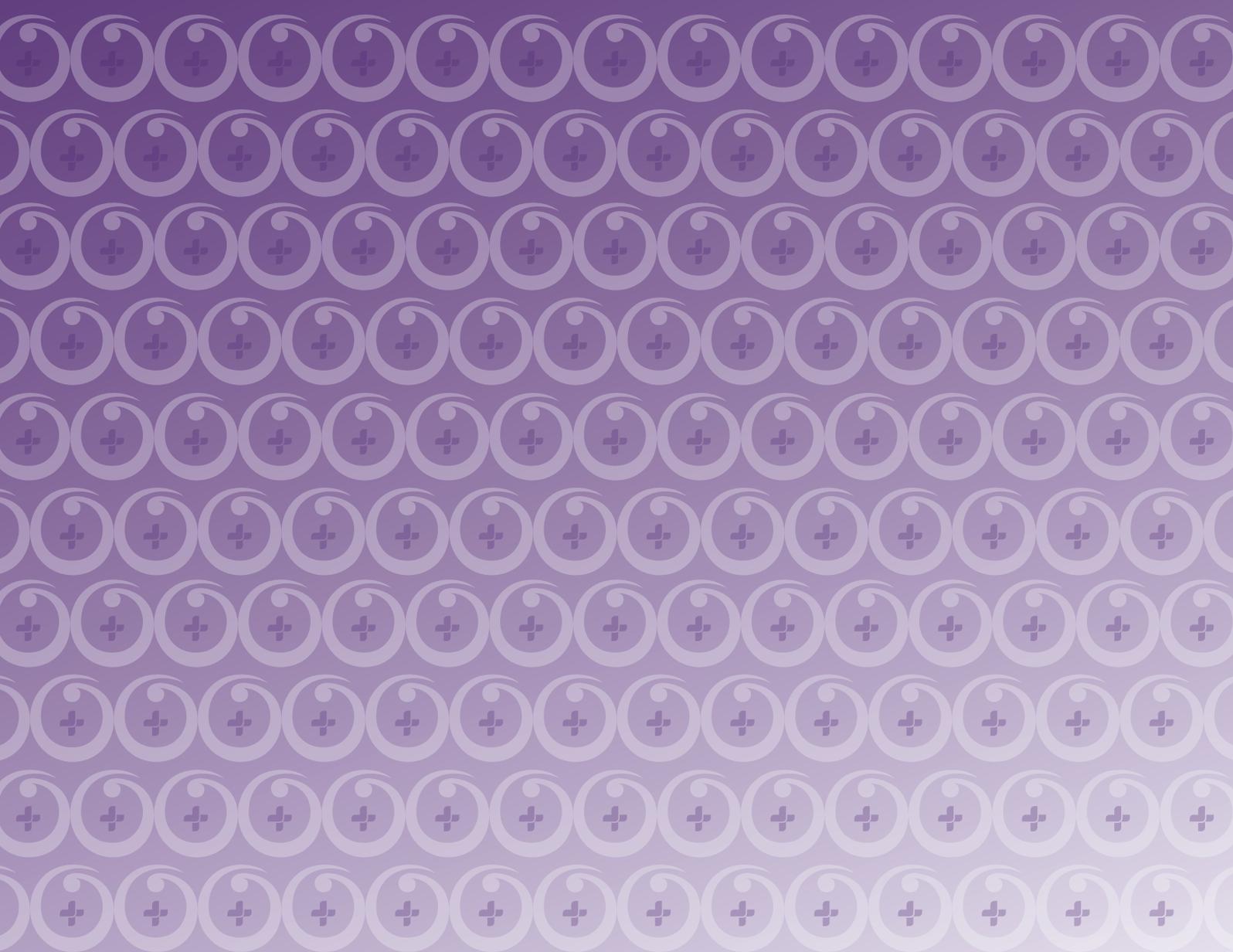
The work leading to the final design of the logo was carried out in conjunction with Sean McGarry, an experienced graphic designer and creative director. Sean has been involved in the technical production of the CENNZ journal for many years and has strong family connections to emergency nursing and CENNZ. The national committee consulted with CENNZ members throughout the refreshment process, incorporating feedback to reach the final design which was then endorsed by members at the AGM in 2022.



## History of the original Logo, 2001 – 2023

The first CENNZ logo was developed for the transition of the Emergency Nurses Section to the College of Emergency Nurses New Zealand – NZNO in 2001 at our national conference held in Waikato. The hands on the logo represent the womb of mankind. Spiritual and physical healing go hand-in-hand. The hands are cupped together to give balance and reflect 'Ngā Ringa Ringa Aroha' – gifted kupu through a Tainui ED nurse, Vi Taha.

# Articles, Case studies and Practice Reflections



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# Patient tracking during response to and recovery of mass casualty incidents: The challenges.

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## Background and objectives:

Mass casualty incidents (MCI) are a reality of emergency care that we should be prepared for. Most departments have kits of clinical resources and documents. However, the patient tracking process is often overlooked until an event proves that tracking-as-normal is ineffective. This article describes the emergency department (ED) efforts to improve its tracking techniques in Christchurch Hospital, New Zealand.

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## Methods

After each of two very large MCIs (the February 2011 Christchurch earthquake and the March 2019 Mosque shootings) reviews by inter-disciplinary teams occurred to identify the problems in patient identification and tracking.

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## Conclusion

Effective and easy patient identification was identified as crucial for tracking, and the initial decision-making for use of MCI registration or standard registration requires ED administration input. The new identification system provides a meaningful 'name' that can work with or without a digital system so is effective for a range of event types. It enables generation of reports of event patients, and for all areas to easily identify their patients.

# Patient tracking during response to and recovery of mass casualty incidents: The challenges cont.

## Keywords

Tracking; Tracing; Identification; Reconciliation; Record-keeping; Mass casualty incident; Major incident;

### Medication and allergies:

Nil allergies or medications. Nil over the counter remedies, or traditional medicines given.

### Common practice

Emergency departments (EDs) are naturally the primary patient entry point to a hospital in a mass casualty incident (MCI). This means that each ED needs to be prepared for a range of incidents such as multi-vehicle accidents, fires, flood and storm events, earthquakes and volcanic eruptions, workplace accidents, and terrorism. While most EDs have MCI plans of different sorts, perhaps with a cache of equipment on standby, and plans for who does what activity, not all EDs have plans for alternative tracking systems. Those that do, keep them proudly simple with unique identifiers such as an alpha or alphanumeric code, often in consecutive order so that they can see at a glance how many patient's they've had. This was our situation when we compared ourselves with others just after the Christchurch earthquake sequence of 2010-2011, although we used two unique identifiers. The use of a unique identifier in health is codified into law (Health Information Privacy Code, 2020, Rule 13), and it is best practice to have at least two (Suclupe, et. al., 2023), such as a National Health Index (NHI) number and either the patient's name or their date of birth.

As an outcome of our incidents, we learnt alphanumeric codes as a name was unsuitable, and this is consistent with the literature which shows that patient identification is a significant issue (Tallach et. al., 2022).

### 2011

During the 2011 initial earthquake and aftershocks, the department moved into the paper-based MCI registration and documentation system, partly because the department's computer system failed with the power-loss and partly from the anticipated surge of patients. The system comprised of standard hospital records in a clear plastic resealable bag, prelabelled with a pre allocated NHI number created by the Ministry of Health systems, and an alphanumeric code for a name (known as the disaster number or D number) for unique identifiers, and as each patient presented we added the apparent sex and approximate age. This D number and the NHI numbers were sequential.

In response to the internal review and ED staff feedback, a small working group was formed with two ED nurses, an ED doctor and an ED administrator. One nurse undertook formal interviews with staff asking about patient registration and tracking, with good

participation inside and outside of the ED. Results contributed to the working group discussions.

The similarity of patient identities led to significant confusion that took weeks to resolve, with one document set identity never fully resolved. In normal working days, patients who have similar names are flagged in various digital or paper ways (such as stickers) to warn staff that there is someone with a similar name in the department, for example two Mr Smith's. The question identified was, if we already know this is a risk, why are we setting ourselves up to risk confusion – especially during a high-pressure event such as an MCI? During the response, the staff added as much true patient detail to paper records, including on the laboratory request forms, to try and mitigate this. But, the laboratories then used their familiar standard processes and used that extra data to look up the patients on their own (still functioning) systems and placed results under the patient's true identity number rather than the incident identity, as a consequence the ED could not see the results as they did not know the true identity number while their systems were non-functional.

The first lesson was that staff throughout the hospital system were unfamiliar with the concept of a temporary identity name and number. The need to educate all staff on why it needs to exist, in whatever format, was clearly essential. An action arising was to document the details of the system to the master MCI plan (at that time it was called the Major Incident Plan or MIP), send posters to all inpatient areas, laboratories, radiology and the doctors and nurses education units for inclusion in the respective orientation sessions. It was also inserted into the ED team day programme where critical nursing and medical training occurs. The other action was to agree not to be 'helpful' to laboratory and radiology colleagues and withhold any additional identifying information obtained from coherent patients so that the teams would process tests on the allocated identity details.

Secondly, the value of the administration team was truly recognised – administrators are essential for all registration and tracking to occur optimally. It was agreed that they need to be a mandatory voice in the choice to use the MCI triage registration and tracking process or maintaining business as usual processes, and this was written into the plan and task cards.

Third, the issue of sequential or similar identity numbers was very obvious with hindsight. The National Health Index (NHI) numbers could not be changed as they're allocated out automatically from the Ministry of Health. Since we had used over two hundred numbers during the earthquake response and there had been a time lapse

# Patient tracking during response to and recovery of mass casualty incidents: The challenges cont.

since the last allocation, the new batch were different from the first – but were still similar. We also noted that having an alphanumeric code for a name was incompatible with the radiology IT system. As an action, we changed our alphanumeric patient names to a fuller version, for example D 123 became 'D-one-two-three', and then randomised them. We also took this opportunity to move from a plastic bag, which was reported as unfamiliar, to confining the patient documents into a standard clinical folder to increase recognition.

Fourth, when patients departed to either wards or back into the community, their data was not consistently captured; this particularly occurred when inpatient doctors had been the treating clinician as they were unaware what to do with the documentation. In some cases, doctors gave the clinical record to the patient and they were thus lost to the system. The action was to ensure inpatient teams work in partnership with ED staff, and to have administrators, or potentially other non-ward-based clerical workers such as clinical coders at all entrances and exits to capture the identity and destination of all patients and hold on to the records.

Fifth, while the computer system was only down for a few hours, it took days to catch up on data entry and weeks to resolve identities to their true details. There were already documents for capturing patient data at the point of triage and a master document to capture who went where. However, there was no system for consistently capturing additional identification and demographic data obtained from the patient during the presentation. The action was to create slips of paper with fields for documenting the additional data and these were added to the patient record packs so that clinicians could record any additional data and hand it to administrators as soon as possible for it to be entered to the master document.

Lastly, the staff did not like the cultural aspect of classing every MCI as a disaster. Generally, for a department an MCI means surges of patients, different ways of working, and the need to support each other, it's not necessarily a disaster or chaos. Various suggestions for names included 'incident' or 'response' or 'action'. The final decision was simply to abolish the disaster concept and adopt mass incident plan or MIP documents, plan and numbers.

## 2019

When the March 2019 shooting at the two Christchurch Mosques occurred, the MCI plan was implemented. The MCI packs had been used in smaller incidents in the interim without difficulty. This terrorism event response demonstrated different difficulties to the earthquake as it was large, quick and without an internal warning such as the shaking of an earthquake. During the earthquake, there was no attempt to enter patient names into the patient management system, this occurred after the event, and often the patient's true identity was already established so their 'disaster' details were merged onto their true details and merged formally on discharge. However, during this event the computer systems were working, and we had good numbers of administration staff, so data entry occurred close-to-concurrently to patient presentations.

In response to the subsequent internal review another interdisciplinary working group was formed. This group consisted of similar ED staff, and also a social worker, the patient flow manager, a health information representative, laboratory and radiology staff, and the emergency planner.

It was evident that the alphanumeric code for a name remained problematic in two ways. Although the numbers for names were randomised by this point, they were still very similar and confusion between patients remained. We also found that some staff were entering either 'D-one-two-three' or 'D-one-twenty-three' for 'D123', etc., while these numbers are equal in theory – they're not in reality.

The first decision was what to use as the second identifier – the patients 'name'. The working group compared notes with national counterparts and found one hospital used zoo animals for names and all the other hospitals remained on alphanumeric codes. The team were uncomfortable about possible cultural connotations of using animals and looked further. After the Boston marathon bombing Boston redeveloped their system to use local geographical features names such as 'Lake X'. This idea was well received; however, our department needs to consider the need to function for the extremely large event of the overdue Alpine Fault earthquake. As such, we elected to use city names as the range of choices is wide. Essential criteria for a name were that they must be:

- Easy to pronounce – to enable verbal communications such as handovers
- Easy to read and spell – to consider accessibility issues such as dyslexia, etc.
- No accents on letters – to enable easy digital entries
- Dissimilar to others – to reduce risk of confusion
- Not interpretable as a person's name – e.g. Richmond
- Not a known war-torn, potentially contentious, or distressing city

A search engine search for cities greater than ten thousand residents provided a long list; these were alphabetised to find and remove duplicates, then shared through the group to review. This removed many names as our team included those with only English language knowledge and others with dyslexia. The shortlist finished with 650 names, more than the 400 originally sought.

This led to a discussion about forenames and what could be used. Initially the idea was simply to use 'unknown' however there is an 'unknown' process for general use and we wanted separation from the two systems. We decided to use the now former Canterbury District Health Board (CDHB) acronym and MIP for the then current term of Major Incident Plan (now known as a mass casualty incident). A benefit of this is that if a report of the current number and locations of MCI patients' needs to be generated (for the police or communications, etc.), the user can search the patient information system using the forename field of CDHB MIP and the incident date,

# Patient tracking during response to and recovery of mass casualty incidents: The challenges cont.

and all patients will be displayed, even if their true identity has by that time been linked to the incident data.

Once these decisions were made and the city names chosen, all the pre-allocated NHI numbers given to us were renamed with a city name in the surname field in our patient information system, and CDHB MIP in the forename field; then wristbands (see figure 1) and identity stickers were generated and new packs using these were created with up-to-date documents. Areas identified as needing education of the processes, particularly the changes and reasons, included:

- Emergency department
- Investigation areas – radiology and laboratories
- Intervention areas – theatres, recovery, and gastro-enterology
- Acute and rehabilitation inpatient areas
- Allied health and pharmacy
- Mortuary
- Emergency Operations Centre and leadership roles

ED education followed and a simple resource for use in orientation was created and added to the Microsoft Teams site that all ED staff are made members of. Education outside of the department could not be truly monitored, only trusted that the key stakeholders completed it.

The data gathering practices remained problematic. The pressure of the workload meant that the additional identity data slips were under-used. The social work team stepped in at this point of the review. They had also reviewed their service responses and redeveloped their roles so that each admitted MCI patient will now have a social worker present with them until the event is over and beyond if required. Their team volunteered to be the staff to gather additional identification data and submit it to the administration team. To enable this, the triage and demographic data collection form was redesigned into a

card perforated in the middle – the triage nurse enters clinical, time-stamp and location data to one side and the other half, which is also pre-labelled, goes with the patient's social worker to complete when able, the administrator then uses the triage nurse's card as the initial data entry and adds more when the social worker has completed their half.

To further improve patient tracking, the patient's notes folder had a barcode added to the front stickier by the clinical coding team (see figure 2). A hospital-standard barcode reader is already available in the administration offices and useable at the ED exit to the hospital for instant recording of departures. This would be especially valuable if radiology and theatres also had the readers to track patients as they enter and leave.

A last identity lesson, particularly for events where the police are involved, was the labelling and tracking of patient property. If not properly labelled, the property cannot be returned to the patient, this may include valuables such as phones left in patient pockets. A single large labelled plastic bag has been added to each pack and smaller paper bags of items such as clothing can go into this large bag.

## 2023

The department has relocated to a new building, and all our plans have been updated or are in the process of doing so. Thus far, the triage, registration and tracking has not been challenged enough to identify a need for further change. It appears that the naming convention of CDHB MIP for a first name and a city for the surname will continue to work. The administration team remain a key deciding group regarding what registration system will be used and have become an integral contributor to the MCI plan review. Collaboration has been key.

The overall message is to **Keep It Simple and Standard** – our variation on the KISS acronym. During an emergency when working under high pressure: people work to minimum and basic processes. By staying close to business as usual (routine) we have the best chance of not confusing pressurised workers.

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Tallach, R, Einav, S, Brohi, K, Abayajeewa, K, Abback, P.-S., Aylwin, C., Batrick, N, Boutonnet, M., Cheatham, M., Cook, F., Curac, S., Davidson, S., Eason, H., Fiore, N., Gaarder, C., Garusinghe, S., Goralnick, E., Grimaldi, D., Kritayakirana, K., ... Gauss, T. (2022). Learning from terrorist mass casualty incidents: A global survey. *British Journal of Anaesthesia*. 128(2), e168-e179. DOI: 10.1016/j.bja.2021.10.003.

# Patient tracking during response to and recovery of mass casualty incidents: The challenges cont.

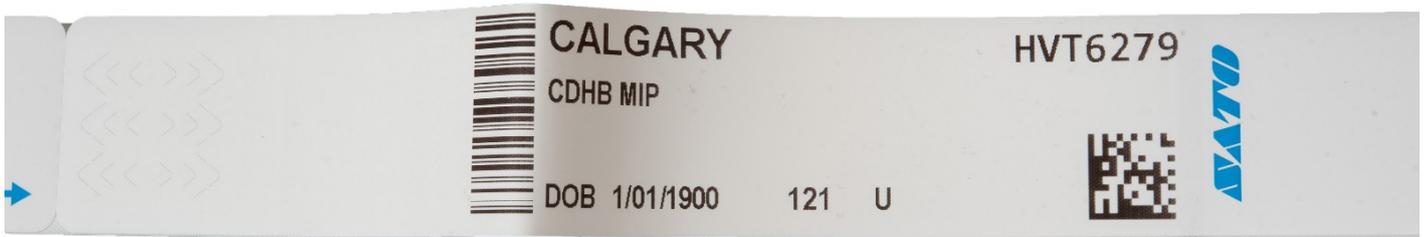


Figure 1. Example of the newest wristband and identity

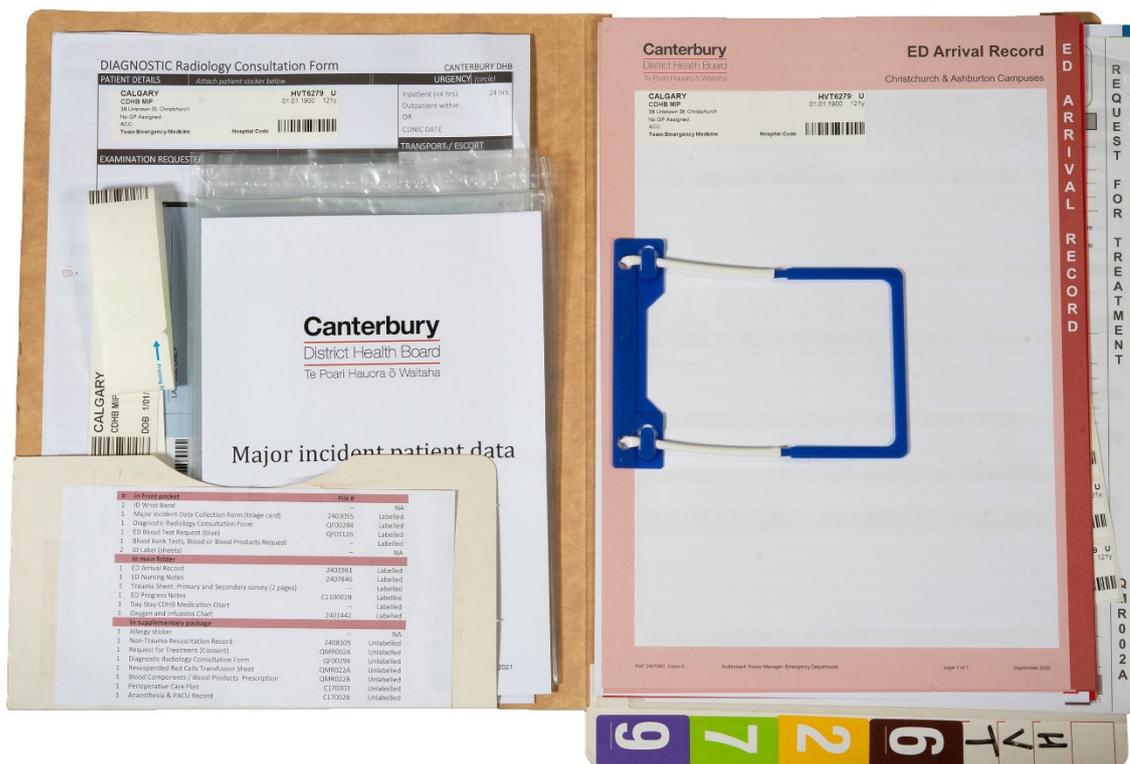


Figure 2 Example of an MCI patient record

# The Value of Mass Casualty Simulation.

## Author:

Lauren Miller, RN, MNurs, DMM, Clinical Nurse Educator, Te Whatu Ora Taranaki

Taranaki ED undertook a review of our Department Emergency Plan and Mass Casualty Plan over the course of 2022/2023. This work was undertaken by a working group of passionate volunteers and comprised of Senior Medical Officers (SMOs), Clinical Nurse Educator, Pharmacist, Maanaki Mana Clinical Nurse Specialist, Clerical Assistant and the Hospital Emergency Manager. The work took approximately six to nine months to complete.

The result was the publication of the Department Emergency Plan (DEP) and a departmental Mass Casualty Simulation (MCS) to test the process that had been described in the DEP.

The review of the Mass Casualty Incident (MCI) plan was structured with a focus on specific topics: MCI Triage, MCI Treatment Zones, MCI Leadership /Team Structure, Patient Identification and Tracking, Patient Flow and Communications.

As a result of the publication of the DEP, a Mass casualty Simulation (MCS) was planned and took place on May the Fourth (be with you 😊). Over previous years, Taranaki ED had completed a MCS (2021) and hospital-wide Emergo Exercise (2022). The focus and objectives for the 2023 MCS were to test out the newly detailed processes within the ED MCI plan and to build on previous learning outcomes from prior exercises. Below are the improvements, challenges and outcomes from the 2023 MCS.

The MCS was developed with clear testing objectives determined in advance. These did not have an overly clinical focus- but instead focussed on the establishment of processes. These were shared with all MCS participants in advance. In support of these testing objectives pre-exercise education and learning were pushed in the weeks leading up to the MCS. This education covered various learning methods such as email, posters and short 5-minute online videos. This ensured wide reach of this information by all staff.

Learning from previous exercises and experiences led to improved scenario development, which included improved simulation fidelity. The hospital had purchased new, improved simulation mannequins, which were tested prior to the event to ensure smooth operation throughout the MCS. Support was sought from national moulage experts, and staff from the Wellington Simulation Centre and Whanganui Civil Defence were flown in to work their magic. The mock patients were local nursing students from Te Pukenga (WITT) and were pre-identified and had briefings and instructions in the

days leading up to the MCS. Script packs were built for each casualty and were reviewed by St John Ambulance crew, WITT students and mannequin controllers.

Throughout the review of the ED MCI plan and with an effort to forecast the MCS early- this MCS had improved engagement. There was wide hospital support and an estimated 50-60 active participants across many different departments and support services, including but not limited to; ED SMOs, RMOs, NP, CNS, Nursing and Reception, delegated observers, mannequin controllers and timekeepers, Surgery, Orthopaedics, Anaesthetics, Medicine, Theatre, Administration/IMT, DNMs, Radiology, Laboratory, Pharmacy, Security, Orderlies, Call Centre Operators, Chaplains and Pouhapai Services.

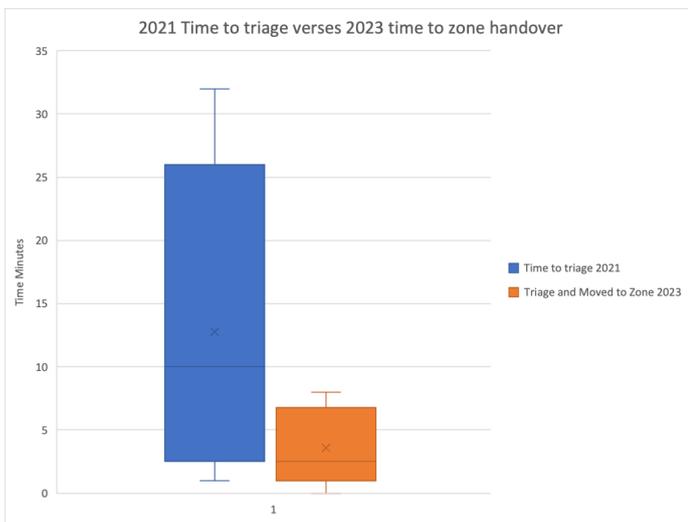
There were several objectives that went well throughout the MCS. The MCI Treatment Zones were all established; the top priority zones (red/yellow) were established within 10-15 minutes, and the green zone took 25 minutes to establish. The pre-planning of the pharmacy requirements ensured that all zones were able to be stocked with the required pharmaceutical support in a timely manner; a significantly improved process from previous exercises.

All the treatment teams were formed according to the MCI leadership framework, and all the key roles were fulfilled. ED Leadership Team, Triage Team, and Zone Teams were all established prior to the first patient arrival, and key members were provided role cards and identifying vests or stickers. Zone Leaders and Coordinators were able to allocate all patients to treatment teams and worked with leadership to prioritise investigations and disposition. The MCI Leadership team was able to successfully stay in an advisory role, which can be a real challenge for clinicians who are used to getting their hands dirty.

One of the key measurable areas of improvement from this MCS was the triage process. The team was established early, and Doctor, Nurse, Receptionist teams stayed together as a unit. As per the MCI plan, they used MCI Triage rapidly and refrained from patient care, which sped throughput. With support from security services, there was a single entry point maintained throughout the MCS. Triage process data was collected from the 2021 MCS and compared to 2023. There were clear and measurable improvements with the time to triage and movement to MCI zone- as displayed in the graph below.

# The Value of Mass Casualty Simulation cont.

Patient tracking and flow was one area that had been highlighted as needing improvement from the 2021 MCS. There was significantly more planning and preparation for this, which was led by the ED clerical staff. This resulted in every patient receiving a pre-made pack and unique patient identifying number allocated at triage. All patient tracking markers were centrally located on the ED MCI patient tracking whiteboard, AND no patients were lost throughout the simulation!!



One area that continued to be a challenge, despite a focus on the processes prior to the MCS, was communication. There were multiple issues identified, including:

- Inability to reach key players (DNM, Theatre Coordinator, IMT)
- Radios did not work well – background noise, radio chatter, switching channels
- Communication channels from treatment teams up through to the leadership Team
- Poor methods of communication so the rest of the hospital know an MCI has been activated
- Need IMT Liaison in ED, best paired with ED MCI Nurse Manager in central ED station.

In the end, first-line face-to-face communication was most effective!

Ultimately, there were several positive key outcomes from the establishment of the ED DEP and the running of an MCS. System safety and latent errors were discovered and fixed, engagement improved with each successive exercise, and there has been improved knowledge of MCI processes.

From here, we hope to continue to improve on the above outcomes and intend to run a MCS annually. With each successive MCS, specific objectives will be established, and collaboration with the wider hospital and support also creates opportunities for testing of wider MCI supports and processes. Familiarisation of the DEP has now been built into the department orientation and is going to be continued as a thread throughout professional development pathways.

This article was written by Lauren Miller (RN) with support from Dr Kelly Pettit (FACEM) and Dr Chris White (FACEM).



# MCI/ Disaster Response – Waitakere ED perspective.

## Author:

Lydia Moore, Clinical Nurse Specialist

On 27th January 2023, Cyclone Gabriele hit Auckland, causing heavy rainfall, flash flooding and widespread catastrophic floods, with the North Shore and West Auckland being the worst affected areas. In what was described as a 1-in-200-year event, an entire summer's worth of rain fell within 24 hours. As a result, motorways and major access roads were closed; the closure of Auckland Airport occurred, stranding thousands; hundreds of cars were stranded; thousands

of people were forced to evacuate from their homes; thousands of homes lost power and water; and supermarkets and petrol stations flooded. Consequently, a state of emergency was declared in Auckland by Mayor Wayne Brown, some hours after the initial flooding. Tragically, three people died due to the event; two drowned on the North Shore and one as a result of a slip in Remuera. In addition, countless animals and livestock were lost due to the floods.



A car trapped in flooding on Auckland's northern motorway as rising water brought traffic going in both directions to a standstill. Photo / Supplied to NZ Herald 28/1/2023



A bus stuck in flood water on Auckland's Great North Rd. Photo / Supplied to NZ Herald 28/1/2023



Flooding in Auckland looking from Beach Rd at the bottom of Parnell towards the Auckland Domain. Photo / Tom McCondach in NZ Herald 28/1/2023

During the event, Waitakere Emergency Department experienced a decrease in patients presenting with medical conditions. However, presentations for social complications increased on and in the days that followed. These were due to a range of reasons, including an inability to access homes due to road closures (particularly prior to the state of emergency being declared when there were no community hubs set up for stranded families), loss of homes,

inability to access medications or home help equipment etc. The wider hospital experienced flooding in some of the older buildings, but thankfully none where patients were. The effect of the floods on these rooms, however, impacted staff in other ways, as these rooms were used for education sessions. The damage caused by the flooding resulted in future study days being cancelled for months until repairs could occur.

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# MCI/ Disaster Response – Waitakere ED perspective cont.

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This was Waitakere ED's first experience of a natural disaster. The staff showed great teamwork as they handled the disaster extremely well. Difficulties identified from a logistics point of view due to the cyclone were: a few staff had to leave to pick up children as schools were closing, change of shift staff weren't able to get to work due to road closures; likewise there were staff unable to get home after their shifts. As a result, the department was understaffed in all areas (nursing, medical, healthcare assistants, cleaners, clerks, orderlies were all affected). In response, the District set up emergency accommodation for staff who were unable to get home or whose houses had been destroyed by the floods. In the days that followed, there were still numerous staff who were unable to work due to inaccessibility, particularly for people living along the coast or staff needing to rehome, leaving staff shortages on the floor.

Lessons we learned as a department from the floods included improvement of our communication in contacting staff by updating the ED staff phone list and looking at creating a communication app; severe weather planning, which adjusted doctors' rosters to work at their nearest hospital (e.g doctors living on the north shore were changed to work at North Shore hospital instead of Waitakere) and adjusting the nursing roster when notified of severe weather events. Evidentially this was tested days later, on 1st February, when further flooding occurred in Auckland, though less severe. In addition, the disaster management plans, which were in the process of being updated, were accelerated for completion.

In 2019, a project was undertaken by a senior nurse on disaster/emergency management education within the department, which identified deficits in staff knowledge across all multi-disciplinary teams. Following this, a pilot education day was conducted, which involved teaching sessions and hands-on training where staff expressed greater confidence and understanding of their role in a disaster event afterwards. Unfortunately, due to COVID-19 and the effects of the flooded buildings, further teaching was delayed. Since then, there has been one further study day provided for senior nurses where feedback was again positive, with the aim for further teaching and Tabletop simulations in 2024. In the meantime, new staff are given a brief orientation of disaster training for the department, with further in-depth training given to ACCNs, and North Shore ED incorporating a Tabletop simulation, which included the use of Teams' app. In addition, Waitakere ED has a Visible Disaster Board with up-to-date information available for all staff to visualise. Depending on the disaster, the ACCN and/or the emergency system planner would be the one to initiate the response. The department has use of a resus sticker board for clear identification and a designated disaster box.

Unfortunately, we are not immune from disasters, and in light of the recent flooding in Auckland along with previous national disasters, it is evident more education is needed around this.

# Christmas Eve: Managing a Mass Casualty Incident.

## Author:

Jan Armstrong, RN

On Christmas Eve of 2016, I was on the afternoon shift in the Gisborne regional ED where I worked, when we started hearing rumours about a bus crash in the Whararatas<sup>1</sup>, 30 minutes from Gisborne. After hearing these rumours from multiple sources, I contacted the St John Ambulance station manager and had the rumours confirmed. We had no idea at this point how many people were involved, only that it was a 'full bus' that was involved.

This was not the first time this ED had experienced a Mass Casualty Incident (MCI), but it proved to be the biggest, and fortunately we had all had training on our disaster response roles within the last two years. I called the Nurse Unit Manager at home, the Duty Nurse Manager in the hospital and the Head of Department. Each time I called someone at their home, I had to reassure them it wasn't a prank.

Not long after making these calls, we received our first couple of patients from the crash. By this time, we had been informed that the incident had involved the bus leaving the road, and that it had been transporting a group of visiting Tongan students and teachers. These first patients had been the ones able to climb out of the ravine where the bus had fallen on leaving the road, and raise the alert.

From the arrival of those first few patients until the next two patients presented, of whom were seriously injured, it was over an hour. During this time, many of the people who had been called in to work began arriving. A little after midnight, without any further patients coming in, the hospital manager in charge decided to send the nurses from the afternoon shift home, as our shift had ended. I was about to leave when we found out that the majority of the people on the bus had been placed onto another bus and were heading for the ambulance station. The intention was for them to be assessed and given initial treatment there, before transferring on to definitive care. I was asked to go there and help, which I did.

I was one of two nurses who went to the Ambulance station to assist with the triage and response to these patients. There was also an Emergency Medical Technician (EMT) from St John, and a member of the Tongan community who had arrived and was there to help with translation and interpretation services.

I organised for the people to come off the bus and move to one side of the room, where I could do rapid triage of who needed to be sent immediately to hospital and who we could treat at the station. I based this on the following: anyone who had pain in their torso was sent to

hospital, and those with foot injuries were managed at the station. This aligned with the predominant mechanisms of injury we were seeing – abdominal and chest trauma from being thrown around inside the bus and impacting against solid objects and injuries to feet from broken glass and debris as many were wearing jandals, open sandals, or were barefoot. Those identified as needing to go to immediately to the hospital were placed across the room from those staying, to help keep track of people. All up, there were around 30–35 people. Eight were sent directly to hospital.

The second nurse then assessed and treated those who were identified as having isolated foot injuries as best as she could with limited equipment and no beds, and prioritised who amongst this group went to the hospital first.

I had the Tongan support person write everyone's name and date of birth on a small piece of paper that they then held on to, and we would write any vital signs and medication and the time we gave them on the piece of paper. This made record keeping easy, especially considering that none of the people on the bus spoke English and we didn't speak Tongan.

At events, St John use a form that collects the name, date of birth, and treatment provided, and we also used these forms to help keep track of everyone we saw and record everything we did for them.

Once I finished triaging, I helped the EMT assess, clean, and dress all of the people with wounds to their feet. I will never travel in bare feet or jandals after seeing how badly their poor feet were cut.

After finishing our management of all of the people with injuries, we still had a couple of patients who were waiting on ambulances to take them to the hospital. I figured that they had remained stable all this time and that an ambulance was not really required, so I decided to drive them to the hospital in my car so the other two could go home and get some sleep before their Christmas morning.

The limited number of ambulances available, and the turnaround time for transporting patient added to the decision making. After helping for about one more hour in the emergency department, I finally went home and got some sleep myself.

Looking back over the next few days after the bus crash, it occurred to me that we hadn't followed the plan that the hospital had put in place for MCIs. On reflection, I thought that this was likely a result of

# Christmas Eve: Managing a Mass Casualty Incident cont.

several factors, including the potential need to identify another area for patient management when the volume of patients exceeded what could physically fit within the ED. An additional factor was that in planning for a MCI, the chances of it happening on Christmas Eve (or similar) is not one that is usually considered, or the impact this might have when planning how to staff a department. Many of the ED staff who were contacted at home to see if they could come in and work had already been consuming alcohol and, therefore, were unavailable to work, even if they had been willing.

Another issue that I personally encountered was the physical position I was in when assessing and treating the patients with wounded feet.

These patients were sitting on chairs, so this left me crouched down in a squat position for around three hours. For the next few days, my quads were very tight and sore!

Overall, 48 people were injured from this incident; from this, two were flown directly to Hastings Hospital, one died at the scene, four presented to the ED via car, and the remainder were transported to the ambulance station for reevaluation. Twenty-seven people were taken to Gisborne Hospital ED.

<sup>1</sup>Wharerata: a hilly region in the North Island of New Zealand; the incident occurred on the main highway which runs through the Whareatas, between Wairau and Gisbourne.

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# Reflecting on Disasters and the Nursing Response.

## Author:

Brendon Tampus, Associate Clinical Nurse Manager (ACNM) Whangārei ED

In 2023, Aotearoa/New Zealand had its full turn of natural calamities. As I reflect on one of the most disastrous cyclones in the history of Aotearoa/New Zealand and the Pacific, I also have the opportunity to reflect on my leadership skills, be grateful that though they were tested I was able to persevere and to learn from this challenging time. Four weeks after commencing my role as associate clinical nurse manager, Cyclone Gabrielle hit Northland over the space of a week and I found myself having to manage the emergency department in the most challenging time. The devastation it caused to Northland felt overwhelming. It resulted in wrecked farm lands and flooding causing power outages, and more than sixty roads were blocked. In terms of medical services and resources, GP clinics were closed, older hospital building structures damaged, shortages of medical supplies became apparent as areas were physically isolated, and patients unable to get to places were among challenges faced. Reports of damage to the Whangārei Hospital during this time included three rooms in the ED that needed to be temporarily closed as a result of leaking ceilings which began during the cyclone (Ling, 2023). Responses included the Civil Defence Force utilising helicopters to supply medications and NZ Defence Force Unimogs<sup>1</sup> taking patients to hospital and rural community clinics for treatment and organising safety shelter for staff and whanau (Trüding, 2023).

Four months later, another tragedy occurred, the caving incident at Abbey caves. In my vivid memory, the emergency department was in full capacity on that day. Once again, I was the nurse in-charge of Whangārei ED when one of my leadership team announce the news that fifteen children and two adults were trapped in the caves pouring with heavy rain. One of the ED staff had a son who was amongst the trapped children, and they felt unable to continue at work, and went immediately to the scene. While understanding that adrenaline response and feeling of fear as a parent, this did reduce our senior staff numbers.

Despite all of the stresses associated with major incidents, I saw spectacular teamwork and camaraderie. In order to free up bed spaces to accommodate incoming patients, along with ED team and departmental SMOs from varied specialities, everyone gave their

best mahi and efficiently collaborated, focusing on working in ED to review, admit and discharge patients as quickly and safely as possible. First time that I have experience an emergency department cleared out so fast! Moreover, the support from nursing colleagues offering their time and dedicated skills to help out the team was a day to remember.

The essential skill to manage disasters is preparedness. By recognising an incoming situation we can act promptly to mitigate and lessen the impact of an event. Whangārei Hospital has Hazmat and Major Incident Protocol to managing unforeseen events involving three or more Status 2 calls from St. John Ambulance expected within same timeframe or seven or more patients from a single incident. This planning makes use of manpower skills appropriately and effectively. Currently, the Major Incident Protocol is being refined and reviewed in response to the recent calamities that have affected Northland.

According to senior nurse Kylie Johnson, "MCI response processes are being updated to better align with other regional hospitals. The team working on this is predominantly nurse led, with senior medical officers from emergency, medical, surgical, orthopaedics and paediatrics specialities and clerical team. Once finalised our aim is to roll out departmental wide education and training simulations. Role specific education will also be provided during staff orientation and annually thereafter. For instance, Mass Causality Triage Scale and Management of Unidentified Patients' education will be provided for senior RN's and SMO's who are most likely to be involved in Triaging during an MCI."

1 The Unimog used by the NZ Defence Force has been described as "4-tonne, 4-wheel drive truck used for various tasks including troop movement, stores carriage and a light gun tractor". Unimogs deployed to help in areas hit by Cyclone Gabrielle are the U1700L (1976-88) model, with massive wheels, high ground clearance, portal axels and a snorkel.

<sup>11</sup> The Unimog used by the NZ Defence Force has been described as "4-tonne, 4-wheel drive truck used for various tasks including troop movement, stores carriage and a light gun tractor". Unimogs deployed to help in areas hit by Cyclone Gabrielle are the U1700L (1976-88) model, with massive wheels, high ground clearance, portal axels and a snorkel.

# Reflecting on Disasters and the Nursing Response cont.

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Photo by: Mel Ewins (2023). Whangārei Base Hospital Ambulance Bay.



Photo by: Mel Ewins (2023). Whangārei Base Hospital Ambulance Bay.

# 'The Day of the Cyclone'

## Author:

Laura Cottrell, Clinical Nurse Educator, Hawke's Bay Emergency Department, Te Matau a Māui

On the 14th of February, 2024, Hawkes Bay was hit by one of the worst weather events since Cyclone Bola<sup>1</sup>. An event that caused mass destruction and trauma to those who lived in the region.

While all of this unfolded in front of the rest of New Zealand (and the world) on your TV screens, we were living hour by hour, not knowing what was going on and trying to make sense of what was happening. All this on top of managing a full emergency department, full hospital and the threat of multiple casualties. We were isolated. We had no idea what was happening in the community, with our family and friends, or even when we could return to our family and friends.

This tested the theory that 'this will never happen in our lifetime', and given how the world is, this well-worn assumption seems now null and void. Now more than ever is the time to ensure that planning for such events is paramount. So many aspects made managing this cyclone tricky from a hospital point of view, and it has since given rise to significant conversation about how to deal with this in the future.

Before cyclone Gabrielle even hit our shores, it was hit-and-miss as to the prediction of its course. New Zealand was notified of the potential of a subtropical cyclone, heading this way, on the 5th of February (Corbet, 2024; Hewett, 2024). As it came closer and closer, there was some confusion about how bad it was likely to be. Leading into it, Hawkes Bay itself was under the impression that most of the impact was going to hit to the north of us. It might be windy, so tie down the trampoline. It might be a bit wet, so clean out the gutters. That's about the extent of our planning as a region.

Now, as an ED nurse, I've grown with the mindset of planning for the worst-case scenario. However, my husband (bless him) does not share the same views on matters like this. I watched the news, turned to him, and said, "Should we go to the supermarket and fill up the cars, just in case?." Being the typical man who marries an ED nurse, he said, "Na, you're overthinking it... this will fizzle into nothing"... (don't worry, I haven't let him forget he said this).

So, as any grown 30-year-old woman would do, I rang my Dad and asked him what he thought. Now, my Dad works for the New Zealand Fire Servicer, so I assumed he would know how much prep was happening in the community. He replied, "Na, we will be sweet; we have been told to send crews to Gisborne to help support them". So, we settled into bed for the night.

And what a night it was! The wind and the rain were non-stop! You would lay in bed thinking, 'Surely this will settle shortly.' It kept hitting harder and harder.

After a night of no sleep, I left bed at 5 am and checked the 'stuff' news site. Hawkes Bay was now in a national state of emergency, a precautionary measure given the battering that had occurred

overnight. However, that was the only damage reported at that time. The worst was still to come.

I opened my curtains and assessed the damage. I rang Amy, our Clinical Nurse Manager and asked if she was okay. A lake of water surrounded her, but thankfully, the houses sat high in the street, so her home was fine. I, fortunately, owned a grunty Toyota Hilux and a grunty husband, so we put on our 'Redbands', picked Amy out of the moat surrounding her house and made our way into work.

It was slow as we made it down the motorway, but it didn't feel that intense. There was a bit of surface flooding around the place, until we approached the Tutaekuri Bridge. When we approached it, the water was licking the side of the road. My husband pulled the car over, looked at me and Amy and said, "If you are going over this bridge now, I don't think you will get back later. Are you sure you want to do this?" The rain was settling down, so we both decided it would not break over; we would be sweet. As my husband dropped us off, I kissed him goodbye, told him to pull some meat from the freezer for dinner, and toddled into work.

We were three nurses short; they had the insight not to travel over the bridge and stayed home. Staff who lived in Hastings offered to come in later. So I jumped on the floor until they arrived. It would have been 15 minutes into the shift when, all of a sudden, everything went black, and there was a 'vooom' of the generators starting up. There was an airy feeling about this 'vooom'... we all looked at each other with a 'here we go' vibe... and then it was all go...

All power in Napier and Hastings had gone. No cell service was available in Napier, and it was very patchy in Hastings. All RT (radiotelephone) communication was cut, and all roads in and out of Napier were closed due to flooding. However, we didn't know how bad this actually was.

Then, the first ambulance arrived with news of what was happening in the community.

Eskdale was the first place to get hit. This beautiful little town is just north of Napier. It was where I grew up, where I got married, and where many of my family still live.

The Esk River runs parallel to the township. Now, the flooding was not caused by the rain itself, but by the 72 Olympic swimming pools of rain that fell every minute for six hours up in the hills. This water came down the hills like a wall, destroying the stock bank and ploughing through the valley. This happened at around 5am, so people were waking to their beds floating in their homes and scrambling in the dark to try and get onto their roofs. No one could get into Eskdale for hours until the rain had started to clear. People were left trapped,

## 'The Day of the Cyclone' cont.

waiting for helicopters to arrive or locals with boats to take them to higher ground (Hendry-Tennant, 2023).

There was a very similar story in Puketapu, just over the hills. The sheer force of the water coming down the river, breaking the banks and taking out homes and farmland. Again, people stuck on roofs waiting to be rescued for hours and hours.

Next to be hit was Omahu, a little township northwest of Hastings. The same story, the sheer amount of water running through the nearby river forced the banks to break, flooding the small town. As this occurred around 0700, they could evacuate quickly to higher ground.

Then, at around 0900, Pakowhai was the next to go, just down the road from the hospital. These were houses, lifestyle and horticulture blocks. All taken over by a wave of water. Now, these locals had evacuated to the emergency evacuation site as directed by Civil Defence. However, while they were there, the water around them had become so overwhelming they were forced to leave or hold on, some to trees, for three to four hours.

It was at this time a terrified-looking police officer came to our ambulance doors in a panic. He told me they were trying to rescue 30+ people from Pakowhai who had been in the water for hours. The majority were elderly and hypothermic. And they were all about to come here. I calmly stood up and went to tell Amy, who looked like she wanted to slap me, and we activated a mass casualty response.

So, we had 10 minutes to prepare the department for an onslaught of patients.

The first thing we needed to do was to clear out what we had. It still makes me laugh that we continue to have overnight stays, every day. Then, as soon as mass casualty is activated, 15 spare beds are suddenly available in the hospital! And all the patients sitting in the ED can suddenly move upstairs! Around ten physios suddenly appeared in front of Amy and were directed to take any patients for admission to the wards. No handover necessary – grab the notes and a brief description and go.

We then had to get any nurse we could into the department. Easier said than done when there was no way of contacting anyone! We sent out a blanket message via text, email and Facebook, telling staff to present to the emergency department for a mass casualty event and contingency planning if they could get to the hospital safely. If you lived in Napier, you were to present to the Napier Medical Centre as they were setting up a makeshift hospital there. Then all we could do was sit, wait and hope that people would know to turn up.

In terms of staff planning, we knew this would be a marathon, not a sprint. So, as good as it is to have everyone turn up at once, we needed to ensure we could staff for at least the next 24 hours, so our Associate Clinical Nurse Manager (ACNM) directed staff to go home and rest, returning later to replace the team already tied up in the mass casualty response.

Across the road from us is the private hospital Kaweka. When this opened last year, a few of our staff members left us to work for them. They could quickly come over and give us a hand immediately, which was fantastic as they knew how the department worked and didn't

require orientation. And with them, they brought bair huggers?! We knew these patients would be wet and cold and need warming, so having 15 bair huggers available was a dream!

Alongside all of this was the need to look after the welfare of our staff. Hawke's Bay is small. Everyone knows everyone, and the whole region was hit hard, everyone impacted differently. Ultimately, we were all affected by the fear of the unknown and uncertainty as to what was happening.

We ensured staff had regular breaks throughout the day by having a floating RN available. We checked in on the team constantly throughout the day, and if they were just not in that mindset to be at work, we sent them home, providing it was safe to do so.

As I mentioned, preparation was underway for the influx of patients we were about to receive. I set up two triage stations in the ambulance bay with a couple of 'computers on wheels'. I, along with our excellent RN Anna, began triaging the patients brought in by the police so that our main triage area could continue with business as usual. As the police arrived with these patients, we could quickly assess where these patients would be best cared for. Those who were hypothermic, elderly and had comorbidities were taken immediately inside our now-empty department. Those walking wounded were directed to our fast-track area, where our Nurse Practitioners could assess, treat, and provide showers.

By this time, welfare centres had been established in the community, so patients who could be discharged were transferred there for further care.

So why were we so isolated?

Four main bridges connect Napier and Hastings. The Puketapu and the Waiohiki bridges were gone entirely, thanks to water/slash<sup>3</sup> and the impact from a rogue blue shipping container.

The Tutaekuri and Awatoto bridges were still in one piece. However, they were completely overwhelmed with water and required extensive assessment before they could be used. It was days before anyone could cross these bridges, including all our nurses, who had managed to get over before it all kicked off.

Thankfully, many nurses based in Hastings opened their homes, with many of these homes being the first to have their power turned on. A house with a hot shower and meal was a massive luxury. So, after 10 hours of franticness, the boss dragged me to our ACNM's home for a much-needed break. After a not-so-peaceful nap, plagued by the sound of back-to-back helicopters picking up those still trapped on roofs in isolated areas and taking them to the hospital and welfare spots, we headed back in for a night shift, as there was not much else we could do.

The night was airily quiet (which, yes, I know, is a word we don't use), but it was a perfect time to take stock of what the heck we had just dealt with during the day. We used it as a time to check in with each other and tell stories of what we had heard or what some could see, depending on whether they had their power back in their homes. As tired, scared and anxious as we were, that night shift served as a necessary debrief for our team at that time.

## 'The Day of the Cyclone' cont.

So after working our night shift, we returned to our ACNM's home, showered and put on a fresh set of hospital scrubs to settle in for a sleep. By this time, the adrenaline had started to wear off, and the reality of the situation had set in. Both Amy and I continued to try and contact our families, with nothing getting through. Both of us sat on each end of the couch, watching the news and sobbed, and sobbed and sobbed.

We recognised this was doing us no good, and sleep was probably a better option. So, we brushed our teeth when my phone rang for the first time. It was my brother, who also works for the NZ Fire Service. He was on his way over in his truck to pick up his partner, who was a nurse in the paediatric ward, asking if we wanted a ride. We had two minutes to decide.

We figured if he could get over the bridge now, we would be able to return tomorrow, so we frantically packed everything away and jumped in with him. Our briefing from him was if asked, to say that we were firefighters coming through to help with the emergency response. I wonder how we got that across the line, given how terrible we looked coming up to 25 hours of no sleep.

As we slowly crossed the bridge back to Napier, we realised it was like looking at an apocalyptic world.

There was no phone coverage whatsoever. The radio went immediately static. People were driving everywhere. There were lines out of the supermarket and at the gas station. No traffic lights. No power. It was anarchy!

We got home, and my husband was nowhere to be seen, so I went to Mum and Dad's and crumbled. By this stage, I was approaching 30 hours of no sleep. Nothing was making sense. I just needed my mum and a bed. Mum put me in the shower and put me to bed, and after telling her I'd be up after a short nap, I slept for 12 hours.

In the days following the cyclone, everyone just went into survival mode. All anyone wanted to do was help out in the community. Most of the time, we would drive to affected places – find a house and grab a shovel. And all you would do is shovel silt out of homes all day long.

Medical clinics opened in affected areas where nursing staff volunteered to help assess injuries, give tetanus boosters, and refer patients to further medical care if needed.

All this work out in the community really strained everyone, as many felt guilty for going to work. They all wanted to be out there helping in some way or form, so it was really important to explain to the team that the work in the ED is essential in these situations and that they needed to be looking after themselves as well. They had all experienced something traumatic, and the come-down from that can be intense, so keeping up those conversations was essential.

These affected areas still have much more work to do to clean up homes and properties. With many unable to return to their homes, Hawke's Bay accommodation has become very tight, with many living with family and friends, waiting for anything to become available. All of this added stress has meant the mental health of those in these areas is continuously tested. A massive amount of mental health and community support has been poured into these areas, especially for those who are living in isolated and rural regions. The need for this will continue as the summer is expected to be hot and dry, creating more issues with dust and stretched farming resources.

So, what was learned throughout this whole ordeal?

- Hospital netting underwear needs improvement – especially if nurses are going to need to wear them while working a shift!
- Staff welfare is paramount in these kind of situations. As I said, everyone was affected somehow, so having regular check-ins and allowing our staff to rest is so important!
- Go through your mass casualty plans! I had been in the educator role for only a month, having come from outside of the hospital, so I had not even set eyes on ours when this all kicked off! Please pick it up! Read it! Go through your equipment and ensure that the process is included in your orientation packages, and regularly refreshed.
- Most importantly, we learned that the impact of support from the nation was a game-changer. We received so many gifts, pizzas, snacks, koha and aroha from our fantastic emergency colleagues around the country that made us all feel like we weren't alone. So, on behalf of our ED team, thank you so much for your love xx

<sup>1</sup>Cyclone Bola struck the Hawke's Bay and the Gisborne / East Cape region on the East Coast of the North Island on 7 March 1988. It caused severe flooding, resulting in 3 deaths and 4 towns declared states of emergency.

<sup>2</sup>3M™ Bair Hugger™ Patient warming blankets are a convective temperature management system

<sup>3</sup>Slash – the term refers to forestry debris and logs that can be swept downstream during heavy rain, causing further flooding and damage.



**Photo 1:** (Cyclone Gabrielle Cleanup) needs the attribution: source: SGT Vanessa Parker/NZ Defense Force, CC BY 4.0 <<https://creativecommons.org/licenses/by/4.0/>>

**Photo 2:** Cyclone Gabrielle source: NZDF 20230219\_NZDF\_R1055669\_025

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# Whakaari/White Island Eruption.

**Author: Jan Armstrong**

Associate Clinical Nurse Manager, Middlemore Hospital Emergency Department

On Monday, 9th December 2019, the volcano on Whakaari / White Island erupted. While this is one of New Zealand's most active volcanos, situated 48km off the coast of Whakatane in the North Island, this eruption was not only unexpected, but also much more violent than previous events. News reports described it as an explosive eruption, descriptions which matched the full Māori name of the island - Te Puia o Whakaari - The Dramatic Volcano. The official NZ Gazetted name was changed to Whakaari/White Island in 1997. At the time of this violent, explosive and unexpected eruption there were 47 people on the island.

I was enjoying my last day of annual leave and was following news of the eruption when I received a phone call from the (Nurse Unit Manager) NUM of MMH ED. I was asked to come in for the night shift as a senior Associate Clinical Nurse Manager (ACNM) to help coordinate the patients who would be arriving from Whakaari/Whakatane Hospital. With our ED being the gateway to the National Burns Centre and hearing the number of victims involved, of course, I said yes.

This was an emergency that involved essentially the whole country and, later, other countries when it came time to repatriate their injured citizens. Our health system was stretched in a way we had never been before - limited specialist burns surgeons for the initial and then daily trips to theatre for debridement; donor skin had to be brought in from overseas; helicopters and crews flying patients from Whakatane to the various burns units around the country (Baker et al, 2022; Longmore, 2021). All of this resulted in a significant fiscal cost as within the NZ health system ACC<sup>1</sup> covers the expenditure associated with accidents. However, as many were from the cruise ships, they also had travel insurance.

That day and night, 22 patients were transferred around the country. Due to the high volume of casualties, they were arriving in tertiary facilities hours after the eruption, intubated and ventilated but not decontaminated, and not having had a trauma workup for potential blast injuries or falls. I think the staff at Whakatane Hospital did an amazing job with the resources they had.

As with most MCIs, the patients were allocated NHIs and an alias until their identities could be confirmed. Unfortunately, this led to a case where two family members were sent not just to separate hospitals but separate islands (north and south), leaving the surviving family member the agonizing choice of which person to be with.

At the time of the incident, MMH ICU was almost at capacity and already had a severe burns patient who was going to OT on a daily basis.

When I arrived, the department was running smoothly but was buzzing with speculation about what to expect. I attended a meeting with the burn's doctors, bed and hospital managers, and critical incident staff.

I was told that we (MMH) had accepted 4 of the patients, but their expected arrival times were unknown. I was surprised that we were only taking four patients as I had thought that having the National Burns Unit, we would have taken the lion's share of the patients.

Over the rest of the night, the patients arrived one by one, flown up with doctors and paramedic crews, all intubated and ventilated. We proceeded to PAN scan them for potential trauma injuries.

When the first patient arrived, they had what we assumed to be volcanic ash on their bodies and the burns doctors asked us to clean it off prior to them going to OT for a scrub down. The ash would not come off. We tried dry wiping, and when that didn't work, washing, but still it remained. The skin on the patients' backs seemed to be the most affected, it was tan in colour and leathery to look at and touch. Interestingly, their skin was protected where they had been wearing cotton clothing, such as underwear, but not where they were wearing synthetic materials.

Because we only received four patients overall, the number of nurses involved in the care of these people was low, and they were all senior and more accustomed to dealing with patients they knew would probably have a poor outcome. We discussed the cases after each case left for OT and reminded everyone involved to reach out to EAP (employee assistance programme) if they felt they needed to. I know that there were formal debriefs offered later, especially for the ICU staff.

Looking back, I'm glad that I was involved, even though it was in a small way. I believe that the nurses, doctors and administrators involved all took away lessons for future disasters.

<sup>1</sup>Accident Compensation Corporation. Everyone in New Zealand is covered by ACC's no-fault scheme if they're injured in an accident. This includes children, beneficiaries and students. It doesn't matter if they're working, unemployed or retired. It also includes visitors to New Zealand.

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**Photo:** White Island Lake with the attribution: Javier Sánchez Portero, CC BY-SA 3.0 <<https://creativecommons.org/licenses/by-sa/3.0/>>, via Wikimedia Commons

# Regular Features:



## A spotlight on ED Pharmacology:

# DROPERIDOL – just dropped into ED!

### Author:

Louisa Sowerby, Pharmacist, Te Whatu Ora Waitaha

The introduction of Droperidol as a regular stocked medication within the Te Whatu Ora Waitaha ED was the trigger for the development of this additional education regarding its use. As with all medications, it is essential to have a clear understanding of any potential side effects, and possible adverse as well as expected therapeutic outcomes.

#### DOSING:

Droperidol will be available as 2.5 mg/mL injection for IM or IV administration, and it is anticipated will mostly be given as a push. By contrast, haloperidol is a 5 mg/mL injection.

I would expect to see 0.625 mg – 1.25 mg for nausea/vomiting, 2.5 mg for migraine or as adjunct for undifferentiated pain (very scant evidence), 5 – 10 mg for sedation/aggression. Evidence for this is outlined later in detail.

Most use will be as a single dose; when used for the purpose of sedation, it is sensible to wait at least 30 minutes before any additional sedation is used.

Reasonable to leave 2 hours if an additional dose is needed in most other circumstances.

#### SAFETY:

##### What does droperidol do to the QTc?

- Expect dose dependent increase.
- Doses below 2.5 mg do not routinely require baseline and frequent ECGs<sup>1,2</sup>.
- Higher doses should be okay but you may want to think about an ECG in vulnerable folk (electrolyte disturbance, malnourished, female, elderly, etc). Sensible to do ECG if accumulating over 10 mg.
- Peaks around 10 min after a bolus dose, normalises 1-3 hours<sup>1</sup>.
- Expect similar to haloperidol – Interestingly, 8.5 mg has been the lowest dose reported to cause arrhythmia. Studies have shown no significant difference in QTc length between haloperidol and droperidol<sup>3,4</sup>.
- Ondansetron: similar or slightly less effect on the QTc compared with low dose droperidol. Available evidence demonstrates no

significant difference in QTc change between IV ondansetron and IV droperidol 0.75 mg; or significant difference with a slightly higher droperidol dose. Either way, the mean increases were around 17 – 24 ms<sup>5,6</sup>. Unlike droperidol, QTc was not significantly increased with increasing ondansetron dose<sup>6</sup>.

#### Other adverse effects<sup>1-7</sup>

- Extrapyramidal side effects (EPSE): akathisia, dystonias and pseudoparkinsonism. Tend to be seen at higher doses and with long term use. I would not expect to see akathisia or pseudoparkinsonism in ED from a one off dose, nevertheless, if there's more than one dopamine blocker...
- Acute dystonia treatment: benzotropine 1-2 mg IM/IV push (see Hospital Health Pathways HHP).
- Neuroleptic malignant syndrome has been reported. Very rare.
- Anxiety, dysphoria, sedation (clearly!), tachycardia and dizziness – may also be related to that alpha blockade dropping the BP.

Brief overview of other useful info – see New Zealand Formulary for further details

#### Interactions:

Other QTc prolonging medications, dopamine agonists, other dopamine antagonists, sedatives. May get additional hypotension with antihypertensives.

#### Contraindications:

Long QT (datasheet defines as 440 ms for females, 450 ms for males). Parkinson's disease. Lewy body dementia.

#### Pregnancy and breastfeeding

Pregnancy – Limited data, but what we do have suggests minimal risk to the foetus or no increased rate of malformations compared to control groups. Best choose other options first however.

Lactation – don't use. No or limited human data, however we know butyrophenones cross into breastmilk, and drug characteristics hint at hazard for the infant.

## A spotlight on ED Pharmacology:

# DROPERIDOL – just dropped into ED! cont.

### EVIDENCE:

#### Nausea and vomiting

Scarce evidence that one antiemetic is more effective than another for undifferentiated nausea and vomiting in the ED. Droperidol however is the only antiemetic showing ANY evidence of efficacy in the emergency setting for moderate to severe nausea<sup>8</sup>. When compared with prochlorperazine and metoclopramide, one trial using 1.25 mg IV droperidol found a significant reduction in nausea at 30 minutes<sup>9</sup>. We know that it has been well used in PONV at 0.625 – 1.25 mg and haloperidol has had a good history of use in palliative care at low doses and in combination with ondansetron<sup>10</sup>. Hence in ED, haloperidol (and now droperidol) are the second line options for undifferentiated nausea and vomiting after ondansetron. All others including cyclizine are 3rd line.

#### Cannabinoid hyperemesis syndrome (CHS)

Evidence limited to case reports, nevertheless with promising reductions in length of stay. The most common doses used were 0.625 mg and 1.25 mg<sup>11</sup>. We have stronger evidence for haloperidol which was shown to be more effective in treatment of CHS when compared to ondansetron. Within the same RCT they also compared 0.05 mg/kg and bravely, 0.1 mg/kg IV haloperidol and found no difference in efficacy between the two but significantly more adverse reactions with the higher doses<sup>12</sup>. So, it would be reasonable to expect you wouldn't need a dose above 2.5 mg for either haloperidol or droperidol, probably effective at lower antiemetic doses.

#### Sedation

Available evidence seems to indicate droperidol as effective as haloperidol, some studies showing droperidol to have a faster onset<sup>7</sup>. A study comparing IM 10 mg haloperidol vs 10 mg IM droperidol found median time to sedation 20 – 25 minutes respectively for aggression in psychiatric patients. Those given haloperidol required additional medication with midazolam (however, haloperidol tended to be used for organic psychiatric causes, droperidol for psycho stimulant use), yet more adverse effects found with droperidol. Both findings were not significant<sup>13</sup>.

Similar results were found in the prehospital setting comparing use of haloperidol and droperidol – no significant difference between adverse events and need for further sedation<sup>4</sup>.

Droperidol (or haloperidol) in combination with midazolam is an effective strategy to tackle severe agitation and combativeness, mitigating some of the potential adverse effects<sup>14</sup>. Perhaps go easy on the doses of each!

#### Headache, migraine

The most evidence available is for migraine. Doses of 2.5 mg have been used IM or IV. For acute migraine higher doses were studied but 2.75 mg IM (make it easy and just use 2.5 mg) seemed to have

similar headache response at 2 hours compared with placebo<sup>15</sup>. For refractory migraine 2.5 mg IV has been studied, up to 3 doses at 30 minute intervals. The mean total dose required for these patients with 88% success was 5.6 – 5.7 mg<sup>16</sup>. This was a small study but gives some indication on frequency and dosing.

For benign headache, droperidol 2.5 mg IV or 5 mg IM was found to be superior to prochlorperazine 10 mg IV/IM in relieving pain. More sedation seen with droperidol<sup>17</sup>. Another study found similar results between droperidol 2.5 mg IV and prochlorperazine 10 mg IV in reduction of benign headache but also similar akathisia incidence<sup>18</sup>.

Haloperidol has been trialled at 5 mg IV for migraine with significant reductions in VAS, but also more significant sedation and akathisia<sup>19</sup>. So, doesn't look dissimilar to droperidol.

#### Pain?

Very scant evidence here. It has been studied in a postoperative setting as an adjunct to opioid analgesia, administered epidurally in 2 out of 3 studies. It was found improve pain scores compared to opioid alone reduced some of the opioid related adverse effects<sup>7</sup>.

#### HISTORY, PD, PK

Droperidol is a butyrophenone, same family as our beloved haloperidol. Predominantly a D2 antagonist with some additional alpha 1 and 5HT2A blocking activity<sup>20</sup>. It was widely used in emergency departments globally until around 2001. Based on case-reports and surveillance data and a couple of studies it was accused of prolonging QTc and causing TdP thus the FDA passed the sentence of Black Box Warning. Droperidol then suffered a decline in popularity and manufacture, despite reviews of the evidence uncovering confounding factors and suprathreshold doses, such as 600 mg. In the interim other agents, such as haloperidol and ondansetron, were chosen in favour until news of its **relative** innocence became common knowledge.

Pharmacokinetic	Droperidol	Haloperidol
IM Bioavailability	Rapid and probably high	70%
Metabolism	Liver	Liver
Half-life	2 – 3 hours	10 – 37 hours
Onset	IM and IV 3 – 10 min	IV 3 – 20 min, IM within 15 min
Peak	30 min	30 min
Duration	2 – 4 hours, may persist up to 12	3 – 24 hours

For those of you happy to keep using haloperidol – I'm happy too. Carry on. Evidence suggests most of the time you'll get a similar result, may hang around a bit longer.

## A spotlight on ED Pharmacology:

# DROPERIDOL – just dropped into ED! cont.

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# NP tips, tricks and trips



## Author:

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## This time I thought I may just open a topic of conversation.

**OPPORTUNISTIC TESTS** triage and acute care nurses, all nurses and parents really.

So **why** you say?

And **what** you think?

As an old campaigner I recall the drudgery of being expected to do a set of vital signs on every patient, even the stubbed toe and the paper cut, sighhh.

And at times this may still be correct. But times have changed, I have become more enlightened and concerned for our health system and the population I serve. I work both in both tertiary and rural settings these days and I how busy our nurses really are, often we ration care (a whole other discussion) and this has been observed as not having vital signs on lower acuity patients, less BGL testing, no B/P in young children. This coincides with, in same areas, a very limited access to primary health care (another very topical issue) so sometimes ED is the ONLY health care provider these patients see.

How often do you see a patient with a sore swollen toe, history of gout, and you do a set of bloods and a set of vitals? Why? You know he has gout as he has had it before, he's been treated for it in the past. Had a positive aspiration, yes?

Yes, a simple example, but who is the classic gout patient and how often do they see a GP? They are the patient who is often not accessing primary health care, who often has other conditions.

### Conditions associated with gout;

- Hypertension
- Cardiovascular disease
- Renal impairment
- Diabetes
- Obesity
- Hyperlipidaemia

About gout;

Gout is due to the deposition of monosodium urate crystals within and around joints, causing acute inflammation and eventual tissue damage.

Genetic variants significantly increase the risk of gout in Māori and Pasifika peoples.

Prevalence is 4% of all adults in New Zealand with 11.7% of Māori males and 13.5% of Pasifika males. 1

Despite the higher prevalence in Māori and Pasifika patients, they receive less urate-lowering therapy.

Long-term management of symptomatic gout is based on maintaining the serum urate level at less than 0.36 mmol/L.

### - Canterbury Healthpathways.

If I see this patient and they are typical of the above guideline, and treat the big toe in front of me, I could miss the diabetes, the renal impairment; a BGL, a B/P, a renal function panel could show a reversible disease process that could alter this person's life expectancy, and their quality of life.

So yes, I am very aware of "Choosing Wisely", the campaign seeking to reduce harm from unnecessary and low-value tests and treatment. If you haven't had the opportunity to hear or read about this I have put in the reference at the end.

I am also aware of Bpac "Best Tests" which help us choose the right test for the patient in front of us. Again in the reference list.

There are a lot of research articles on reducing harm, using the test that has the best efficacy, sensitivity, specificity and safety profile, But.....

### Why, the advantages;

Addressing simple vital signs that any nurse can do, and initiate simple diagnostics e.g. BGL, B/P (lots more) can help address;

- Health disparity,
- Health inequity
- Cultural inequity
- Early disease detection
- Preventative care
- Patient education and health promotion

Summary, opportunistic testing can be valuable in identifying diseases early, promoting preventive care, and improving health outcomes for patients. If we integrate opportunistic testing into routine care, utilise evidence-based guidelines, engage patients in preventive care, and health education we can go some ways to addressing concerns related to resource utilization and health equity.

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## NP tips, tricks and trips cont.

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I am now a believer in opportunistic testing, I believe it is my responsibility as a healthcare provider to consider the whole person in front of me. Not a full body CT scan at the doorway or a full set of every blood test invented on every living being, which I have sometimes thought about 😊

This time the 'tips and tricks' is just something to think about, to critically reflect on and perhaps include in your future decision making.

### References:

Choosing wisely;

<https://www.hqsc.govt.nz/resources/choosing-wisely>

Best Tests,

Bpac: <https://bpac.org.nz/BT/BT.aspx>

Gout;

<https://canterbury.communityhealthpathways.org/18727.htm>

# 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 towards 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 by increasing the wider understanding of Te Ao Māori – the Māori world view – and use of Te Reo – Māori language.

## Māori Models of Health: Te Wheke

Sandra Richardson, RN, PhD  
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Continuing on from our last edition, where we looked at Mason Durie's iconic Te Whare Tapu Wha model which has been widely incorporated into understandings of health and wellbeing and used in the management of patient care in many settings, we continue our journey looking at further adaptations and developments in Māori health care models. The overarching focus in traditional Māori health involves acknowledging and valuing the links between the mind, the spirit, the human connection with whānau, and the physical world in a way that is seamless and uncontrived (Ministry of Health, 2023). There was no division between these until the introduction of Western medicine and its reductionist approach, with the separation of mind and body.

The model for review in this edition of the journal is Te Wheke (the octopus), developed by Dr Rangimarie Turuki Rose Pere.

### Rārangi Kupu (vocabulary list)

- Te whānau – the family
- Waiora – total wellbeing for the individual and family
- Wairuatanga – spirituality
- Hinengaro – the mind
- Taha tinana – physical wellbeing
- Whanaungatanga – extended family
- Mauri – life force in people and objects
- Mana ake – unique identity of individuals and family
- Hā a koro ma, a kui ma – breath of life from forbearers
- Whatumanawa – the open and healthy expression of emotion.

Dr Rose Pere (Ngāi Tūhoe, Ngāti Ruapani, Ngāti Kahungunu) was born at Oputao, Ruatahuna and had a 33 year career in education working as a teacher, adviser, and school inspector. She was highly regarded in her field, and among the many recognitions she received over her lifetime, were the 1990 award of the Queen's Commemoration Medal for her contribution to New Zealand education and in 1996 the award of a CBE in the New Year's Honours List for services to Māori education. She also received a Doctorate of Literature from the University of Victoria in 1996. When she died in 2020, Dr Pere left behind a significant legacy, including the publications *Ako* and *Te Wheke*, and is acknowledged for her contributions in relation to well-being, healing and mana wahine in addition to building the strength of indigenous learners (Rolleston, 2020).

The concept underpinning Te Wheke is based around the construct of the octopus (te wheke) and has been used to define family health, identifying the elements contributing to wellbeing. At the broadest level, the head of the octopus can be seen as representing te whānau, hapu or iwi. The eyes of the octopus reflect waiora (total wellbeing for the individual and family) and the eight tentacles each illustrate a dimension of health. These dimensions are intertwined and related, in the same way as the tentacles of the octopus.

Te Wheke presents a Māori model that recognises the healthy individual as intertwined with and inseparable from the health of the whānau; in turn the health of the whānau is embedded in that of the hapu, and the health and well-being of the hapu is indivisible from that of iwi. This continuity and interconnectedness offers a much more synergistic approach to health and well being than that associated with the typically individualistic and autonomy focussed Western healthcare model. By being inclusive of all levels and connections within Māori society, the model is applicable to small or large groups, from individuals to communities (McIntosh et al 2021; Love, 2004).

# Cultural Safety and Te Ao Māori cont.



Figure 1 Te Wheke (MoH 2023)

Each of the eight tentacles of te wheke symbolises a different strand of wellbeing, with the suckers on the tentacles further illustrating that there are many aspects within each of these strands. The tentacles all originate within the whānau or head/body of the octopus which contains the stomach and three hearts, and from here receive the nourishment that keeps them alive, and in turn they act to feed the body, creating the interaction necessary for waiora or total wellbeing to be achieved. Waiora has been described as 'the seed of life', incorporating the foundations necessary for life and existence and the total well-being, health and development of people. Te wheke embodies adaptability, intelligence and resourcefulness, it navigates a challenging environment with flexibility and grace.

The eight arms are described as aspect of selfhood (McIntosh et al 2021; Love, 2004), and are identified by Pere as *wairua*, *mana ake*, *mauri*, *whanaungatanga*, *tinana*, *hinengaro*, *whatumanawa*, and *ha a koro ma a kui ma*. The multiple arms of te wheke are capable of independent movement, yet function seamlessly together, showing the ability to work in unity while still valuing diversity. In the same way, the connections illustrate that the well being of the individual is valued yet connected and dependent on the completeness of the contributing parts and the impact of the environment.

## References:

- Love, C. (2004). Extensions on Te Wheke (Working Papers No. 6-04). Lower Hutt, New Zealand: The Open Polytechnic of New Zealand.
- McIntosh, J., Marques, B. & Mwipiko, R. (2021). Therapeutic Landscapes and Indigenous Culture: Māori Health Models in Aotearoa/New Zealand. In James C Spee, Adela J McMurray, Mark D McMillan (Ed.), *Clan and Tribal Perspectives on Social, Economic and Environmental Sustainability: Indigenous Stories From Around the Globe* (pp. 143-158). Emerald Publishing Limited. <https://doi.org/10.1108/978-1-78973-365-520211016>
- McNeil, H. (2009) *Maori Models of Mental Wellness*. Te Kaharoa, vol. 2, ISSN 1178-6035.

Wairua is the spiritual dimension or arm of te wheke, mana ake acknowledges the absolute uniqueness of each person and each family. She describes this as being given the authority to stand in one's own power and wisdom, and talking of her own wellbeing, describes this as: "...there has never been anyone else exactly like me, and there never will be...I am able to stand up against the odds, and for what I believe in" (Pere, n.d.). Mauri has been described as the life force, the 'essence' that is present in people and objects. Pere describes the "mauri ora" that comes in at conception as unique to each individual, whereas the "wairua" is eternal, and has been held by others in the past. Whanaungatanga is the kinship ties, the extended family, and relates to the need for belonging and oneness. Taha Tinana refers to the physical world and physical wellbeing. Pere describes her physical body as the "Kai Pupuri / the Keeper" of my Spirit, which is eternal" (Pere, n.d.). Hinengaro can be seen at its simplest as relating to the mind, although Pere more eloquently refers to this as "The Hidden Mother", the Intellectual, or Mental dimension within us. She defines this further, saying that the hidden Mother has two children, the Left Brain "Tumatauenga", her son who is sequential, rational, and logical, and the Right Brain "Rongo" her daughter who is creative, and intuitive (Pere, nd). Whatumanawa relates to the Emotions and Senses, and the healthy expression of emotion. The eighth arm of te wheke is described as *ha a koro ma a kui ma*. This refers to the valuing of traditional cultural legacy, and in particular *te hā* (the breath of life) passed on from ancestors.

The emphasis within this model is on positive articulation and valuing of traditional Maori philosophical beliefs and values. It has been critiqued as having less focus on connection to whenua and acknowledgment of cultural deprivation, and that some aspects of the model are harder to apply in practice, so may tend to be overlooked.

Ministry of Health (2023). *Māori health models - Te Wheke*. <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-wheke>.

Pere, R.T. (1997). Te wheke : a celebration of infinite wisdom. Ao Ako Global Learning.

Pere, R.T. (nd). Te wheke kamaatu - the octopus of great wisdom. Nature Play NZ. [https://www.natureplaynz.co.nz/pdf/tewheke\\_rosepere.pdf](https://www.natureplaynz.co.nz/pdf/tewheke_rosepere.pdf)

Rolleston, Te Aorewa. (14.12.2020). Dr Rose Pere, spiritual leader and academic, dies age 83. Radio New Zealand <https://www.rnz.co.nz/news/te-manu-korihiri/432837/dr-rose-pere-spiritual-leader-and-academic-dies-age-83>.

# Pae Ora Report November 2023

Author: Natasha Kemp (Te Arawa), Whakatane Emergency Department



**Vision:** To provide a Culturally supportive environment for Māori accessing care and working within the Emergency Departments of Aotearoa.

**Mission:** CENNZ continues to work towards improving and supporting Māori whanau and the Māori workforce within the Emergency Departments of Aotearoa.

## Highlights for the past year have included:

Development of A Māori Health Strategy that brings attention to Improving the Cultural Environment for Māori accessing care and working within the Emergency Departments of Aotearoa, including promoting and supporting the Māori Workforce.

Ongoing discussion and awareness of improving Equity within ED continues. A meeting took place in August with Minister Ayesha Verrall to discuss Equity issues within ED, including advocating for increasing Māori nurses support and sharing CENNZ Māori Health Strategy with the ministerial office.

Pae Ora survey and feedback article published in CENNZ Journal. Pae Ora education and awareness with Nurse Educators, Triage Instructors.

Ethnicity data of CENNZ members now captured on registration to capture our increasingly culturally diverse workforce.

Updated the Knowledge & Skills framework to acknowledge Te Tiriti O Waitangi principles "Aspects of Responsive to Māori". This has included the provision of a Toolkit to enable culturally responsive care in practice within ED. Further work has seen the inclusion of Māori knowledge frameworks to reflect matauranga values.

Updated Triage Manual sections on Māori Health, Kawa Whakaruruhau/Cultural Safety. Also, in updated sections are included 'Considerations for Māori'.

Presentation given at the National CENNZ Conference "Are you Ready to Respond to Improving Health Inequities for Māori and Indigenous patients within the Emergency Departments of Aotearoa".

Supporting Kaupapa Research Māori study for nurses working in ED.

# Snippets: Disaster and Crises

## Snippets

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](mailto:Editor.cennzjournal@gmail.com)

## Useful Links and Resources

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

### New Zealand Resources

Civil Defence National Emergency Management (CDEM) Sector: <https://www.civildefence.govt.nz/cdem-sector>

Health New Zealand /Te Whato Ora. (2023). Environmental Health in Emergencies. <https://www.tewhatoora.govt.nz/our-health-system/environmental-health/environmental-health-in-emergencies/>

Health New Zealand /Te Whato Ora. (2022). Emergency management. <https://www.tewhatoora.govt.nz/whats-happening/work-underway/emergency-management/>

Ministry of Health (2011) National Health Emergency Plan. <https://www.health.govt.nz/our-work/emergency-management/national-health-emergency-plan>

Ministry of Health (2024). Emergency Management. <https://www.health.govt.nz/our-work/emergency-management>

Ministry for Primary Industries. (2023). Food safety in natural disasters and emergencies. <https://www.mpi.govt.nz/funding-rural-support/adverse-events/food-safety-in-natural-disasters-and-emergencies/>

National Library of NZ Disaster Recovery (nd) <https://natlib.govt.nz/collections/caring-for-your-collections/disaster-recovery>

NZNO (2022) Obligations in a pandemic or disaster, 2022. <https://www.nzno.org.nz/Portals/0/publications/Guideline%20-%20Obligations%20in%20a%20pandemic%20or%20disaster%202022.pdf?ver=9H5rMGYfzRS0CEYpBxf9cQ%3d%3d>

NZ Government (2021) Home emergency checklist. <https://www.govt.nz/browse/housing-and-property/home-emergency-checklist/>

## Guidelines, Standards and Policies:

### Australasian Guidelines

ACEM Australasian College of Emergency Medicine (2020) Emergency department disaster preparedness and response P33 [https://acem.org.au/getmedia/f955b382-891c-46d1-aaf6-11f9a695ee35/Policy\\_on\\_ED\\_Disaster\\_Preparedness\\_and\\_Response](https://acem.org.au/getmedia/f955b382-891c-46d1-aaf6-11f9a695ee35/Policy_on_ED_Disaster_Preparedness_and_Response)

ACEM Australasian College of Emergency Medicine (2020) Emergency department hazardous material response plan P30 <https://acem.org.au/getmedia/131e7d73-942d-47b6-a92a-78e08cdd5156/P30-Policy-on-ED-Hazardous-Material-Response-Plan-Mar-11-v03.aspx>

ACEM Australasian College of Emergency Medicine (2023) Heatwave preparedness for emergency departments and emergency medicine systems P59 <https://acem.org.au/getmedia/e5f064bc-0e29-493e-9385-206e2fa45315/P59-Policy-on-Heatwave-Nov-10-v01.aspx>

# Snippets: Disaster and Crises cont.

## Websites:

These websites and apps have links to information relevant to emergency nursing and offer resources or further ideas you may find of interest. Please note that while these are offered for consideration,

Emergency Nurse NZ and NZNO does not endorse any specific products that may be mentioned.

Websites	Links
Society for the Advancement of Disaster Nursing	<a href="https://disasternursing.org/">https://disasternursing.org/</a>
ANA Disaster Preparedness	<a href="https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/">https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/</a>
International Resource Centre for Pandemic and Disaster Nursing (John Hopkins)	<a href="https://nursingresourcecenter.centerforhealthsecurity.org/">https://nursingresourcecenter.centerforhealthsecurity.org/</a>
New Zealand Medical Assistance Team	<a href="https://nzmat.co.nz/">https://nzmat.co.nz/</a>
Center for Research and Training in Disaster Medicine, Humanitarian and Global Health (CRIMEDIM)	<a href="https://crimedim.uniupo.it/home">https://crimedim.uniupo.it/home</a>
WikEM	<a href="https://wikem.org/wiki/Main_Page">https://wikem.org/wiki/Main_Page</a>
GeoNet	<a href="https://www.geonet.org.nz/">https://www.geonet.org.nz/</a>
GNS Science	<a href="https://www.gns.cri.nz/">https://www.gns.cri.nz/</a>
ICN International Council of Nurses*	<a href="https://www.icn.ch/">https://www.icn.ch/</a>

\*International Council of Nurses (ICN) (2019). Core competencies in disaster nursing version 2.0.  
[https://www.icn.ch/sites/default/files/inline-files/ICN\\_Disaster-Comp-Report\\_WEB.pdf](https://www.icn.ch/sites/default/files/inline-files/ICN_Disaster-Comp-Report_WEB.pdf)

# College Activities:



# CENNZ 2023 Conference Report



**CENNZ CONFERENCE 2023**  
19-20 October 2023 | Christchurch



It is with great pleasure that I can declare the great success of the 29th College of Emergency Nurses New Zealand (CENNZ) conference held at Rydges Latimer, Christchurch on Thursday 19 to Friday 20 October 2023. We are proud to report that interest in attendance, despite having to reschedule twice due to Covid-19 pressures, saw us with a full complement of attendees and then a rearrangement of the seating to allow more attendees in each room, and finally needing to operate a waiting list.

Our theme was 'Ready to Respond - Kia Mataara' since, let's face it, preparedness for everything is the definition of an emergency nurse - we need to be ready to face whatever comes through the door at any time. One interesting point that was repeatedly raised by the speakers was about the need or effect of collaborative communication. Most presenters identified the need for clear communication and collaboration to achieve their aims and objectives or outcomes.

The conference itself provided an excellent opportunity for demonstrating the value of collaboration, and there were some entertaining, moving and educating examples of communication at its best. As much as anything else, the opportunity to meet with colleagues whom we've not been able to see face-to-face for so long was definitely appreciated; so much has happened in our lives since the last conference, and these days were a wonderful chance to catch up.

We had an amazing line up of presenters, some of whom are well-known personalities seen in the media, others are team members from our local emergency departments, acute care facilities, and Te Pūkenga - the NZ Institute of Skills and Technology (AKA our polytechnic institutes).



'Key note speakers and Committee members'

# CENNZ 2023 Conference Report cont.

Our programme featured keynote presentations on issues close to our hearts:

- The positive side to Covid: how we've learnt, changed, and developed – and what we can still learn (Prof Michael Baker)
- The science advice including advice to support three responses of the Christchurch mosque shootings, the response to the Whakaari / White Island eruption, and the Covid-19 pandemic (Dame Juliet Gerrard)
- The Christchurch mass shooting and nurses as frontline responders (Sandra Richardson)
- The Whakaari / White Island eruption – the pre-hospital response and the Whakatāne hospital response (Craig Ellis and Colleen MacGregor respectively)
- Safe staffing (Hilary Graham-Smith)
- Managing mass casualty incidents from the prehospital perspective (Dean Brown), and
- Gaps and opportunities for equitable mental health care in ED (Silke Kuehl)

Our concurrent sessions were grouped into the four themes of: simulations, equity, research, and innovation, and our panel discussed how to care and support our familiar patients who repeatedly return for care – particularly considering the inequities in healthcare. You can see all their abstracts and the biographies on the conference website until Christmas, and most of the presenters have agreed that their presentations can be added to the CENNZ-NZNO website and are online now.

The day prior (Wednesday October 18) was dedicated to the Advanced Emergency Nurses Network (AENN) study day, with the theme of 'Putting Research in to Your Practice'. The feedback from the attendees was that it was an extremely well put together study day, with interesting presentations, and a lot to learn and use. Also featuring on the Wednesday were the National Nurse Managers Network and National Nurse Educators Network Meetings. These meetings were well attended and included a presentation by Margie Apa – Chief Executive Te Whatu Ora to the Managers Network, interesting discussion was generated.

Socially, the evening dinner was held in the Christchurch Transitional Cathedral, also known as the 'Cardboard Cathedral'. The theme for the night was the Great Gatsby, we asked you to pack your sequins and feathers and dress up for a night of fun – and you did! There was plenty of glamour and fun. During the evening, the following awards were presented:

- **Honorary Life Membership Award – Anne Esson, Nurse Manager, Christchurch, and Suzanne Rolls, Professional Nursing Advisor (NZNO)**

This is awarded only occasionally, in recognition of personal and positive contribution to emergency nursing at a national level, promotion of the work and aims of the College and advancing the status and public recognition of Emergency Nursing in Aotearoa New Zealand.

- **Foundation Award – Sue Stebbeings, Nurse Practitioner, Whangarei**

This is awarded annually, in recognition of an outstanding Emergency Nurse who has enhanced the profile and shown excellence in Emergency Nursing, Aotearoa New Zealand.

# CENNZ 2023 Conference Report cont.

- **Advanced Emergency Nursing Award – Chantelle Dick, Nurse Practitioner Intern, Whakatāne, Bay of Plenty**

This is awarded annually, in recognition of contribution to the advanced nursing role within Emergency Nursing, Aotearoa New Zealand. Specifically, in improving quality and promoting excellence in patient care.

- **Kirsty Morton Award – Amanda Donnell, White Cross Clinic, Auckland**

This is awarded annually, for outstanding achievement and participation while undertaking the National Triage Course, Aotearoa New Zealand.

- **Conference Presentation Award – Libby Haskell, Nurse Practitioner, Starship Children's Emergency Department**

Chosen by the CENNZ Committee, using a standard judging sheet after presenting. Libby's presentation was, "Can targeted interventions change clinicians' beliefs in the treatments of infants with bronchiolitis"

Crucially, we would like to thank our sponsors (alongside CENNZ) who funded us to allow us to make this all happen. Our silver sponsors were Medtronic and Stryker, Essential Helpcare also gave us a morning tea and Cepheid gave us a lunch, the other sponsors were Abbott, BD, Connected Healthcare, Cubro, Douglas Pharmaceuticals, Healthcare Australia, Intermed, and ZOLL Medical. We contacted each sponsor after the conference to thank them, and their feedback about our participants – many of you – was entirely positive. They said they enjoyed talking with you, they learnt a lot about what you want and need, and they hope to return for the next conference. Likewise, we were gifted many items for our conference bags from a wide range of local and national companies, some of which were very valuable. Hopefully everyone will enjoy using those gifts – perhaps onward gifting them this Christmas!

Finally, Lauren Miller, the incoming CENNZ Committee Chairperson, had the pleasure of announcing that the next conference will be held in Taranaki. The date and details are yet to be confirmed and we look forward to seeing you there. Planning will start very soon, so keep watching our CENNZ media – in future journals and online.

Noho ora mai rā – Look after yourself / All the best, Meri Kirihimete me te Hape Niu Ia – Merry Christmas and a Happy New Year, Nā Polly

**Polly Grainger, Chair of the 2023 CENNZ-NZNO Conference Organising Committee.**

Cconference speakers and exhibitors



The Great Gadsby conference dinner & awards



# College Awards

CENNZ has a number of awards and grants available each year to members, which are presented as part of the College's commitment to promoting excellence in emergency nursing within New Zealand. While not all awards will necessarily be presented in a single year, the College is pleased to celebrate the recipients of the five awards that were presented at the CENNZ Conference, 2023.

These included the **Kirsty Morton Award**, which is presented to a participant from one of the National Triage Course's held during the year prior to the College AGM, and identified by the triage course coordinator and instructors as being an outstanding student. This award was established in memory of Kristy Morton, a widely respected emergency nurse and triage course instructor who worked at Tauranga Hospital Emergency Department. Kirsty set high standards for herself and for others, and exemplified the qualities that all Emergency nurses aspire to.

The award for 2023 was made to **Amanda Donnell, White Cross Clinic, Auckland.**

The **Advanced Emergency Nursing (AEN) Award** was established by CENNZ in recognition of contributions to the Advanced Emergency Nursing role. This award is granted to an individual AENN member in recognition of their contribution to the advanced nursing role, specifically, in improving quality and promoting excellence in patient care.

This award was presented to **Chantelle Dick, CNS - Whakatāne Emergency Department.**

In presenting this award, Sue Stebbings, Nurse Practitioner and former Chair of CENNZ described Chantelle's presentation at the Advanced Emergency Nurses Network Study Day hosted by Tauranga, as engaging and informative, taking the audience with her on the patient assessment and diagnostic journey. The case that she presented highlighted the complexities and multiple factors that lead to people presenting to ED.

On the surface, the main presenting problem of hip pain appeared straight forward yet initial history revealed many contributors to the person's situation, including some with potentially serious outcomes. Describing the process of examination, investigations, and concurrent treatment to reach provisional diagnoses made the eventual less common diagnosis feasible, even for less experienced advanced emergency nurses.

The support of senior clinicians and liaison with the emergency care team was highlighted. We are privileged to work within teams as our skills develop, and there is always more to learn. Chantelle encouraged us to think broadly and take the next steps.

An award that is not always presented, is the prestigious **Foundation Award.**

This award is made to acknowledge an Emergency Nurse who has enhanced the profile and/or shown excellence in Emergency Nursing in New Zealand. The significant contribution of the recipient to NZ emergency nursing resulted in the award being presented in 2023 to **Sue Stebbeings, Nurse Practitioner - Whangārei Emergency Department.**

The following is the nomination for this award, submitted by Lyn Logan:

Sue has been a member for CENNZ for over 15 years with her taking on the role on the committee in October 2018 and subsequent chair from Feb 2021 to Dec 2022.

# College Awards cont.

In her role as an RN and NP in Whangarei for over 25 years she has been involved in governance groups, quality and risk as well as being the lead for the opening of the low acuity fast track area in ED. She has been a mentor and preceptor to many nurses including some of the new NPs within the dept.

Sue took on a great deal of work as chair of CENNZ especially with conference deferred numerous times due to COVID. She tirelessly supported new committee members and was a wealth of information to us all coming on the committee.

She meets the remit of enhancing the profile of Emergency Nursing with her support on various national advisory groups as well as giving statement to the media as chair of our college.

I can find no better person to receive this award for all Sue does for emergency nursing and the nursing profession. Her tireless work and commitment to Emergency Nursing has shone through with all she has done in supporting the college and promoting excellence via the various position statements she has helped support. I am honoured to nominate her for this award.

The final two awards were for the **Honorary LifeMember Award**.

Honorary life membership may be bestowed from time to time to any member or ex-member of the College of Emergency Nurses New Zealand – NZNO in recognition of their contribution to emergency nursing in New Zealand. Such membership is rare and unusual. This award hasn't been bestowed since 2020. In order to be made a Life Member, the recipient must have made a personal and positive impact on Emergency nursing in New Zealand and have undertaken activities on a national and international level which has increased the status and public recognition for Emergency nurses in New Zealand. Due to the calibre of the nominations, two recipients were bestowed with this award.



This special award goes to **Suzanne Rolls** and **Anne Esson**.

# College Awards cont.

The following are the letters of nomination for the Honorary Life Membership Award 2023, for the two recipients.

## **Anne Esson – Nurse Manager – Christchurch Emergency Department.**

Anne has a long and distinguished career in nursing, having trained at the Christchurch Hospital School of Nursing and graduating in 1976. She has a broad base of nursing knowledge, having worked in nursing clinical, education and management roles. She is highly respected and valued, not only for her knowledge and skills but also for her calm attitude and the care she has consistently demonstrated towards patients, colleagues and all she those has contact with.

Anne first worked in Christchurch ED as a Nurse Educator, before taking her current role as Nurse Manager in 2006. In her 17 years at the helm, she has navigated through multiple challenges, departmental reviews, and local, regional and national crises.

Throughout she has remained a constant and strong leader of Christchurch ED, providing professional direction and ongoing vision for nursing. Anne has remained active throughout her tenure as Nurse Manager in one of our country's largest emergency departments; her office door is 'open' when possible to allow a free dialogue; She has contributed to and facilitated a strong professional nursing voice in local and national forums.

During her time as Nurse Manager, Anne has been responsible for fighting for, and securing, increased representation in senior nursing clinical leadership within the ED and has overseen the introduction of front-of-house advanced nursing roles in the forms of Clinical Coaches, Clinical Nurse Specialists and Nurse Practitioners into the department. Behind the scenes, she has ensured the continuation of a Nurse Researcher role, and nurses to support clinical projects and programmes to ensure nurses have the correct resources to undertake their role. She is a strong advocate for professionalism in nursing and promotes high professional and ethical standards of care. Anne is passionate about nursing education and growing the nurses in her department. During Covid when education/training was the first casualty, she fought to ensure that essential education and training were prioritised and continued for ED nurses.

Anne was involved in the development and securing of the national 6-hour ED targets, which for the first time held the issue of the ED flow and hospital crowding to the government attention and called for accountability. At the same time, Anne took part in the debate that decided upon the entire suite of quality measures for emergency departments which were outlined in Quality Framework and Suite of Quality Measures for the ED Phase of Acute Patient Care in NZ (2014). Anne has negotiated for robust data collection that measure achievement of the wide variety of expected standards of care, and then facilitated discussion of the findings and follow-up of improvements arising, through business meetings of various types including the E-Quality group open to all staff. Anne has also overseen the introduction of the new patient online feedback and the actions that are arising from that. Anne has been the long-term chairperson of the Restraint Committee, advocating for emergency situations regularly.

Perhaps of most significance, Anne has been in charge during times of considerable turbulence, not only for the staff working in the ED but for the wider Canterbury Community. We are referring to the devastating impacts from the Canterbury Earthquakes and the Mass Shooting of March 15th. Anne is admired for her dedication to supporting her team. She ensured nurses were supported through well-being initiatives, particularly during these

# College Awards cont.



most challenging times and events. Anne has been present and responsive to individuals who have experienced personal crises, as well as everyday departmental crises of access block, and hospital crowding; Anne has enabled the change of work conceptualisation addressing the developing crises and the introduction of new models of care and new terminology.

Anne has been firm in maintaining a patient centred response while looking out for staff welfare. She has navigated the threatened isolation and infection control situations, those that were less problematic – swine flu and the possibility of Ebola, and those that continue to threaten us such as COVID-19. Throughout this, she has maintained a focus on providing the best possible care to the people of Canterbury, and to trying to provide the best models of care to support staff. As if this were not enough, she also oversaw the transition of the department to an entirely 'new build' during recent times, and then the ongoing development of a true children's emergency service and the fight to reopen the observation area, as well as the major changes to the way care was provided. All the while supporting movements to address violence and aggression, recruit staff, and encourage staff functions and wellbeing initiatives.

On an individual level, Anne has presented at the National Regional ED conferences with a focus on patient flow, management and the six-hour targets, as well as at the CENNZ conferences. She has been actively involved in the CENNZ serving two terms on the national committee between 2012-2016. During her time on the committee, Anne has contributed to the growth of Emergency Nursing, leading a team to create and develop the Knowledge and Skills (K&S) framework, to build, maintain and advance the emergency nursing specialty to provide quality and safe nursing care. Since leaving the committee Anne has remained involved in the K&S project and is committed to seeing this update of the framework completed, with the development of an associated 'toolbox' of resources to support its use. Anne has continued to regularly support the college through involvement in facilitating the Charge Nurse Manager network meetings – helping to grow and promote a unified and supportive network for nurse managers to connect and share ideas through CENNZ.

There is not enough space in a brief nomination form to do justice to all the elements that have made Anne a highly valued and vital member of the emergency nursing workforce. To be nominated for this award, it is necessary to identify where and how the potential recipient stands out from the many nurses who contribute to the culture and ethos of emergency care in Aotearoa New Zealand. We have no hesitation and great honour in recommending her for this award.

Submitted by: Keziah Jones

# College Awards cont.

## **Nomination for Honorary Life Membership Award 2023.**

### **Suzanne Rolls – Professional Nurse Advisor – NZNO.**

I would like to nominate Suzanne Rolls for CENNZ Honorary Life Membership in recognition of her significant and ongoing contribution to emergency nursing and CENNZ.

Suzanne has demonstrated her commitment to supporting excellence in emergency nursing practice, workplace safety for emergency nurses, and growth of emergency nursing as a specialty through varied roles including as an emergency nurse in Wellington ED, CENNZ committee member (1999 – 2003), CENNZ conference organizer, and for many years as NZNO Professional Nursing Adviser. Suzanne's energy for using every feasible strategy strengthens our collective response to addressing the challenging situations emergency nurses have continued to face over many years.

Suzanne's activities and actions in national forums ensure the voice of emergency nurses can be heard. The depth of her experience at the national and international level provides a strong foundation in her advisory role. Suzanne encourages nurses to participate in national conversations and raise issues through appropriate channels to enable ongoing advocacy for emergency nurses. Suzanne has a strong grounding in the realities of clinical practice that brings a common-sense approach and wisdom to national conversations and activities.

Suzanne's role as Professional Nursing Adviser to CENNZ national committee has supported numerous committees in the work and mission of CENNZ. Suzanne's knowledge of previous work and projects, and availability is invaluable in each committees' ability to continue with core and developing priorities for emergency nurses.

Suzanne's research and passion for addressing workplace violence is crucial to both CENNZ and NZNO projects. We hugely appreciate Suzanne's commitment to emergency nursing and nurses and are extremely grateful for her ongoing support of CENNZ.

Submitted by: Sue Stebbeings.

Zoe Baker

# Education Opportunity

## Reflection on postgraduate education opportunity

I am extremely grateful to CENNZ for their generous grant, which has facilitated my pursuit of postgraduate studies. In the first semester, I successfully completed the Advanced Health Assessment paper at Otago University.

Having dedicated seven years to the challenging field of emergency nursing, I entered this course with a degree of confidence in my abilities, particularly in the areas of patient triage and rapid assessment. However, this paper has made me reflect on my practice and challenged me to re-evaluate the rationale and clinical evidence that I use to underpin my patient assessments.

This course encouraged me to critically analyse the diagnostic tests and investigations to help develop differential diagnoses. Through a variety of assessments, I had the opportunity to solidify my learning. One particular aspect was the clinical mentorship hours, during which I was privileged to be mentored by a Nurse Practitioner. This experience provided me with invaluable insights into their role and expanded my understanding of advanced nursing practice.

The curriculum covered an extensive head-to-toe assessment, from cranial nerve examinations to respiratory assessment and limb evaluations, all of which were rigorously tested through OSCEs and during the clinical mentorship hours. The encouragement I received throughout the course, from the instructors and my mentor, to extend my critical thinking and incorporate advanced assessments into my practice was instrumental in making the study directly relevant to my role. As I progressed through the course, I couldn't help but notice the increasing workload and patient numbers in the emergency department. Balancing these demands with the desire to practice and refine my advanced assessment skills became a personal challenge.

I was determined to find the time to follow up on blood tests and review X-rays, even amidst the chaos of an overflowing waiting room. This determination drove me to apply for a clinical specialist role in the emergency department. In my first week, I have seen wounds with visible tendons, burring of rust ring on the eye, and sutured wounds. I now eagerly look forward to the opportunity and time to grow my advancing my nursing practice.

**Zoe Baker, Clinical Nurse Specialist**

Christchurch Emergency Department

# CENNZ Reports



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

# 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	Lauren Miller	<a href="mailto:cennzchair@gmail.com">cennzchair@gmail.com</a>
Secretary	Vicki Bijl	<a href="mailto:cennzsecretary@gmail.com">cennzsecretary@gmail.com</a>
Treasurer	Brendon Tampus	<a href="mailto:cennztreasurer@gmail.com">cennztreasurer@gmail.com</a>
Membership	Lyn Logan	<a href="mailto:cennzmembership@gmail.com">cennzmembership@gmail.com</a>
Grants and Awards	Lyn Logan	<a href="mailto:cennzawards@gmail.com">cennzawards@gmail.com</a>
Staffing Repository	Vicki Bijl	<a href="mailto:cennzrepository@gmail.com">cennzrepository@gmail.com</a>
NZ Triage courses	Katie Smith	<a href="mailto:cennztriage@gmail.com">cennztriage@gmail.com</a>
Professional Nursing Advisor (NZNO)	Suzanne Rolls	<a href="mailto:suzanne.rolls@nzno.org.nz">suzanne.rolls@nzno.org.nz</a>
Te Rūnanga Representative		
Knowledge and Skills Framework	Lauren Miller	<a href="mailto:cennzchair@gmail.com">cennzchair@gmail.com</a>
Website and Social Media	Shannon Gibbs	
Webinars	Laura Cottrell	
Pae Ora	Natasha Kemp	
Networks	Name	
Clinical Nurse Educator Network	Lauren Miller	
Charge Nurse Managers Network	Vicki Bijl	
Advanced Emergency Nurses Network	Shannon Gibbs	
Emergency Nurse Practitioner Network	Shannon Gibbs	

# Committee Regional Representatives

## Committee Regional Representatives

Region	Name	Daily Role
Te Rūnanga		
Northland / Te Tai Tokerau	Brendon Tampus	Associate Clinical Nurse Manager, Te Tai Tokerau Emergency Department
Auckland	Anna-Marie Grace	Clinical Nurse Specialist, Waitakere Emergency Department
Auckland	Lydia Moore	Registered Nurse, Professional Teaching Fellow – Auckland City Hospital
Midlands / Bay of Plenty	Wendy Sundgren	Associate Clinical Nurse Manager, Middlemore Hospital, Professional Teaching Fellow, Auckland University
Hawkes Bay / Tairāwhiti	Laura Cottrell	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	Vicki Bijl	Clinical Nurse Manager – Nelson Hospital
Canterbury / Westland	Keziah Jones	Registered Nurse – Christchurch Hospital
Otago / Southland	Michelle Scully	Associate Charge Nurse Manager – Southland Hospital Emergency Department

# Chairperson's Report



**Lauren Miller**

CENNZ Chairperson

Contact:

[cennzchair@gmail.com](mailto:cennzchair@gmail.com)

## Kia ora koutou katoa,

I sit down to write this after recently attending the "Kia Mataara- Ready to Respond" CENNZ conference, with a renewed motivation, admiration and invigoration for the specialty of emergency nursing. The conference was significantly delayed from its original planned date of 2020- but was well worth the wait! Ōtautahi really turned on the weather and the Latimer Rydges was the perfect central venue. The conference streams of simulation, equity, research and innovation – under the overarching theme of Ready to Respond – saw an amazing collection of presenters- with a breadth of experience and knowledge. A highlight for me was the opportunity to experience growth and understanding through hearing the experiences and lessons learnt from those emergency practitioners

that have dealt with some of New Zealand's toughest and most challenging emergencies over the last few years. The theme really highlighted the importance and strength of NZ emergency nurses and how essential our specialty is.

The Christchurch Transitional Cathedral was the most spectacular dinner venue to celebrate the conference and the Gatsby theme really gave everyone the chance to shine. The dinner provided the opportunity to present the annual CENNZ awards, to acknowledge those who achieved over the last year and much longer. This year saw the awarding of two life membership awards to Anne Esson and Suzanne Rolls. The calibre and dedication of Susanne and Anne to the profession of emergency nursing is outstanding and we sincerely thank them for the past and ongoing contribution and support towards CENNZ.

I would very much like to thank Marg and her team from The Conference group and the Christchurch conference organising committee- who deserve a massive shout out for the high standard and organisation of an outstanding conference!

Another exciting event at the conference was the launch of our new CENNZ Logo. The design is confident, contemporary and spirited, representing and expressing who we are and what we do. The logo consists of three elements- the college name, the Ngā Ringa Ringa Aroha descriptor and the 'Koru Cross' graphic. The koru graphic embraces, supports and protects, while the central cross symbolises healthcare, and the interconnected arrows- patient care, connection and support and the ongoing development of CENNZ. We are excited to share and start identifying CENNZ and our work via this branding.

CENNZ committee members and the ED Clinical nurse managers network, recently had the opportunity to meet with Margie Apa the CEO of Te Whatu Ora, Health New Zealand. During this meeting we focussed on the ongoing challenges with obtaining safe staffing in the ED. We highlighted that we understood the need for commitment to CCDM/TrendCare in ED's and indicated that TrendCare is far from perfect from an ED perspective. We agreed that IT issues were the main prohibitor for the roll out of TrendCare to the outstanding ED's throughout the country. We expressed frustrations for areas where FTE calculations have been completed and this is yet to result in financed FTE positions. We made it clear that from the time of implementation of TrendCare to being supported and equipped to have FTE calculations performed, there is an average of a two year delay. We suggested that this delay in formal calculations be mitigated by providing a temporary increase in FTE for all EDs where TrendCare is delayed or yet to be fully implemented. CENNZ also touched on workforce development – such as education, clinical leadership, equity and NP/CNS pathways. We highlighted that there is no standard and no equity for educator/clinical coach hours across the country and asked to be an active party in the conversations going forward.

It was great for all the CENNZ networks, Nurse Educator Network, Advanced Emergency Nurses Network and Emergency Nurse Managers Network, to have the opportunity to meet together twice this past year. This allows for ongoing networking and growth nationally.

## In 2024 our focus areas of work are:

- Promoting and driving the provision of Safe staffing in ED.

# Chairperson's Report Cont.

- Promotion and growth of our Pae Ora workstream
- Support towards collective growth and position statements for the NP/CNS and Educator networks
- Completion and launch of the Triage Course refresh.
- Publish revised KSF and the development of a KSF toolkit

Naturally at this time of year we take time to thank those who have moved on from their respective roles for CENNZ. I would like to acknowledge Amy Button who for a majority of this year- took on the role of Chair, before finishing up with the committee at the completion of the conference. Her leadership

and passion were second to none and we thank her for all that she contributed to CENNZ.

Tanya Meldum also finished up as the CENNZ Triage Director - which she valiantly continued to fulfil, after officially stepping down from her representation on the committee. She played the key organising role in ensuring that the CENNZ Triage course ran smoothly- all over the country and we appreciate her willingness to carry this role through for so long.

Katie Smith (previous Mid Central committee rep) has now taken over as the Triage Director and we look forward to working with her to continue to deliver a high calibre course. CENNZ have also recently interviewed and appointed two new Triage instructors. Ronelle

Van Dongan and Abbey Johnson are the successful candidates and we are excited to have them joining the triage instructor team.

Finally, I would also like to thank Ben and Erika who will both be finishing up with CENNZ in their Triage Instructor roles. You both played a key role in ensuring that 1000's of NZ RN's became Triage qualified. We wish you all the best for your next endeavors. Only include if we get confirmation of this.

The committee looks forward to continuing to work with you in 2024 so that we can keep making progress.

**Ngā mihi nui,**

**Lauren Miller**

## Northland/Te Taitokerau Region



### Regional Representative

#### Brendon Tampus

#### Associate Clinical Nurse Manager

#### Whangārei Base Hospital Emergency Department

#### Te Whawtu Ora Te Tai Tokerau

### Ko Brendon Tampus tōku ingoa.

Winter season in Northland felt similar to that in the tropical islands of the Pacific as the region was pouring with rain and cold snaps were fewer than usual. The cool climates did not spare our people, particularly the older adults and children, from seasonal illnesses like influenza, rhinovirus and RSV. Whangārei emergency department was incredibly busy as were many other EDs across Aotearoa. It used to be a "big thing" for us when 'code black' flashes could be seen from the ED screens. Now those cruisy shifts of the past are long gone and 'busy' has become an understated norm. Scary thoughts, but factual from our ED at a glance (EDAAG) data.

Northland has a growing population. The country's current recession affecting

many Kiwis there, from Whangārei up to Kaitaia. Many are unable to afford GP consultations and the increased presentation of patients with social issues is evident. These concerns have impacted the flow of patients in and out of Whangārei ED. Certainly, we are seeing ramping of ambulances and patients being treated in corridors due to the overwhelming patient numbers. Moreover, understaffing, staff sick days and skill mix of novice and inexperienced nurses in every shift are among the common predicaments that are continuously presenting in our ED this season.

Our initiatives in Whangārei ED involved formulating Admission Holding Order forms to speed clerking of patients to the ward in a safe efficient manner. Secondly, we have improved our management plan for patients with social issues, using a comprehensive approach involving medical team, social workers and other key links

in the community with the use of Te Whare Tapa Whā model. Lastly, the ED Flow Navigator role was trialled by our Clinical Nurse Specialist Reanne Subritzky, which aims to reduce delays in bed availability and appropriate room allocation of patients and to assist staff with resources and facilitate prompt discharge, with efficient and effective processes. We hope this role will continue and officially come into recognition.

Despite it all, Whangārei ED team have survived another winter. As our team say, bring it on summer!!

On behalf of the team, I would like to highlight the gift given to Whangārei ED as part of our wellness program. A beautiful piece of art by artist Mike Paora, inspired by their kaupapa of Te Kahu Atawhai which means a blanket of kindness, compassion and love.

Ngā mihi nui,

Brendon



Photo from Te Whatu Ora – Te Tai Tokerau (2023)

# Tāmaki Makaurau | Greater Auckland Region



## Regional Representative

**Lydia Moore**

Clinical Nurse Specialist

Waitakere Hospital Emergency  
Department

Te Whatu Ora Waitematā



## Regional Representative

**Wendy Sundgren**

Associate Clinical Nurse  
Manager

Te Tari Rongoaa Ohorere | Middlemore  
Hospital Emergency Department

Te Whatu Ora Counties Manukau

Professional Teaching Fellow

School of Nursing

Waipapa Taumata Rau | The University  
of Auckland

## Waitākere and North Shore Hospital Emergency Departments.

### Kia Ora from the Waitematā.

The last few months across both ED's at Waitematā have been over capacity, with bed blocking, corridor patients, and delayed ambulance offloading. However, recruitment has been high with an influx of new staff, and Waitakere now fully recruited. The addition of staff has been welcome, however, the skill-mix remains challenging. New employee orientation, in-house study days, and regular simulation scenarios with follow-up emails help address this across both sites. With many senior staff stepping up to the Clinical Charge Nurse role, excitingly, a new ACCN study day at Waitakere has been implemented to help support these nurses.

Waitakere initiated monthly meetings to allow an opportunity for departmental sharing, addressing important issues, and the opportunity to exchange ideas for improvements in the department. In addition, our wonderful educators send

out helpful regular newsletters with information and education bites for all staff. The department is looking forward to supporting six New Graduates in January and four Nurse Specialists who have been accepted into the Nurse Practitioner Training Program. North Shore ED has two Nurse Specialists who have almost completed their Nurse Practitioner training, which will be extremely useful to the department.

Online notes, E-vitals and medications are well and truly established across both sites and have made caring for patients accessible for all staff. Online notes continue to evolve, with Best Care Bundles being added and quick links to make the process smoother.

We are so proud of all our staff and all the mahi they have done and continue to do, but we are all looking forward to a break over Christmas and a (hopefully) warm and quieter summer.

**Lydia Moore,**

Clinical Nurse Specialist.

## Starship Children's Emergency Department.

Starship's Children's ED has had an increase in tamariki presenting compared to our last normal busy year of 2019. Every month on record (except June compared to June 2021, which was the RSV surge) has been our busiest on record. Poor access to primary health care has contributed to this increase in presentations. We had our first FTE calculations in May

this year after having implemented Trendcare in January 2022 and have had a significant increase in our Nursing FTE (about a 40% increase). This is our first increase in RN FTE in nine years. We have been able to recruit and aim to be fully recruited to our new FTE by March-April next year - in time for next winter.

**Anna-Marie Grace,**

Nurse Unit Manager.

## Auckland Region cont.

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### **Auckland Adult Emergency Department.**

As a part-timer who has worked at Auckland Emergency Department for over 12 years, I am still often amazed by the resilience and adaptability of my emergency care colleagues. Challenges and changes have been unrelenting over the past few years, and there is no reason to believe things will 'settle' in the future. This is the new normal. While social determinants of health continue to decline and primary and residential care providers remain insufficiently resourced, New Zealand's ageing and increasingly medically complex population will often have no choice but to seek emergency department care.

Our leaders are working to find solutions to improve patient flow and minimise the risks to patients and staff associated with overcrowding and understaffing. I won't say they're 'working tirelessly' because we're all pretty tired.

We've been sad to say goodbye to some wonderful team members who have left the department, but new staff bring enthusiasm and professional pride, and we're close to our funded FTE in nursing staffing. Other team members have taken time out for travel, family, or other roles and returned to Auckland ED with fresh energy and new insights.

As is the trend around Aotearoa, record-high occupancy has led to increased ambulance ramping and patients waiting or being assessed in informal spaces like corridors and waiting rooms. The atrium space – once reserved only for MCIs or disasters – now has permanent lighting and other fixtures. In response to overcrowding, our built environment is undergoing its latest evolution – an extension at our entrance – to make more space in our triage area and waiting room. Of course, this is only part of the equation, and increased medical and nursing staffing will be needed to ensure that

we are providing safe emergency care – not just accommodation. On that note, the Triage Assessment Team (TAT) pilot saw ED SMOs working at the 'front door' at our busiest times in an attempt to improve patient safety and expedite key investigations, symptom relief and rapid referrals for patients held in the waiting room and awaiting space in the department. This role was particularly well-received by the nurses working in triage. Always a cognitively challenging role, triage nurses are now also experiencing moral distress, cognitive overload and increased frustration, violence and aggression from patients and family members. Support associated with having a doctor in this area was good for staff morale and patient safety, and nurses hope it will continue during our busiest times.

**Natalie Anderson,**  
Staff Nurse.

## Auckland Region cont.

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### Middlemore Hospital Emergency Department.

Middlemore ED continues to be its usual busy self, with the average difference in patient presentations over the past 12 weeks being up by 138.25 patients compared to 2022. While it's nothing to celebrate, it is important to acknowledge the number of patients presenting to our department and, therefore, the level of mahi needed by our team. October was our eighth consecutive month with more than 10,000 patient presentations to the ED.

We are pleased to say that we are fully recruited to our current staffing model. While we know that our current staffing model does not meet the current needs of our patients and the healthcare system – it's a small step in the right direction and something worth celebrating. Our focus now needs to shift to enhancing our skill-mix and, of course, retention.

Recently, Middlemore ED has undergone a further staffing restructure. The structure looks to introduce two new Charge Nurse Manager (CNM) positions, taking us to a total of four. The aim of this is to provide a more consistent approach to leadership, management and support for staff in the department and create greater clarity in line management.

Several exciting new initiatives have been piloted in the department over

recent months. Maanaki Tangata addresses the need as we continue to treat more and more patients in our waiting room. Our waiting room has seating for about 28 patients, but often has 40-50 patients in it. The role aims to provide patients and their whaanau with a contact point, and to "welcome" patients into our space, thus improving the patient experience. The role has a more clinical side to it and is tasked with "walking the line" at triage and identifying patients at risk, both in the triage line and in the waiting room. The role also aims to have an overall view of the waiting area, addressing patient needs, from cups of water to analgesia, and expediting care for patients who need it.

Middlemore ED and Whaanau Ola, our Pacific Health Department at Counties, are currently running a Pacific Health Pilot. This Pilot seeks to address the needs of our Pacific population, a large proportion of our patients, especially after hours. The pilot's aim is to apply a culturally appropriate assessment model to caring for our patients in order to strengthen the accuracy of information conveyed, allowing us to better meet patient needs. The role also aims to ensure that information is shared with patients in the right health setting to meet their needs in the future and to provide referrals to Whaanau Ola for wrap-around care in the community after discharge.

Telehealth is being trialled across the adult and paediatric sides of the department. We are looking forward to the results from this trial to ascertain its potential future benefits.

In an attempt to limit the effects of hospital occupancy on patient flow, we trialled an initiative called 'ED Ring fencing'. This meant that a selection of bed spaces in the Adult Short Stay Unit were reserved for Emergency Medicine specialty patients only. Some of these bed spaces were transformed into an ambulatory active treatment area, fitted with several lazy boys so that patients could be observed and finish off treatment before being discharged. The trial proved effective, with throughput increasing through the SSU. Ring-fencing has since become part of our standard practice.

To our amazing team at Middlemore ED, thank you for all your hard mahi throughout the year – it does not go unnoticed. We wish you and your whaanau a safe and happy festive season. For those of you taking one for the team and working through it, we thank you very much and hope that you find some time to take leave later in the new year.

Take care whanau.

**Chris Chu,**  
Nurse Unit Manager.

## Midland / Bay of Plenty Region



### Regional Representative

**Linda (Lyn) Logan**

Associate Clinical Nurse  
Manager (ACNM)

Rotorua Emergency Department

Te Whatu Ora Lakes

### Rotorua Emergency Department.

Similar to other EDs, Rotorua has had a busy winter period with increased presentations, acuity and bed block. We continue to seek safe staffing, and with the impending implementation of TrendCare, we will seek to see increases in FTE similar to other EDs nationally. At present, we will be sitting around 7-8 FTE down and have struggled to appoint new staff with ED experience.

The introduction of the troponin trial within the department will look to improve patient care and decision-making while decreasing the wait for blood results.

Our new social worker Hine Harris, has made a big impact on our department and below she states in her own words regarding what it means:

"My role, I believe, is to bring strong relationship skills and partnership that applies wider than the health sector - community. I set a well-being and strength-based vision. I have guiding principles to help shape the way I mahi with both our whānau and the people who care for the people. I act with aroha, recognise that treating people with

kindness and care enables healing and shows what respectful relationships look like. Kaitiakitanga - working together in a partnership for all to understand their roles and responsibilities to ensure the safety and well-being of people and their whānau.

I try to embody the characteristics of Te Ao-Kapurangi, who famously saved the lives of Te Arawa people by straddling the roof of Tamatekapua. The history of Te Arawa people on Mokoia Island. Te Ao-Kapurangi had married into Ngāpuhi (my ancestors), and she was desperate to save her people, so she appealed to Hongi Hika. He said whoever fits beneath her thighs will live, and so she climbed on the whareniui roof. I try to embody her characteristics because she protected people by thinking differently.

Regardless of our roles, we should work together to keep each other safe. 'Whiria te tangata' - people together."

**Lyn Logan,**

Associate Clinical Nurse Manager.

**Hine Harris**

Emergency Department Social Worker.

## Midland / Bay of Plenty Region cont.

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### Waikato Emergency Department.

Ahh..... nothing like a great CENNZ conference to inspire and rejuvenate us all into making our work environments better for both ourselves and our patients. Many thanks to the CENNZ organising committee for putting together a thoroughly enjoyable event – and to Christchurch for the beautiful weather! With a Nurse Manager, Charge Nurse Manager, two Associate Charge Nurse Managers, a Nurse Practitioner, two Clinical Nurse Specialists, and a long standing RN attending we had great representation in Christchurch. This ability to share across our nation, the tools and tricks of our trade, can only help in our desire to provide the best care we can.

And here we are, now coming to the end of another interesting year in health... COVID, to mask or not to mask (yes, at the time of writing we are still in N95 – handy for the current little blip in numbers though), how to return to our new normal, and the ongoing challenges of hospital bed block, long ED stays and even longer wait times.

The surprising thing is our presenting numbers have still not reached the pre-

Covid numbers... so that does leave some questions.

The positives include some good action around our Letter of Recommendation/ PIN documents issued under the HSWA to Te Whatu Ora. While these are something that should never have been needed, they have most definitely ignited some energy and fire to make necessary changes for the safety and wellbeing of both our patients and staff. The work is ongoing.

Staffing (with fingers crossed that I dont jinx it) is currently at budgeted levels, and courtesy of TrendCare our rosters have capacity for more – read 'the budget isnt there yet but TrendCare is highlighting the deficits VERY clearly to management, and they are responding'. The debate around the validity of this tool vs. patient ratios will be interesting.

From the mighty Waikato to the rest of our NZ ED colleagues.... may you have a merry, festive and safe Christmas and New Year, may Santa bring you lots of treats, and may time with family be full of new memories.

**Tracy Chisholm,**  
Staff Nurse.

## Midland / Bay of Plenty Region cont.

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### **Taupo Emergency Department.**

In 2019, after many discussions on how to improve care for neonates, Taupo Emergency Department (ED) introduced bubble continuous positive airway pressure (B-CPAP) for neonatal respiratory distress. Taupo ED has a co-located midwife-led birthing unit that delivers approximately 180 low-risk babies per year. Although the babies are deemed to be planned and low risk, there is a small percentage that require initial respiratory resuscitation and then ongoing resuscitation; this is where ED acts as the primary MET response team.

Historically, babies transferred into the ED would receive lengthened support via a T-piece resuscitator, low flow oxygen, or intubation if required, until the introduction of B-CPAP.

B-CPAP has allowed neonates of the Taupo district with respiratory distress to have equitable care offered in more metropolitan areas. A recent retrospective study by Dr Glen Barker of Taupo ED demonstrated an 11% reduction in the use of rescue helicopters to transfer at-risk babies and an 18% reduction in admissions to level three neonatal units.

Usually, this is offered to neonates in NICU/SCBU by specialist trained nurses; as it stands, we are one of the few rural EDs offering this service. The staff absorbed the learning by attending regular in-services led by our Clinical Nurse Educator, Sharyn Wallis. The 4-step teaching method was applied, and all new staff were given repeat demonstrations and in-service training. Being able to provide the best standard practice from a rural capacity is what we love most about our use of B-CPAP.

We could not be more proud of our small department, their efforts, and their ability to deliver the best standard practice for the most vulnerable population, even in a challenging locality with little access to help.

### **Michelle Knight**

Clinical Nurse Manager.

### **Hailey Holmes**

Staff Nurse/Clinical Nurse Educator.

## Tairāwhiti/Hawke's Bay – Te Matau-a-Māui Region



Regional Representative

**Laura Cottrell**

Clinical Nurse Educator

Hawke's Bay Emergency Department

Te Whatu Ora Te Matau a Māui,  
Hawke's Bay

Hawke's Bay Emergency Department started the year with a fresh new management team ready to support our staff through the recent changes that Covid-19 brought to the nursing profession. This was hit with an immediate hurdle with the damage and destruction caused by Cyclone Gabrielle on the 14th of February.

The cyclone immediately quashed the notion that 'this will never happen in our lifetime' and brought the worst-case scenario to life. People's homes and livelihoods were completely washed away. There was so much unknown as to what was going on. People were isolated from their loved ones, living with no power or communication for days.

The emergency department was required to swing into our emergency response, accepting patients from flooded areas with hypothermia and injuries caused by escaping raging waters. Staff isolated in Napier swung into action, setting up a makeshift ED in the Napier medical centre, working under torchlight and limited resources to provide immediate health care to the area.

Those able to get to the hospital worked incredible hours, responding to the mass casualty event, and plugging the gaps due to staff not being able to make it into the department.

On days off, nurses would dig houses out of silt and respond to the clean-up. Those at work dealt with the anxiety and guilt of not being out in the community helping those in need. Staff welfare was paramount during this time. It was important for staff to recognise that this was a marathon, not a sprint and that looking after ourselves and each other needed to be a priority.

The outpouring of support provided by the emergency community was a massive morale boost, and we felt like we weren't doing this alone. The gifts of snacks, pizza, koha, and words of support brought comfort to the team and warmed our hearts. So, thank you all for those who contributed.

In the recovery phase of the cyclone, mental health in the region took a huge hit, especially in the rural communities. It became routine in the department to not only treat our patients for their emergent needs but to ask about the mental impact the cyclone has had and provide support where we could.

The department continues to experience large patient volumes, extreme numbers of inpatient overnight stays daily, and high FTE vacancies. With many senior nurses leaving the profession, our priority is growing our own nurses. Education opportunities have increased for our staff, ensuring they are well-rounded and given the knowledge to succeed. We have allowed our new graduates ten weeks of orientation to ensure they are supported and not at risk of burnout due to the high demand early in their careers.

It is also vital that our staff have a bit of fun at work as well! With the introduction of 'Wacky Wednesday,' teams are given the opportunity to wear their own scrub tops, bringing character and colour into the department. This has become a big hit with our patients, who report they feel the ward is less intimidating and more welcoming.

With unprecedented circumstances surrounding this year, I am so proud of everything our nurses achieved and can't wait to see what they can bring to the department in 2024.

# Taranaki/Manawatū/Whanganui Region



Regional Representative

**Lauren Miller**

Clinical Nurse Educator

Taranaki Emergency Department

Te Whatu Ora Taranaki

## Taranaki Emergency Department.

We have a new Acute Transition and Discharge Unit, while we plan towards an Acute Assessment unit in our new build (due for completion in 2025). Patients who are waiting for a ward bed and are unable to go due to lack of physical bed (i.e. awaiting discharge bed on the ward) may be moved to the ADTU until the bed is available. This is to facilitate acute patient flow from the Emergency Department. It is also currently used for discharging patients from the wards who are simply waiting on transport/medication to facilitate decanting the wards so we can move patients up to the wards from ED. It is currently open from 0900-2100 Monday to Friday.

Our patient presentations have not changed greatly, but we are seeing higher acuity patients with a lot of flu symptoms over the last couple of months (20% of patients). Around 15% of our presentations are due to chest pain and 20% to abdominal pain.

A new initiative in the ED is our ED Peer Support team – made up of ED staff – medical, nursing and clerical team. They aim to provide a listening ear to help and support their colleagues, especially after a difficult shift/case or if they are going through a hard time, in or outside of work, and want a chat with someone.

Challenges for our ED include high patient volumes, with not enough capacity in our ED to give patients privacy, often on busy afternoon shifts. We had our first evening shift where we needed to ramp ambulances for a few hours on a busy Monday in early August. We had good support from St Johns over this time. In regards to successes, we have two senior RN's completing the CNS paper and aiming to become ED CNS's by the end of the year.

## **Therese Manning,**

Clinical Nurse Manager.

# Taranaki/Manawatū/Whanganui Region cont.

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## **MidCentral Emergency Department Te Pae Hauora o Ruahine o Taranua.**

Our new ED Observation Area (EDOA) has opened and is now fully operational. The staff are enjoying the new and bigger space, which has added an additional four beds to the ED. We have also managed to recruit to this extension, which is positive. The old EDOA space will be converted into a dedicated paediatric assessment and procedural area; this is due to start in February 2024, with a completion date set for April 2024.

Our patient presentations have not really changed. We continue to see high acuity presentations in ED, and along with our colleagues from other districts, access block continues, so we are continually holding admitted patients within the department.

We have been extending the scope of our HCAs to include phlebotomy

and will trial having those HCAs in the waiting room as part of our waiting room 'team'. We are seeing more and more patients have their full journey in the waiting room, so we are changing the model of care in this space to keep up with demand.

Ongoing access block and keeping our higher acuity patients for longer is a challenge. We are also struggling medically with shortages across our RMO and SMO teams. Lately, we have also been seeing high rates of violence and volatile patients within ED with the increased use of synthetic drugs and laced drugs.

Fully recruiting to our nursing FTE is something we have managed to celebrate over the last couple of months. We also have permanently appointed to the Educator team..

**Kellie Stickney,**  
Charge Nurse.

# Te Upoko o te Ika a Maui | Greater Wellington Region



Regional Representative

**Shannon Gibbs**

Mātanga Tapuhi | Nurse  
Practitioner

Masterton Emergency Department

Te Whatu Ora Wairarapa

## **Masterton Emergency Department.**

We recently farewelled Kathryn Wadsworth from the CM role she has been sharing with Corrina Rooderkirk for several years. Kathryn previously held the membership and grants portfolio within CENNZ, and her leadership of the department through the COVID years and then through TrendCare implementation was invaluable. She has embedded a culture of care and respect for the humanity of both colleagues and patients in the Emergency Department, which is reflective of her own values. She has been a deeply human and courageous Nurse Manager. She is loving her return to nursing patients on the floor (part-time) alongside her role as Clinical Nursing Director at Masterton Hospital.

The department remains busy with usual patient numbers, but echoing national trends, our patients are sicker and staying longer, contributing to bedblock. We continue to hold acute orthopaedic patients requiring surgical input until they can be transported over the hills to the Wellington Orthopaedic Team.

Acute services (ED and the adjoining HDU) have been recruiting into the greatest FTE increase Masterton Hospital has seen on the basis of six months of trendcare data. Vacant FTE continues to fluctuate with the recruitment of both experienced nurses and juniors. A consistent focus on the basics with inexperienced staff - safety checks, documentation, monitoring for and escalating deterioration, etc is helping to mitigate the risk of a junior team.

At the senior end of the team, Di Sigvertsen has stepped into a newly developed Trauma CNS role, building connections with regional colleagues and rolling out a trauma bundle with her usual enthusiasm.

The other exciting development is the funding secured in the HDU for a fixed-term Manaaki Whānau Kaimahi, which will benefit both HDU and ED patients, staff and whānau.

**Shannon Gibbs,**

Mātanga Tapuhi | Nurse Practitioner.

# Te Upoko o te Ika a Maui | Greater Wellington Cont.

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## Te Pae Tiaki | Wellington Emergency Department.

We are seeing high acuity presentations in ED, delirium/dementia patients requiring watching.

Our LOS has increased. We have a significant number of patients in our ED for over 24 hours.

New in the department in Wellington is the permanent appointment of our Manaaki Whānau staff member. This is currently a Monday to Friday 0800-1630 position, with the hope it will extend to 7/7 am and pm in the future.

On the equity front, we have a PRIORITY project in place for identifying and prioritising Māori and Pacific patients, and patients living with a disability, in the ED. This has been adopted by our whole team:

- To be triaged
- To be placed in a cubicle
- To be reviewed by an ED doctor
- To be referred and reviewed by the specialty team
- To be allocated a ward bed

We continue to be challenged by bed block due to inpatient delays for ward placements and ED demand far exceeding capacity. We frequently run out of physical space and beds in ED, even with patients nursed in the corridor. There is limited support due to limited resources being available, but the impact of feeling as if we are managing this alone is significant for the entire team.

On the plus side, staff are really engaging in TrendCare – producing good quality results and progressing to FTE calculation. This is still in process, and no approval has been given yet.

**Mel Taankink (She/Her) – edited by Shannon Gibbs**

Tari Kaiwhakahaere Tapuhi | Nurse Manager.

## Te Tau Ihu | Top of the South Region



Regional Representative

**Vicki Bijl**

Charge Nurse Manager

Nelson Emergency Department

Te Whatu Or Te Tau Ihu, Te  
Waipounamu

### **Nelson Emergency Department.**

Nelson ED has been approved the refurbishment to increase our footprint to ensure we have an ED that is fit for purpose for our growing community. The refurbishment will include a total of 28 beds, have a dedicated Mental Health area, isolation rooms that are built to international standards, and larger staffing areas. The building will likely start May 2024, with the ED remaining operational during the building process!

Like many EDs, there is a higher level of staff that are new to ED, so we have introduced clinical coaches into our team to ensure staff are supported during onboarding and during orientation into triage and resus. The clinical coaches have been well received.

Many EDs do have specific study for each level of RN in ED, and so we have also developed this into our educational plan. The feedback from staff has been positive, as it builds the team and allows staff to grow in confidence with skills and knowledge specific to the ED.

We introduced TrendCare in October 2022, and we are now eagerly waiting to find out the first tranche of FTE at the

end of this month. We are predicting this to be very positive!

Currently our vacancies have all been appointed to, and most of our casual staff are back from overseas contracts. Therefore filling our roster gaps has gone relatively well.

We have taken on a higher level of nursing students than we normally would. Our Clinical Nurse Educator facilitates weekly one hour teaching for the transition students over the 9 week period. Knowing that our TrendCare FTE will be positive - we need 'grow our own'. So many of these students will receive NETP roles in our ED in 2024. This extra education will have served them well.

Patient presentations continue to increase, combined with an increase in acuity, which has been exacerbated by a reduction in primary care provision. Nelson also recorded the highest number of major trauma in September.

2024 will be a busy year with the building, and recruiting into the FTE from our first TrendCare tranche.

**Vicki Bijl,**

Charge Nurse Manager.

# West Coast/Canterbury – Te Tai o Poutini/Waitaha Region



## Regional Representative

### Keziah Jones

#### Staff Nurse

Christchurch Emergency Department  
Te Whatu Ora Waitaha Canterbury

## Christchurch Waipapa ED.

### Kia Ora from Christchurch ED,

We are ticking along with average presentations per day over the past three months Sept - 364, Oct - 381, Nov - 371. There has been a steady increase in patient presentations with our busiest day a Sunday in November reaching 428. For the first time, due to staffing issues, we are faced with the impact of absent colleagues at the 24hrs surgery who have had to close overnight. This has unfortunately had to occur over the past few months, and is reflected in our increasing numbers as we have become the only remaining service available overnight.

We thoroughly enjoyed hosting the CENNZ conference in October and welcoming you all to Christchurch for a much needed ED Nurses catch up coupled with fantastic presentations that really encompass the Emergency part of our job. It was great to see everyone celebrating emergency nursing and sharing some of the great initiatives across the motu.

In October Christchurch ED also farwelled Anne Esson our Nurse Manager - we have some great shared memories of her 16 years at the helm. All the best Anne.

We are excited to welcome Jo Ashton our new Nurse Manager and look forward to getting to know her better in the coming months as we frequently see her around on the floor and she settles in to her role.

Our final FTE calculations using trendcare data have resulted in an increase of 23.37FTE which will bring Christchurch ED to a total FTE 165.96, recruitment is in full swing and we are welcoming lots more new nursing staff which is great as we continue to build our team with nurses bringing varied knowledge and experience, personalities and fun.

#### New Initiatives:

We have had some positive initiatives and trials since the last regional report.

- STAR – Specialist Telehealth Aoteroa, runs 1200 –2200hrs 7 days a week: this is an SMO led phone consult

with a focus on pre hospital patients who are likely to be able to stay in the community, working closely with St John and rural health professionals.

- GP in ED with a focus on minors; so extra physician input able to see GP type presentations.
- The Point of Care Troponin roll out has been positive, resulting in shorter stays and quicker decision making for those chest pain patients, who can otherwise have a long turnaround time.
- New violence and aggression reporting with a similar system to Auckland, easy and fast to record any incidents, simply swipe your ID card and push the corresponding button on the wall to indicate verbal abuse, physical abuse or both. We still encourage safety first reporting but it will be interesting to see what data this new reporting method captures.
- Telehealth booth – Low acuity Patients seen for consult in a booth connected to a telehealth doctor. The booth is located in, but intended to be independent of ED input.

We hope that some of these trials get approval to stick around for the summer.

### Keziah Jones,

Staff Nurse.

## Southern Region – Te Tai Tonga



### Regional Representative

#### Michelle Scully

#### Clinical Nurse Educator/ Registered Nurse

Southland Hospital Invercargill  
Emergency Department

Te Whatu Ora Southern

### Invercargill Emergency Department.

Janet Andrews, CNM in Dunedin, has reported that there has been 110-155 presentations per day with acuity increasing significantly, and patients presenting with multiple comorbidities and more complex conditions. There has been an increased number of triage category one and two patients. Staffing recruitment has been positive, and although there has been some delays in processing visas, staff have started and are progressing through their orientations. NETPs have been interviewed and the challenge is predicting what vacancies there may be to enable permanent positions to be offered in 2024.

Barriers and challenges in Dunedin are continual access block, along with staff sickness and staff on ACC. Dunedin's escalation plan is working well between ED and St. Johns. Emergency Nurses Day celebrations were held and awards given.

Leigh-Ann Fearn, CNM of Invercargill ED, reports that patient acuity has increased and challenges and barriers in the department continue to be the lack of space and capacity. On average there has been 106 presentations per day. Access block is an ongoing issue. Ambulance ramping continues. A positive change is the clinical coach position, which is soon to commence, and an increase in the number of NETPs, four will start next year.

Lisa Friesen, CNM from Queenstown, hospital reports they have had an extremely busy winter, with their busiest day on record, seeing 80 patients in one day, and 1500 for the month of July. A challenge for Queenstown ED is the continued growth in population, with the needs of the community changing constantly. There is a larger number of retired people moving to the

district, which has changed the patient population and types of presentations. On a positive note, Queenstown now has a designated morning and afternoon triage nurse, and there is work ongoing to finesse the triage process. Some building work is occurring which will help to streamline the ED presentations. In regards to successes, Queenstown is now fully recruited.

The three Southern EDs, Dunedin, Queenstown and Invercargill look forward to implementing TrendCare in 2024.

**Education** in Dunedin, Queenstown and Invercargill EDs continues. The Southern Educators appreciate the Clinical Nurse Educators network facilitated by CENNZ enabling a sharing of resources, which often saves reinventing the wheel. They also appreciate the CNE face-to-face meetings facilitated by CENNZ. The networking, shared experiences and stories are invaluable.

**Dunedin** has weekly insitu and monthly resuscitation simulations which are well attended and provide valuable interdisciplinary learning opportunities. A NetworkZ simulation has also been held, with high fidelity inter-agency/interdepartmental simulation (Heli, ED, ICU, Surgery). The clinical coach is busy and well utilised by staff. High ED occupancy and winter staffing challenges are barriers to education delivery. There are many BN, MNSc and CAP students in the department. The CNS and Education teams are spending time supporting new staff with the new front of house model of care. The ARISE fluids study, looking at early versus late vasopressors, and liberal versus conservative crystalloid use in septic shock is in progress. In house study days are ongoing such as casting, foundations and paediatrics. One senior nurse attended APLS.

## Southern Region – Te Tai Tonga cont.

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**Invercargill** has hosted two TNCC courses and one triage course. These are fed into from the entire region. There is disaster planning occurring at Southland hospital with emergo training next week. Education in the department has had many themes and foci, often in response to feedback from other areas, especially paediatrics. A PLS course has been held, along with some paedics focussed ED study days. These have been valuable and will hopefully run regularly.

In response to delays in getting patients transferred to Critical Care, or retrieved to a regional hospital, Invercargill ED staff are focussing on upgrading their knowledge and becoming more competent in caring for ventilated patients.

Our CNS's play a huge role in education in the department and run plaster refreshers and fundamentals study days. In response to triage nurses wanting triage education, triage refresh education has been provided to all triage nurses in the department and this has been a resounding success.

The Southern CNMs and CNEs continue to network in order to continually improve their regions processes to improve patient care. It's a great region in which to work. Our people are known for their friendliness and our scenery is stunning. We, the ED nurses, all strive to give our best and love the collegiality of ED nursing.

**Michelle Scully,**

Clinical Nurse Educator / Staff Nurse.

# College Vacancies

## Vacancy for Canterbury Westland Region Representative on CENNZ National Committee

The committee invites nominations for a regional representative from the Canterbury Westland 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](mailto: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](mailto:cennzchair@gmail.com)

Ngā mihi nui

Lauren Miller

Chairperson

# Education: Webinars

## Webinars;

A reminder to all emergency nurse's and those interested in on-going health care education about the series of webinars offered by CENNZ via the Mobile Health MyHealth Hub platform. These webinars are presented by highly qualified and experienced emergency nurses, doctors or other health professionals. The sessions are recorded and available post the live feed for additional viewing if you unable to attend the original presentation. There is no cost to view these. The link to the index page for the CENNZ specific presentations is: <https://myhealthhub.co.nz/coming-soon/cennz/>

Upcoming CENNZ webinars		
Topic	Presenter	Original presentation date
Tuesday 23 July	Pae Ora	Natasha Kemp
Wednesday 29 May	Inequities in Healthcare	Natasha Kemp
Wednesday 3 April	Management of acute Stroke	Julia Slark

# Education: Webinars cont.

Previously recorded CENNZ webinars		
Topic	Presenter	Original presentation date
Trauma informed care and trauma screening	Anna Elders, NP/Cognitive Behavioural Therapist	22nd February 2024
12 Lead ECG's / Advanced ECG	Damar Kaur, NP	15th Nov 2023
Management of Cardiac implantable electronic devices in the ED	Theodore Pearson, Cardiac Physiologist	5th Sept 2023
Managing the breathless patient	Nicola Corna, NP	20th July 2023
Bronchiolitis don't just do something, stand there	Libby Haskell, PhD, Paed. NP	16th May 2023
The importance of pausing in the ED	Demi Du Toit, RN	23rd March 2023
Suicidal or not reviewing risk with the Columbia suicide scale – CSS-6 version	Debora Anderson, RN, MN, CNE	21st Feb 2023
The Impact of long-term mental health conditions on physical health	Cath Allwood, Mental Health Educator	28th Nov 2022
Violence and Aggression in the emergency nursing workplace	Sandy Richardson, PhD, RN	14th June 2022

# College 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](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](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](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](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](mailto: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](mailto:sharon.acen2014@gmail.com), Phone: 027 245 7031

## Submissions Guidelines - (Brief)

# Journal Submissions

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.

## 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](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

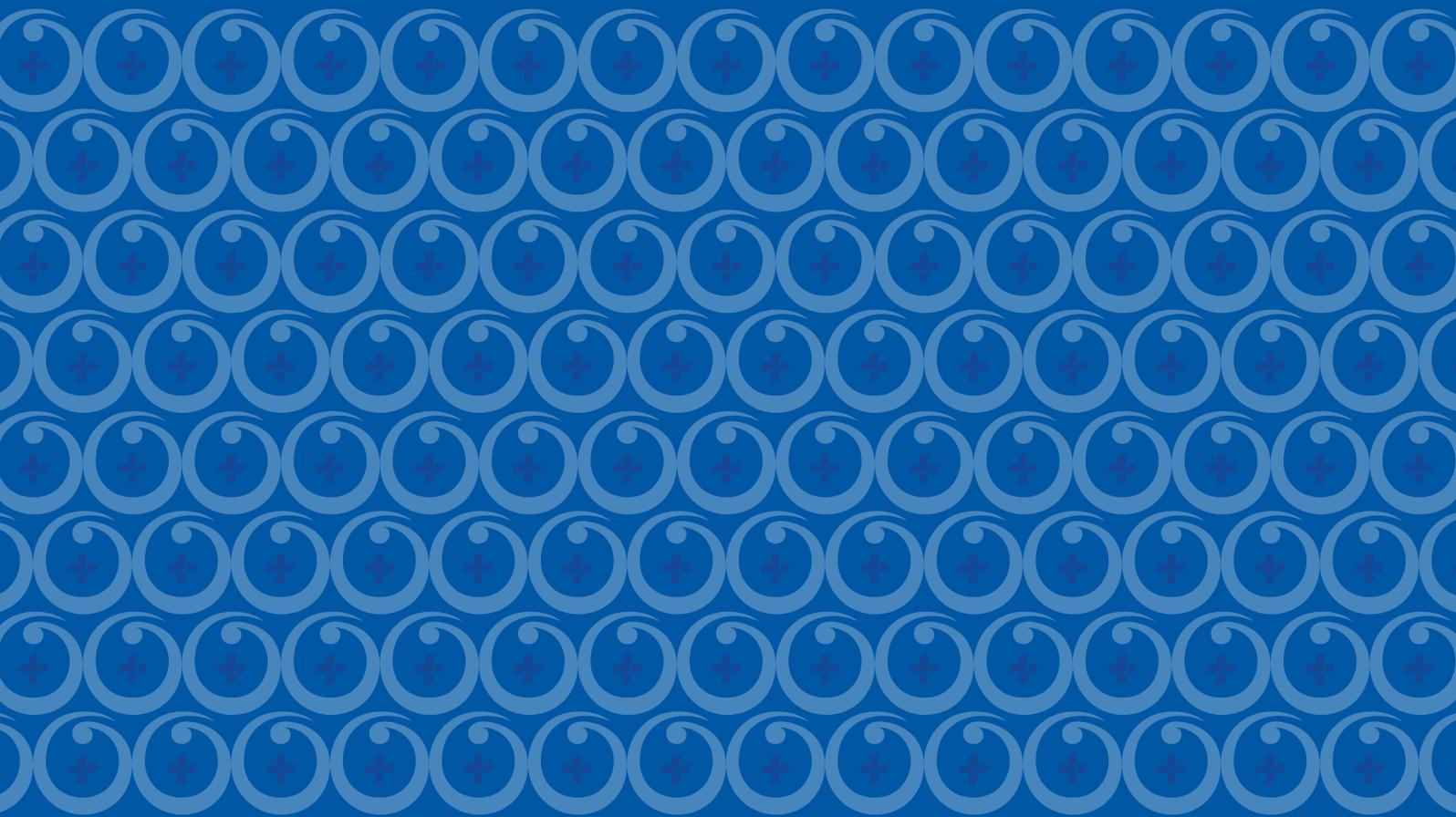
**Format:**

**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



**College of  
Emergency  
Nurses NZ**



Ngā Ringa Ringa Aroha NZNO