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In this issue

Editorial Information

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Editorial

Dr Sandra Richardson
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Caring for older adults – core ED practice.

This edition of the journal focusses on the management of one of Eds most significant population groups – older adults. We know that our populations are growing older, that any specialty area in nursing will involve care of the older patient, and ED is no exception. The need to see geriatric patients as part of (even a major part of) our core business has never been more significant. We need to recognise the opportunities as well as the challenges, seeing this as an area for further skill development and an clinical expertise. For too long the care of older individuals has been seen as one of the less desirable areas of health care – relegated to rest home, dementia units and often dismissed as the antithesis of the high acuity, exciting areas such as ED. The reality is that this group are complex, interesting to work with, and represent a population where we can make a significant difference. This edition offers a number of articles and updates that touch on the importance of recognising frailty, and responding to risk assessments. We see the difference that introducing a specialised role such as the GEDI nurse can make. Working together with our colleagues in allied health, and identifying alternatives to admission can be an effective intervention. We often focus on the vulnerability of older adults, but need also to acknowledge the resilience and experience that these individuals often bring with them. We refer to various age points in relation to ageing, and need also reflect on how this is increasingly relevant to the nursing workforce. How many of us, or our colleagues, if unfortunate enough to end up in ED would be classed as 'older adults'? How would we want (and expect) to be treated?

Ka haere te tōtara haemata, ka takoto te pukatea wai nui.

- The tōtara floats, while the pukatea lies in deep water.
- Young people are like the tōtara, free to move around easily, while older individuals are like the pukatea, settled and grounded.

Sandy.

Guest Editorial

The fall and rise of Geriatric emergency medicine.

An 83 yr old man is brought to your Emergency Department. He lives independently and alone. His son who lives in Sydney was speaking to him on the telephone but thought his father was confused. His son rang the ambulance. On their arrival the man was disorientated and febrile. Vital signs otherwise normal . At triage he is given a triage score of 3 but you know that it is likely he will wait for several hours to be assessed and treated.

How often does this type of patient arrive in your Emergency Department (ED) or with minor changes to the details? Older adults in our EDs are now common and ED staff are becoming adept at managing such patients. Some colleagues will argue that this is not "core" emergency medicine. But I would argue strongly that just as our communities change, we have to morph into providing the acute services that our communities need. Older adults are becoming a larger proportion of our society. In addition, it is increasingly common to find adults in their 90s and older who require ED services. The proportion of people age 65+ years in New Zealand currently sits around 17% or 1 in 6. This is estimated to increase to 20% by 2028 and 25% by 2050s. Around 25% of ED attendances are age 65 years and older with high admission rates of 50-60%. So we are all going to spend increasing amounts of our time assessing and caring for this population.

All organ systems are affected by ageing but importantly there is a steady decline in renal function due to loss of nephrons leading to impaired drug metabolism and excretion. We all see manifestations of changing physiology of the older adult whether it is the falling patient due to postural hypotension or the patient with sepsis influenced by the attenuation of B cell and T cell responses that occurs with ageing.

Chronic comorbidities are to be expected in the older adult. Diabetes, ischaemic heart disease, atrial fibrillation, chronic obstructive pulmonary disease are common. Therapy of these conditions has progressed and so too our own knowledge of these treatments. Understanding the four pillars of heart failure management and change in diabetic therapy e.g. SGLT2 inhibitors is important for ED nurses and doctors. We may not be prescribing these drugs in ED but we will see interactions and drug side effects.

In addition to managing flares of chronic conditions, there are the geriatric syndromes that have been well described. Non specific presentations are common in the older adult. A fever of 38 degrees or higher is associated with a higher risk of bacterial infection. But an absence of fever does not exclude a serious infection. Blood pressure thresholds that are relevant in younger adults in sepsis do not necessarily apply in older adults. Comparison with previous blood pressures is essential to clarify a deviation from baseline. Typical chest pain in acute myocardial infarction may be modified or absent entirely. Our approach to assessing and investigating the older adult has to be thorough to detect potentially serious illness presenting in an "atypical" way. Cognitive impairment due to delirium or dementia makes assessment of acute illness or injuries more complex. Difficulties in explaining symptoms can lead to dismissal of certain diagnoses and this adds to the complexities of assessment. Delirium is frequently missed in the ED, especially hypoactive delirium. Using screening tools such as the 4AT can assist with its detection as does taking a careful history from relatives or caregivers. Frailty is a syndrome that leads to increased functional limitations. Understanding the severity of frailty for the individual is relevant for targeting treatment and management decisions.

Falls are a common reason for ED attendance. Assessment should focus on the diagnosis and treatment of traumatic injuries, diagnosis and management of the causes or predisposing factors leading to the fall and prevention of future falls. Same level falls can lead to significant injury and the clinician needs to focus on a careful secondary survey to exclude injuries. Common sites of injury include intracranial bleeding, spinal injuries, thoracic injuries (rib fractures) and skeletal problems (wrist and hip fractures). With improved access to cross sectional imaging, older adults who fall and have a chest injury but a "normal" chest Xray are now often found to have multiple rib fractures. This can be very useful in planning disposition decisions. The common use of anticoagulants and/or dual antiplatelet therapy in the older age group means assessment for internal bleeding needs careful attention. The description of a fall as a simple trip or "mechanical" fall should be avoided. Falls are always multifactorial. Regardless of how it is described (" I just tripped on the mat"), changes in muscle strength, vestibular function, vision, hearing, proprioception and cognition all contribute to this final common pathway. Avoiding the

Guest Editorial cont.

term "mechanical" means we explore these potential contributions and can then look at preventative measures. Trauma from other mechanisms is now increasingly common in older adults including bicycle and vehicle crashes and falls off ladders or down stairs. Early escalation of assessment with the use of criteria activated trauma teams should be encouraged to ensure that these patients are vigorously managed. There should be a low threshold for use of trauma panscans to investigate these individuals.

Polypharmacy is typical and the likelihood of adverse effects from drug interactions increases with increasing medications prescribed. Although it may not always be appropriate to intervene with medications prescribed by the patient's general practitioner (GP), it may be relevant to raise concerns in the discharge information going to the GP. Modifying the dose of a diuretic is very different to the decision to cease anticoagulation due to a fall. Emergency physicians can be proactive in communicating concerns to the patient's GP.

After ED attendance, the likelihood of admission to hospital increases with increasing age. This is usually necessary to facilitate appropriate care including relevant urgent investigations and treatment or managing symptoms. However, there are some features of admission to hospital that can potentially harm older adults. Delirium increases and because individuals are not familiar with the environment, there is a risk of further falls. Deconditioning occurs rapidly due to inactivity and can leave the older adult with less muscle strength at the time of discharge than prior to admission. Recovering from this deconditioning takes longer with advancing age. Emergency physicians are risk averse and generally will have a low threshold to admit the older adult. The risk of discharge needs to be balanced with the risk of admission. In our acute ED focussed world, the risk of the former tends to be exaggerated whilst the latter is underestimated. Telehealth systems have a place in preventing unnecessary transfers to hospital whilst providing necessary treatment.

End of life care is now becoming a skill set for the emergency team. How can we meet the emotional and physical needs of the dying patient and their whanau in our busy acute focussed EDs? When should vigorous treatment be limited due to futility? When is escalating care to intensive care appropriate? Sometimes these decisions are straightforward but often they are nuanced and always need to be made in the context of the individual and their own wishes or those of whanau.

In keeping with the complexities of caring for older adults, a team approach is essential. Our allied health colleagues have much expertise to add in the care of this complex group. Occupational therapy, physiotherapy, social work and pharmacists all form part of a highly functional team. Some systems have teams of geriatrician and nurse specialist that are proactively seeing patients in ED but this is not something that most organisations are able to achieve. Often funding remains limited for these groups to resource adequate staffing. Nevertheless, using this combined expertise can develop confidence in discharging older adults where previously admission was thought necessary.

Geriatric emergency medicine is an expanding area and highly relevant to what we do every day. Every shift in the ED, we will be managing several older adults with all their complexities. Although some issues may be difficult for us to control such as long waits in corridors for hospital beds, there are some immediate interventions that are helpful. EDs may find it useful to consider how patient complexities can be reflected in triaging decisions. Doctors and nurses can explain the system of the ED. What will happen in the ED during their assessment and the team members they may see. Although some patients will need ongoing cardiovascular monitoring, often it can be discontinued early in the ED course, facilitating a "detethering" from cardiac monitoring leads and blood pressure cuffs. Patients should be provided with regular fluids and food if not nil by mouth. Older adults can spend several hours in ED without attention to this. Patients should be regularly asked about pain and this needs to be actively managed. Ensuring a "geriatric friendly" ED is good for everyone. And our 83 yr old man...

A urine was obtained that confirmed a urinary tract infection. Antibiotics were administered. He had a large bruise on his temporal scalp and since he was on anticoagulants, a head CT scan was obtained. This demonstrated a small subdural haematoma. No surgical intervention indicated but his rivaroxaban was stopped. He was admitted to hospital but able to be transferred for rehabilitation three days later. He was discharged home with increased community supports but still living independently.

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Articles, Case Studies and Practice Reflections

Allied Health: Supporting the older patient in Christchurch ED.

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Allied health professionals are qualified health practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. There are 43 different Allied Health professions in New Zealand, including occupational therapists (OT), physiotherapists, pharmacists, and social workers. Increasingly, these health professionals are being incorporated into emergency departments, offering a range of services to improve the patient journey – decreasing the need for admission, reducing length of stay, and adding to the comprehensive health response offered. Allied health workers not only add their specialised knowledge and skills to the ED team, but often bring additional links to community services, expediting rehabilitation, and the chance for supported discharge (Ashley et al., 2020; Holmes et al., 2016).

Frail older adults present a challenge for busy emergency departments due to their often non-specific presentations and complex needs. They frequently have multiple chronic conditions and are at higher risk of adverse outcomes (McCabe & Kennelly, 2015). Frailty refers to a state of increased vulnerability and decreased physiological reserve in an individual, often due to older age or chronic health problems (Church et al., 2020). Data indicates that 29,712 patients over 65 were seen in Christchurch ED in 2023; this number is expected to increase in the coming years with an ageing population.

Allied health plays a large role in supporting the elderly patient throughout their ED journey. The occupational therapy and physiotherapy roles in the emergency department add value by addressing patients' functional needs and promoting independence in occupations important to them, which can lead to better outcomes and reduced hospital stays. Both these services now have an extended, day service in place with expert extended scope therapists. An extended scope approach in this ED context involves working within a transdisciplinary model and providing a more comprehensive assessment and plan for follow up and future needs. It requires being proactive at addressing barriers to performance of essential daily occupations and ultimately, discharge from the hospital setting to the person's own home.

The primary objective of the allied health team in relation to the frail elderly in ED is to facilitate a safe discharge back to their community residence and avoid un-necessary hospital admission. Assessment includes assessing aspects of physical function, cognition, and a home environment review. Mobility and adaptive equipment aids are also reviewed as well as specific objective measures dependent on the needs of the patient. Head injury and concussion assessment and education is a large and invaluable aspect of expertise the Occupational Therapy team also offer for both the older and younger patient in ED. The assessment is modelled on aspects of a comprehensive geriatric assessment to evaluate important facets of health and reversible causes of frailty.

The service continues to link closely with community and primary care teams and looking at further opportunities and approaches, such as direct referrals from St Johns and how we can link in with the telehealth service running from ED.

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Frailty and a Snapshot Audit in the Emergency Department: A Focus on Early Identification and Intervention.

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Who do we see?

Abstract

Frailty is a clinical syndrome characterized by increased vulnerability across multiple systems, including neuromuscular, metabolic, and immune systems. It compromises an individual's ability to respond to acute stressors and illnesses. Although frailty can be prevented, it remains a common, progressive condition that impacts quality of life (QOL) and increases the risk of adverse outcomes. This study aimed to assess the prevalence of frailty among emergency department (ED) patients in Dunedin, by conducting a snapshot audit. We sought to determine the proportion of patients classified as pre-frail or frail, as well as identify trends in frailty scores by shift and triage acuity. The audit utilized the Clinical Frailty Scale (CFS) for frailty assessment and aimed to highlight strategies for improving frailty management in the ED.

Introduction

Frailty is a clinical state of increased vulnerability that results from declining reserve and function across multiple bodily systems, including neuromuscular, metabolic, and immune systems. As a result, frail individuals experience a reduced ability to cope with acute stressors and illnesses. Although frailty is often associated with aging, it is not exclusively an age-related condition. Frail patients are at heightened risk of poor outcomes such as increased mortality, higher rates of residential care after discharge, and increased dependency. Symptoms of frailty may include falls, delirium, changes in mobility and cognition, mood disturbances, weight loss, and polypharmacy-related side effects such as constipation.

Various frailty assessment tools, including the Clinical Frailty Scale (CFS), Fried Frailty Phenotype, and Edmonton Frailty Scale, help clinicians quantify the degree of frailty in patients. However, frailty remains underrecognized in acute care settings, leading to suboptimal management and outcomes. This audit aimed to assess the prevalence of frailty in the ED at Dunedin Hospital and to understand how frailty is identified and managed during ED visits.

Methods

A snapshot audit was conducted in the Dunedin ED on two separate shifts: a morning shift (1030-1130 AM) and an afternoon shift (2:30-3:30 PM). The total number of patients seen during these shifts was 40 and 43, respectively. We reviewed patient data from the ED Information System (EDIS) and, when necessary, supplemented information from Health Connect South to assess frailty. For each patient, we examined their mobility, comorbidities, and presenting condition to determine their frailty status. Frailty scores were assigned using the Clinical Frailty Scale (CFS), with scores ranging from 1 (very fit) to 9 (terminally ill). The CFS was accessed through both a printed visual version and an app for ease of use.

Results

Of the total patients reviewed:

- **14% of patients under 65 years of age** were classified as frail.
- **69% of patients over 65 years of age** were classified as frail.

Additionally, the audit revealed that a higher proportion of patients aged over 65 were seen during the afternoon shift (39%) compared to the morning shift (33%). In the morning shift, a larger proportion of triage level 2 patients (higher acuity) were over 65 years old. Furthermore, over **one-third of patients waiting more than 5 hours in the afternoon shift** were 65 years or older and were awaiting inpatient beds, highlighting issues related to bed block and delays in care.

The use of the CFS for frailty scoring proved to be straightforward. Both a clinician and a non-clinician were able to assess frailty accurately, with a success rate of **90%** in predicting the frailty score based on triage notes alone by the end of the second audit.

Discussion

This audit highlights the high prevalence of frailty among patients presenting to the ED, particularly among those aged 65 and older. The findings are consistent with global trends indicating that frailty is a significant factor influencing health outcomes in the elderly

Frailty and a Snapshot Audit in the Emergency Department: A Focus on Early Identification and Intervention cont.

population. Despite the commonly held belief that frailty is primarily age-related, the audit revealed that frailty was also present in a substantial proportion of patients under 65 years old, often in the presence of comorbidities.

The higher proportion of frail patients in the afternoon shift may be due to increased numbers of older patients presenting later in the day, compounded by delays in the admission process. The finding that over one-third of patients over 65 were waiting more than 5 hours for an inpatient bed emphasizes the strain placed on hospital resources, which can exacerbate frailty-related complications.

One notable takeaway from this audit was the utility of the Clinical Frailty Scale (CFS) in the ED setting. The tool was easy to use, even for those without a clinical background, and it helped identify frailty with a high degree of accuracy. This suggests that integrating frailty assessment into routine ED triage could improve early identification and management of frail patients, leading to better clinical outcomes.

Quick Tips for Screening Frailty at Triage

Clinicians can use the following indicators to screen for frailty during triage:

- **Mobility:** Is the patient able to walk independently, or are mobility aids in use?
- **History of falls:** Has the patient fallen recently, or do they have a history of multiple falls in the past year?
- **Age and support:** Is the patient aged over 65? Do they receive home help, meals on wheels, or other forms of assistance? These factors may suggest frailty, warranting further assessment and tailored care plans.

Interventions

Recognizing frailty early in the ED can lead to better patient management. Interventions include:

- **Reducing time on the ED trolley:** Prolonged periods of immobility can exacerbate frailty.
- **Mobilization:** Encourage patients to move if possible or aid to do so.
- **Intentional rounding:** Ensure regular assessments of continence care, nutrition, pain management, and reorientation for delirious patients.
- **Effective communication:** Engaging with whānau (family) and kaumātua (elders) can provide additional support and cultural considerations in patient care.

Conclusion

Frailty is an underrecognized but significant issue in the emergency department, particularly among older adults. Early identification using tools such as the Clinical Frailty Scale (CFS) can improve patient outcomes by guiding appropriate interventions. This audit highlights the importance of integrating frailty assessments into routine ED triage and emphasizes the need for systemic changes to manage frailty more effectively in acute care settings.

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Caring for older Adults in Taranaki ED.

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Who do we see?

This brief summary presents an overview of the management of care for the older adult in Taranaki ED. The ED see's on average 39,000 patients annually, of which approximately 11,800 (30%) are aged 65+ years. As can be seen in figure 1 below, as the population ages, a higher percentage within each successive age band are likely to experience an ED presentation.

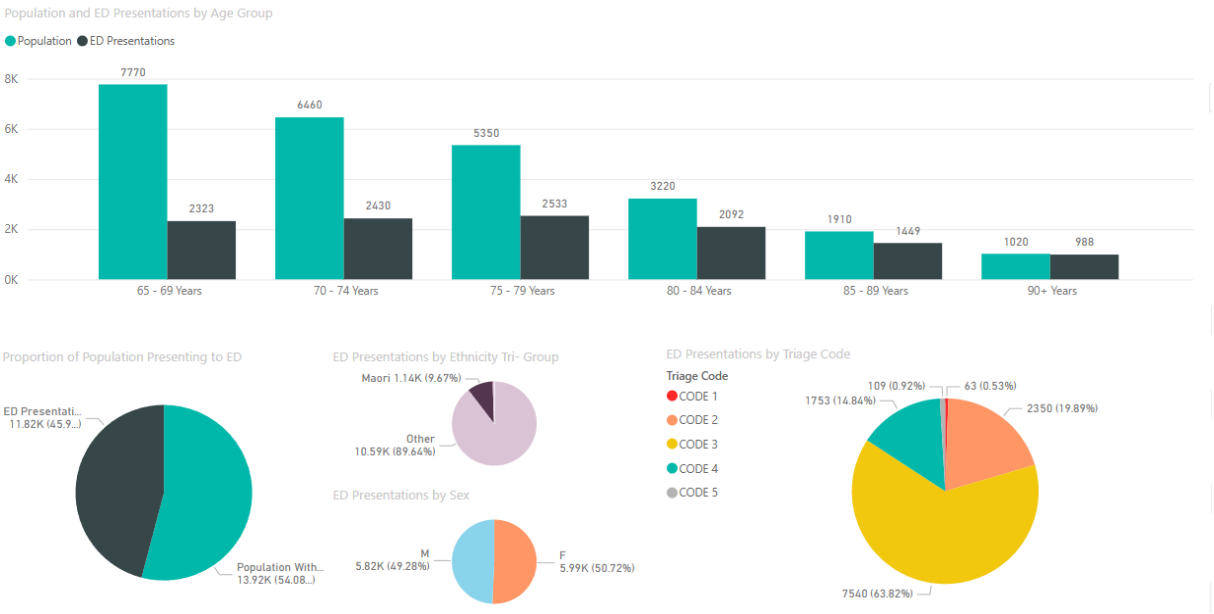

Figure 1: Taranaki ED population and presentations 65+

Caring for older Adults in Taranaki ED cont.

There are further images of some analytics below - these indicate the presentations per population (2013 Census data) broken down into two age groups, those aged 85-89 and those aged 90+.

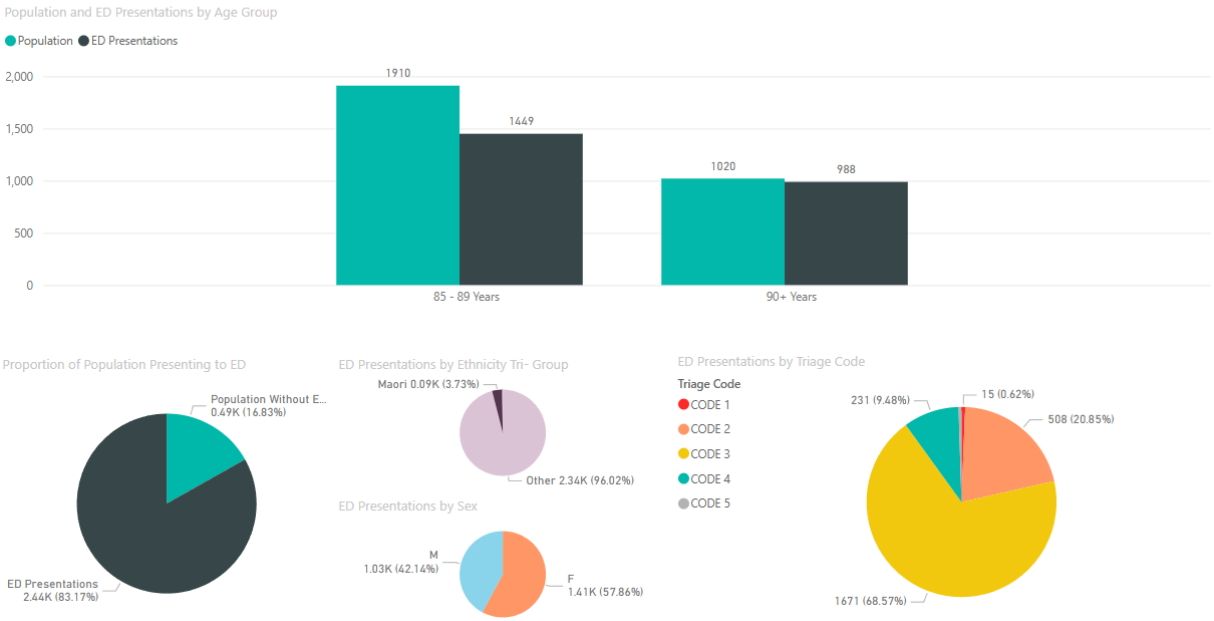

Figure 2: Population and ED presentations - 85-89, 90+

Recognising the importance of differences

As with many EDs (and indeed many other health care agencies), Taranaki ED utilises a different metric for determining age related protocols that apply to Māori and Pacific Peoples. This is evident in the general risk screening assessment, where this is triggered at 55 years for Māori and Pacific Peoples, and 65 years for those of other ethnicities.

We have also considered the possibility of unconscious bias towards older adults, knowing that research undertaken internationally has suggested that this may be present in relation to areas of practice such as triage and pain management. One response we have taken is to focus on the significance of abdominal pain in elderly patients, and the risk of deterioration while waiting in the waiting room area. We have increased the education focus and highlighted the need for the triage nurses to maintain a high index of suspicion in relation to this presentation.

Specific policies and protocols

The most commonly used tool that relates to the older adult in ED is the Clinical Frailty Scale, which is initiated for all presenting patients who identify as Māori or Pacific Peoples from the age of >55y and for non-Māori from >65years.

A score of 5-8, triggers a referral to our Allied Response Team for further assessment.

We generally try not to discharge elderly patient's overnight and instead we utilise the EDO option and refer to out ART for review in the AM. For those that do go home our ART also has a team that visit in the community to assess the need for Physio, OT or Social work input.

A significant issue that we face in caring for older adults is finding access to respite and permanent Aged Residential Care. This is an increasing concern nationally, with the Taranaki region no exception.

As our ageing population continues to live longer, we are seeing a higher number of individuals who come into our EDs at the end of life. For some, this is a result of secondary, acute conditions on top of an existing trajectory, for others it may be that families or care givers are

Caring for older Adults in Taranaki ED cont.

struggling with palliative or end of life care, and that ED becomes an avenue to seek reassurance and assistance. While we do not have a specific ED policy related to palliative care or dying in the ED, we do utilise the Shared Goals of Care (SGoC), where a person, alongside their family/ whānau and clinician(s), explore their values, the care and treatment options available to them and agree the goal of care for their current admission. This includes a discussion around what their wishes are if their condition should deteriorate.

We also utilise the national framework, Te Are Whakapiri, in our care for the palliative/dying patient.

https://www.tewhatuora.govt.nz/assets/Publications/Palliative/Te-Ara-Whakapiri/te-ara-whakapiri-toolkit-apr17.pdf

SGoC Factsheet nurses and allied health workers.pdf

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

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

Caring for older Adults in Taranaki ED cont.

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PATIENT LABEL

CLINICAL FRAILTY SCALE

Screening should be completed by the primary nurse for all **Māori >55** and **non- Māori >65.**
If patient scores 5 – 8: In ED: please refer to ART who will review whether further input is needed. On wards: consider geriatrician referral.

	1. **Very Fit –** People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.
	2. **Well –** People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active **occasionally**, e.g. seasonally.
	3. **Managing Well** – People whose medical problems are well controlled but are not regularly active beyond routine walking.
	4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.
	5. **Mildly Frail** – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.
	6. **Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.
	7. **Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).
	8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
	9. **Terminally Ill** - Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.
In **severe dementia**, they cannot do personal care without help.

DALHOUSIE UNIVERSITY Inspiring Minds

* 1. Canadian Study on Health & Aging, Revised 2008.
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Why every ED needs a GEDI CNS.

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A Geriatric Emergency Department Intervention (GEDI) Clinical Nurse Specialist (CNS) OR Nurse Practitioner (NP), is needed in every ED in New Zealand. As our population becomes majority geriatric (over 65-years-old) we need to better address their complex health needs and conditions in our acute care settings.

I leapt at the opportunity to establish the Geriatric Emergency Department Intervention (GEDI) Clinical Nurse Specialist (CNS) role for Hawkes Bay. I have a passion for change and improving health care and with the older population of Aotearoa growing, specific assessment and care is needed. This new initiative allowed me to complete geriatric specific assessments at the front door, reducing length of stay and in some cases avoiding admission. I was able to provide the older person with information and follow-up to ensure their independence was extended and increase their understanding of supports.

The GEDI model of care was established in Queensland, Australia in 2020. The resources from Queensland Government have been greatly beneficial in my journey as this model of care isn't currently established in New Zealand.

In April 2024, I commenced a GEDI CNS trial in Te Matua-a-Maui ED, using the Queensland "Tool Kit". Focusing on objectives of the GEDI model, these are:

- Maximise patient-centred multidisciplinary decision making for frail older persons in the ED
- Identify the goals of presentation that are important to the patient and/or carers
- Fast track patient assessment and multidisciplinary decision-making
- Identify functional decline
- Reduce morbidity
- Increase appropriately supported safe discharges from the ED
- Reduce avoidable admissions to hospital
- Reduce hospital length of stay
- Reduce avoidable re-presentations to the ED

To achieve this, I established great relationships with local rest home staff, needs assessment coordination service, general practitioners, pharmacy, MDT within the hospital and community, emergency, medical and surgical specialists. This ensured linkage between different sectors, improved coordination and efficiency of service delivered within the hospital and post discharge.

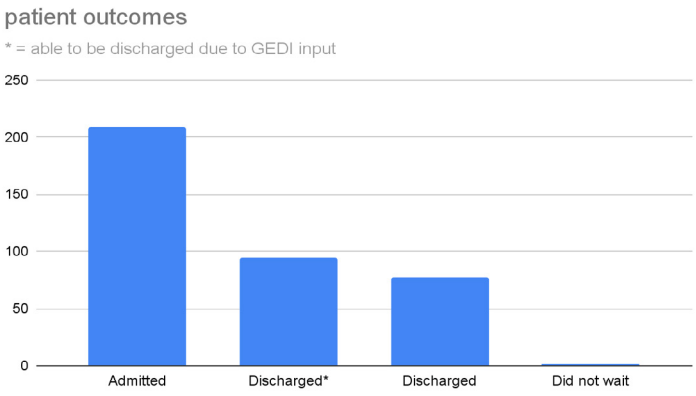
Due to the complexity of older people, I began using the Geriatric 5M's (shown below). This framework ensures I gather all information for a holistic assessment and treatment plan, in a timely manner.

Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: a new way of communicating what we do. J Am Geriatr Soc. 2017;65(9):2115.

Why every ED needs a GEDI CNS cont.

To ensure information was gathered and shared appropriately I would write notes in the ED discharged summary, allowing other hospital teams, and GPs to have access to this holistic assessment.

As this role was a trial in Te Matau a Maui last year, I collected the data on patients seen and outcomes. Below shows patient outcomes post my review (during my second trial 12/8/24 -10/12/24).



This shows nearly 100 patients were discharged from the Emergency Department with the contributions of the GEDI role preventing admissions - this was in consultation with either an Emergency, Medical, or Surgical SMO.

During my second trial of 4 months, I reviewed 382 patients in the emergency department, held 44 Family discussions, first to review 46 patients with known dementia to ensure adequate cognitive care and orientation was upheld to reduce risks of delirium.

(One News New Zealand, 2024)

One example of the benefits of the GEDI nurse role is, I was able to get a palliative patient reviewed by hospital palliative care team, geriatrician, NASC and discharged to Hospital level of care in approximately 6 hours on a Friday, preventing an over the weekend admission.

The cost of GEDI CNS role in Hawkes bay has not been fully reviewed. However, results from the Australian GEDI indicate significant opportunities:

Cost saved can be demonstrated by a reduction in hospital admissions in this cohort. For example; these results from the GEDI research evaluation show:

Item	Pre GEDI time period	Post GEDI time period	Savings
Number of admitted bed days	649	480	169 bed days saved
Average Inpatient Cost	$4897.66	$7,320.00	
Inpatient cost TOTAL	$1,430,115,61	$911,340.08	$518,775.53

(Marsden et al., 2017).

Some barriers to the role were that the Queensland toolkit is established for a MDT, working 7 days a week. Due to restrictions, I worked full time Monday-Friday 8:30-6pm, I found the start time ensured I could review overnight ED stays and hopefully prevent ward admission or reduce the length of stay by starting the ward interventions in ED.

I have learnt a lot doing this role and appreciate the complexity of geriatric care and am looking forward to further developing this role when a permanent position becomes achievable. My hope is that the GEDI model of care expands and develops throughout Aotearoa. I would be more than happy to be contacted if anyone has questions.

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Why every ED needs a GEDI CNS cont.

Queensland Health

Clinical **Excellence** Queensland

The patient journey

ED patient journey prior to the GEDI service

Janet, 82 lives in a RACF. AIN reports she is confused. Assessed by RACF RN who finds she is febrile.

RACF RN phones GP. GP advises transfer to hospital. RACF RN calls ambulance and family.

Janet is transferred to the ED by ambulance.

The ED is busy when Janet arrives. Janet must *wait* for triage and for a bed to become available.

ED primary RN conducts baseline observations and assessment. Janet must then *wait* to be seen by medical officer.

Janet *waits* and becomes more confused, she wants to go to the toilet and is hungry.

Janet is seen by the doctor. Further assessment and investigations are performed. Janet *awaits* a head CT.

A *few hours* go by as the ED staff now *await* a urine specimen and CT scan results. Janet becomes increasingly confused and unable to communicate her basic needs.

Janet is sedated due to her escalating behaviour.

Janet is reviewed by ED physician for her escalating behaviour, delirium and need for sedation. This results in hospital admission. Eventually her UTI is diagnosed and treated.

Queensland Government

ED patient journey with the GEDI service

Betty, 82 lives in a RACF AIN reports she is confused. Assessed by RACF RN who finds she is febrile

RACF RN phones GP GP advises transfer to hospital. RACF RN calls ambulance and family RACF RN calls ED GEDI team provides information and goals of transfer.

Betty is transferred to the ED by ambulance

The ED is busy when Betty arrives GEDI nurses anticipate arrival and liaise with triage Betty is met by GEDI nurse on arrival and *facilitates* appropriate bed allocation

ED primary RN conducts baseline observations and assessment. GEDI nurse conducts targeted geriatric assessment and delirium screen. GEDI nurse liaises with RACF, GP, Betty and family to *determine goals of care* to *determine disposition*.

GEDI nurse *organises/orders* appropriate and *timely* investigations and case management by medical officer Coordinates acute and chronic disease management including end of life care planning

GEDI nurse and medical team *review* the case and investigations. *Early diagnosis* of delirium secondary to UTI with ED environment contributing. Early disposition decision making Betty and her family prefer to return to RACF with support

GEDI nurse phones RACF to ensure ongoing treatment plan can be managed Organises for follow up by GP at RACF Provides nursing discharge summary (DS) to accompany medical DS and ensures new medications prescribed and provided.

GEDI informs Betty's family of discharge Betty goes back home to RACF Hospital admission is avoided

Regular Features:

Pharmacology and the Older Patient in ED: anticholinergic burden.

Author: Louisa Sowerby

Many of our elderly patients tend to have multiple medical conditions, and as a result be on multiple pharmaceuticals. Furthermore, the elderly are more vulnerable to adverse effects and interactions from medicines, as part of the impact of polypharmacy. All of which seems rather unfair. The term "anticholinergic burden" is used to refer to the cumulative anticholinergic exposure a person may experience i.e. how many medicines and how "anticholinergic" each medicine is. For example, a patient with atrial fibrillation (AF), postherpetic neuralgia and urinary incontinence presenting with musculoskeletal (MSK) backpain could well be prescribed digoxin, amitriptyline, oxybutynin and orphenadrine, which add to the accumulated anticholinergic action.

What is meant by anticholinergic?

The specifics of anticholinergics are worth revisiting. The significance of pharmacotherapeutics and pharmacodynamics for nurses (not only for those actively involved in prescribing) is increasingly apparent. Within the ED setting in particular, we need to be alert and aware of the underlying processes that are present for our patients.

Acetylcholine is a neurotransmitter – most commonly at the neuromuscular junction in activating muscles, but also in many places in our peripheral autonomic nervous system and throughout the CNS. There are two cholinergic receptors: nicotinic and muscarinic. Medications and agents affecting acetylcholine, receptors and acetylcholine esterase (rapidly breaks down acetylcholine esterase in the synapses) are vast in number, anticholinergic to variable degrees. The rest of this article will focus on anticholinergic medicines or adverse effects, often called antimuscarinic so we're paying attention to effects at the 5 muscarinic receptors. The cholinergics, neuromuscular blockers (nicotinic receptor inhibition) or agents affecting acetylcholine esterase won't be discussed here.

Muscarinic – receptors in various organs. This is what we're talking about when we refer to anticholinergic effects of medicines, why we often call them antimuscarinic effects:	
Cardiovascular	vasodilation, negative chronotropy (bradycardia), reduced force of contraction
Gastrointestinal	release of sphincters, action on smooth muscle and thus peristalsis increases, GI transit time decreases
Respiratory system	smooth muscle bronchoconstriction, breathing speed and depth
Urinary tract	contraction of bladder detrusor muscle increasing the emptying pressure through urethra
Exocrine gland secretion	lacrimal, salivary, digestive, tracheobronchial, sweat glands
Eye	miosis, accommodates the lens for close vision, contracts pupillary sphincter and ciliary muscle

Acetylcholine is also involved in memory, so inhibition or absence of acetylcholine creates forgetfulness or prevents learning of new information.

Pharmacology and the Older Patient in ED: anticholinergic burden. cont.

Anticholinergic effects

Looking at the list of the effects above one can deduce what blocking the acetylcholine receptor might do. Old mnemonic to remember this is: red as a beet (cutaneous dilation) dry as a bone (decreased lacrimation, dry mouth), hot as a hare (decreased sweating), blind as a bat (mydriasis), mad as a hatter (CNS effects), full as a flask (urinary retention, constipation). Possible link between increased cardiac events time congruent with an increased anticholinergic burden. These are the immediate effects. Long term effects of regular use may mimic what we might put down to normal aging: decreased mobility, cognition; increased falls. Prolonged decrease in salivation has effects on dental care, taste and therefore nutrition.

Anticholinergic effects of medicines can be used to great advantage. In ancient times enlarged pupils in women were considered beautiful (ironic that the woman herself could barely see). To achieve such a beauty standard, women would apply the anticholinergic Belladonna found in deadly nightshade to the eyes to cause mydriasis. In more recent times we have mydriatics to aid eye examination or ophthalmic diagnosis. To aid in bronchodilation we have ipratropium, tiotropium, most commonly used in managing COPD and to a lesser extent asthma. As these examples are restricted to local rather than systemic action we don't tend to see the wider anticholinergic actions.

A good illustration is oxybutynin – used for incontinence. Its anticholinergic action inhibits enervation of the detrusor muscle, so we get decreased bladder emptying. It is taken orally so many patients will experience systemic anticholinergic effects. The solution? Make a drug that is more specific to the bladder (i.e. won't affect other areas of the body so much): solifenacin.

There are also medicines whose mode of action and purpose is not anticholinergic, but will have anticholinergic side effects. Tricyclic antidepressants (amitriptyline, impipramine), antihistamines, orphenadrine, clozapine, digoxin. There are many medicines available with anticholinergic effects, intended or not, that could have consequences for especially our elderly patients and thus our choices of medicines.

Examples of anticholinergic drugs – note some variability between sources on degree of anticholinergic activity.

Strongly anticholinergic	Moderately anticholinergic	Low anticholinergic activity
Amitriptyline	Amantadine	Alprazolam
Atropine	Carbamazepine	Atenolol
Benztropine	Levomepromazine	Bupropion
Chlorpheniramine	Pethidine	Chlorthalidone
Chlorpromazine	Paroxetine	Codeine
Clomipramine	Quetiapine	Colchicine
Clozapine		Digoxin
Diphenhydramine		Fentanyl
Imipramine		Furosemide
Meclizine		Haloperidol
Nortriptyline		Hydralazine
Olanzapine		Isosorbide
Orphenadrine		Loperamide
Oxybutynin		Metoprolol
Procyclidine		Morphine
Promethazine		Nifedipine
Scopolamine		Risperidone
Trimipramine		Theophylline

How does this effect ED? A high anticholinergic burden will increase risk of all-cause ED visits and ED visits for anticholinergic adverse effects. Consider the patients presenting for constipation, urinary retention, falls, vision changes, malnutrition, not to mention delirium. Many of these

Pharmacology and the Older Patient in ED: anticholinergic burden. cont.

patients will benefit from a medication review. Anticholinergic medicines may require dose reduction, switching medication, or titrating down. In some clinical situations such as delirium, withholding or completely stopping them will be appropriate. A review should assess the purpose for which medications have been prescribed, achievement of said purpose, the effects experienced or noticed, any possible interactions, change in clinical condition and therapeutic goals.

Sometimes medications with anticholinergic effects are required, it isn't reasonable to expect to avoid them all the time. There are some ways we can mitigate the risk, however. This includes the use of a medicine with lower anticholinergic activity i.e. gabapentinoid over TCA , lowest dose for the shortest possible period or a set period of prescribing to review efficacy. Sometimes there are non-pharmacological alternatives. The best example is physiotherapy over orphenadrine for musculoskeletal back pain. With the growing presence of physiotherapy on site in EDs, as well as the opportunity for referrals, this is a good option to keep in mind.

So when you come across an elderly patient who has been exhibiting symptoms of becoming more elderly, consider the medicines. It would be untrue to say one can reverse aging, but reducing anticholinergic burden may add quality years to a patients life. At least it might increase time between ED visits.

Sources used for this article;

Anticholinergic burden in older people - bpacnz – aimed for use in primary care. A lot of great information.

Impact of anticholinergic burden on emergency department visits among older adults in Korea: A national population cohort study - ScienceDirect

"The Anticholinergic Risk Scale and Anticholinergic Adverse Effects in Older Persons"

Anticholinergic burden: considerations for older adults - Kouladjian O'Donnell - 2017 - Journal of Pharmacy Practice and Research - Wiley Online Library

Physiology, Acetylcholine - StatPearls - NCBI Bookshelf

Article of Interest, Reports & Policy Releases

The following are a selection of recent articles and reports of interest to those working in the emergency health sector, nursing and with relevance to New Zealand / Aotearoa health services.

Articles of Interest: Older Adults in ED

Author/s	Title	Journal	DOI
De Brauwer, I., Cornette, P., D'Hoore, W. et al. (2021)	Factors to improve quality for older patients in the emergency department: a qualitative study of patient trajectory	*BMC Health Serv Res* **21**, 965	doi.org/10.1186/s12913-021-06960-w
Haimovich AD, Shah MN, Southerland LT, Hwang U, Patterson BW. (2024)	Automating risk stratification for geriatric syndromes in the emergency department	*J Am Geriatr Soc. 72*(1): 258-267.	doi:10.1111/jgs.18594
Wang, H., Takiue, K., Liu, X., Koujiya, E., Takeya, Y., & Yamakawa, M. (2024)	Appropriateness of Nursing Home to Emergency Department Transitional Care for Older Adults With Dementia: A Scoping Review.	*Journal of Gerontological Nursing, 50*(9), 37-45.	doi.org/10.3928/00989134-20240809-08
Wolf LA, Lo AX, Serina P, et al. (2024)	Frailty assessment tools in the emergency department: A geriatric emergency department guidelines 2.0 scoping review.	*JACEP Open*. 2024; 5:e13084.	doi.org/10.1002/emp2.13084
Hwang, U., Dresden, S.M., Southerland, L.T., Meldon, S.W. (2024)	Geriatric Emergency Departments	In: Malone, M.L., Boltz, M., Macias Tejada, J., White, H. (eds) *Geriatrics Models of Care*. Springer, Cham.	doi.org/10.1007/978-3-031-56204-4_24
Burnitt, E., Grealish, L.A., Crilly, J., May, K., & Ranse, J. (2024)	Providing end of life care in the emergency department: A hermeneutic phenomenological study.	*Australasian Emergency Care, 27*(3) 161-66.	doi.org/10.1016/j.auec.2024.01.002
Moloney, E., O'Donovan, M.R., Sezguin, D., et al. (2024)	Frailty Knowledge, Use of Screening Tools, and Educational Challenges in Emergency Departments in Ireland: A Multisite Survey.	*Journal of Emergency Nursing, 50*(1) 22-35.	doi.org/10.1016/j.jen.2023.08.008
Hall, Y., Smith, J., Turner, R.M., Greco, P., Hau., K., & Barak, Y. (2022)	Creating opportunities to improve detection of older adult abuse: a national interRAI study	*BMC Geriatrics 22*:220	doi.org/10.1186/s12877-022-02938-3
Schumacher, J.G. (2024)	Geriatric Emergency Departments: Emerging Themes and Directions	*Current Geriatrics Reports 13*:34-42.	doi.org/10.1007/s13670-024-00410-1

Policies & Websites

Older Adults in ED

Policy Documents		
Organisation	**Title**	**Journal**
ACEM (2020	Care of older persons in the emergency department	https://acem.org.au/getmedia/bfd84f83-fcb2-492a-9e66-47b7896e5c70/Policy_on_the_Care_of_Older_Persons_in_the_ED
ACEM (2020)	End of life and palliative care in the emergency department	https://acem.org.au/getmedia/d55cb8ce-2d26-49d5-823a-f7f07b5c19cc/P455-PolicyonEoLandPalliativeCareinED-Jul16.aspx
ACEP, AGS, ENA, SAEM (2013)	Geriatric emergency department guidelines	https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/geriatrics/geri_ed_guidelines_final.pdf

Policy Documents		
Organisation	**Title**	**Journal**
RCEM Royal College of Emergency Medicine	Care of older people in the emergency department	https://rcem.ac.uk/wp-content/uploads/2023/10/RCEM_COP_2023_25_QIP_Information_Pack_V5.pdf
GEAR	GEAR Geriatric Emergency Care Applied Research	https://gearnetwork.org/
GEDC	Geriatric Emergency Department Collaborative	https://gedcollaborative.com/

NP Tips, Tricks and Trips

Author:

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Early Recognition of Frailty and Delirium in Emergency Department.

It was suggested that this edition was focusing on elderly in the Emergency Department and of course we know that our older population is getting older, and there are more of them, and they can have poor outcomes, particularly if they languish. I am not going to get political and talk targets, bed block, staffing levels or funding as I would be still going in years to come. This piece is reminding us as nurses we can intervene early for this vulnerable population.

So frailty, delirium, sepsis, they could be considered on a continuum. Frailty increases risk of delirium which increases risk of sepsis which we know increases mortality in the elderly. There is a huge focus on sepsis, early recognition and treatment as a priority in Emergency Departments. But there is less on delirium and even less on frailty, although this may become a focus during admission.

Understanding the differences between frailty and delirium is crucial in the ED. Frailty is a chronic state of decreased reserve, while delirium is an acute, often reversible cognitive disturbance.

Clinical Management

Frailty, use a tool if you suspect frailty or on all patients over 65 and utilise this to start early MDT interventions. Focus is more on support treatments, or management options, early rehab, whānau involvement, and early referral to geriatric services.

Clinical Frailty Score (CFS) on MDcalc is what I use personally. Tip: You need to say you use the Canadian Triage Acuity Scale to get the full 9 options. It is a 5 score system not unlike our current triage scale. Check your local guidelines to establish the current recommended tool and/or practice.

Delirium is often a reversible diagnosis. Prompt investigations, looking for causes (infections, dehydration, electrolyte imbalances, new medications) is needed. Again, use a tool. Your place of work will have a delirium screening tool. I, again, use MDcalc, the 4AT. If this shows cognitive impairment, I will do more formal testing. It is useful for referral to inpatient teams.

Why

Reduces complications; both frailty and delirium are associated with a risk of poor outcomes, mortality, increased bed days, readmission.

Early intervention can reduce cognitive decline, preserve functional status and decrease hospital stays. This can be done on presentation, and is relatively quick.

What can you do?

Consider frailty and delirium early.

The earlier article by Megan Livingstone-Young in this edition is what introduced me to early recognition of frailty rather than just delirium or sepsis. Whilst I would not advocate for the triage nurses to do more than they already do in our busy ED's I suggest that the first nurse to assess the patient at risk or over 65 could do a brief delirium score. Megan also has some quick tips which I won't repeat but these are well worth reading.

Depending on where you work and the processes, often nurses can start an early referral to appropriate resources early. If this patient were to discharge how would they manage? What supports do they have and would this be safe? Advocating early for your patients can be both beneficial for them and rewarding for you.

So, many resources already – here are just a few:

THINK Delirium

https://edu.cdhb.health.nz/Hospitals-Services/Health-Professionals/think-delirium/Documents/Think-Delirium-236949.pdf

Te Tahu Haura; Delirium

https://www.hqsc.govt.nz/resources/resource-library/delirium-mate-kuawa-frailty-care-guides-2023/

Healthify; Frailty

https://healthify.nz/health-a-z/f/frailty

MDCalc is a free online medical reference for healthcare professionals that provides point-of-care clinical decision-support tools, including medical calculators, scoring systems, and algorithms. MDCalc is also a mobile and web app.

https://www.mdcalc.com/

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..

Reviewing Māori Models of Health: Kapakapa Manawa Framework.

Sandra Richardson, RN, PhD
Christchurch Emergency Department, Waitaha

Rārangi Kupu (vocabulary list)

- He ngākau aroha: a heart of love, expression of kindness and consideration
- Kapakapa: 'to get the heart to throb, pulsate or flutter'
- Manawa: heart
- Manaakitanga: a reciprocal process of sharing, caring and mutual respect
- ōhākī final instructions before death

Introduction

The Kapakapa Manawa Framework is described by its authors as a bi-cultural approach to compassionate care. This model was designed to improve the way in which palliative care is provided to patients. Increasingly we are seeing patients at the end of life transitioning through emergency departments, or ending their lives in EDs, as they either wait for transfer to in-patient wards or as a result of unanticipated deterioration. Emergency nurses have often asked for additional education about managing end of life care, and this model offers some insights and direction that may be helpful in building that knowledge.

The focus of this framework is facilitating nurses to provide compassionate care, and draws on the Fundamentals of Care (FoC) framework (Kitson, 2018). The emphasis within FoC is on the practical, everyday essentials of nursing care – nutrition, hygiene, elimination, pain control. More than just the actions, however, is the acknowledgment of the relational element central to good care. This is the commitment to care, the connection with the patient/family that makes the provision of care meaningful (Robinson et al., 2020). The role of compassion is recognised as a critical element in this provision of good nursing care, but it is argued that less focus has been given to the convergence of relational care and cultural values. The Kapakapa Manawa framework was developed in response to this need. The bi-cultural approach taken in its development incorporated input from senior kaumatua and Māori researchers, bringing together Māori values of compassion and care at the end of life, with both European and Māori worldviews reflected. While developed within a context of palliative, end of life care, the authors see this framework as equally transferable to other aspects of nursing.

Key to the Kapakapa Manawa Framework is the establishment of the caring relationship, essentially Whakawhānaungatanga which the authors describe as incorporating "an ongoing process of knowing and anticipating patient's needs, evolving trust and focus" (Robinson et al 2020 p. 1793). The title of the framework includes two elements - Manawa refers to the heart and Kapakapa "is defined as causing the heart to beat, throb, pulsate, or flutter" (Wilson et al 2021 p.3545). It is this beating or throbbing of the Manawa that triggers a person to engage their emotions as part of their care in meaningful ways. This is linked to the active application of compassion – recognition, empathy and action. The meaningful engagement that takes place moves this compassionate care to encompass Māori values. In this way, the practitioner is able to provide culturally informed compassionate care and to meet the unique needs of Māori and their whānau at the end of life. Table 1 identifies the four elements that comprise the Kapakapa Manawa Framework.

Cultural Safety and Te Ao Māori cont.

Table 1. Kapakapa Manawa Framework (adapted from Robinson et al 2020)

Element	Description
He ngākau aroha	Relationships that express care, kind heartedness, benevolence, consideration for others, compassion and empathy
Whakawhānaungatanga	The process of establishing good relationships and nurturing ongoing connections by relating well to others
Te tuakiri o ngā tangata Māori	Health professionals use contextualised knowledge of patient and whānau to adapt their practice to the person's world views (Te Ao Māori), beliefs, spirituality, personality and qualities of self and of others (feelings, skills, knowledge, etc)
Manaakitanga	The relationship between peoples (hosts and visitors/guests); the hospitality, support and kindness towards others. A reciprocal process for sharing and caring for one another and showing mutual respect

Working through the Kapakapa Manawa framework requires development of 'he ngākau aroha' (a heart of love). This involves the nurse establishing relationships that communicate care, compassion and empathy. This relational care is further expressed through Whakawhānaungatanga. This involves the need to understand the patient and whānau, which requires te tuakiri o ngā tangata Māori – a willingness to engage with the world view and beliefs of each unique individual. As well as engaging with Māori and their whānau in an empathetic and compassionate way, Manaakitanga requires expression of hospitality, kindness, caring, generosity, and respect. The authors acknowledge the increasing difficulty faced by many in health care in finding the time to engage in meaningful ways with patients and family. The impact of busy clinical loads and work environments is often cited as cause for nurses to have reduced meaningful interaction with patients, focussing instead on 'essentials'. This has the potential to limit the ability to provide compassionate care, and it could be argued that the ED setting is one such area that may be particularly prone to this risk. However, Robinson et al (2020) argue that in focusing on the physical aspects of care at the expense of relational aspects, the nurse not only risks providing a poorer standard of clinical care, but also a higher chance of experiencing compassion fatigue, burnout and ultimately leaving the profession.

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Pae Ora Report March 2025

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.

Our Kaumatua population in Aotearoa, NZ.

In Aotearoa, New Zealand, the population demographics continue to undergo change, especially for our Kaumatua, elderly Māori. Kaumatua have historically been, and continue to remain, cultural, whānau, and hapu leaders.

By 2026 the predicted growth for Māori kaumatua aged 65 years or older is predicted to increase by 115% (Statistics NZ, 2018). The impact of this growth is visible in our emergency departments as we continue to care for all elderly in an environment with increasing social, cultural and financial challenges.

As our ageing population increases, the number of people living with dementia is expected to double over the next 20 years. For Māori and Pacifica people the risk of dementia is 45-80% higher when compared to Pākehā, due to the higher rates of risk factors in this ethnic group (Ma'u et al, 2024). Māori also experience stroke 10 years younger and at a higher rate than Pākehā (Ranta et al, 2023). These health disparities are just two examples that we observe in emergency departments. These disparities have existed for decades and will continue in the current social and political environment.

The impact of these changes for Kaumatua and whānau learning to live with these changes is visible in our emergency departments as the number of elderly presenting for care continues to rise. This growth of elderly kaumatua adds to the clinical and social needs in an environment where resources, including staffing at all levels and inpatients beds, are stretching our already confined healthcare services. Placement of Kaumatua in the homes and communities where they live also places pressure on the whānau unit as they have to consider kaumatua needs within their own whānau dynamics. Whilst physical health is an absolute goal for all elderly, Māori view of wellbeing is closely linked to an ability to fulfill a cultural role, that is participation in Māori society, such as land, Te Reo, marae and whānau relationships (Durie, 2004).

Resourcing to these needs will need to be spread over Hauora services, Primary Care and Te Whatu Ora providers if we want to even begin to serve the needs of kaumatua. As the restrictive funded health machine called 'Health NZ-Te Whatu Ora' prioritizes getting back to budget, needs such as these are increasingly marginalized. Current healthcare funding is insufficient to support the growing elderly population and meet the healthcare needs through all of Aotearoa. It is easy to be distracted by the challenges that come with ageing. However, we have to remember that it is also an honour to care for our kaumatua. For those like my parents' generation who suffered assimilation practices imposed by previous governments that punished my parents' generation for speaking Māori and were 'caned' by Pākehā teachers for just being Māori. This 'social dissonance' is the result of an indigenous culture being forced to dissociate from their own culture. This 'dissonance' still has detrimental impacts today (Hokowhitu et al, 2020).

Our elderly generations have endured hardships and built a nation where we, the younger generations get to enjoy a nation called Aotearoa, New Zealand. For that I am grateful to all our kaumatua and elderly population of all cultures. The guidance, knowledge and aroha that our kaumatua provide is immeasurable.

Naku na, Natasha Hemopo

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College Activites:

CENNZ Reports

Northland/Te Tai Tokerau | 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	cennzchair@gmail.com
Secretary	Vicki Bijl	cennzsecretary@gmail.com
Treasurer	Craig Jenkin	cennztreasurer@gmail.com
Membership	Lyn Logan	cennzmembership@gmail.com
Grants and Awards	Lyn Logan	cennzawards@gmail.com
Staffing Repository	Vicki Bijl	cennzrepository@gmail.com
NZ Triage courses		cennztriage@gmail.com
Professional Nursing Advisor (NZNO)	Suzanne Rolls	suzanne.rolls@nzno.org.nz
Te Rūnanga Representative	Natasha Kemp	
Knowledge and Skills Framework	Lauren Miller	cennzchair@gmail.com
Website and Social Media	Wendy Sundgren	
Webinars	Wendy Sundgren	
Pae Ora	Natasha Kemp	
Networks	**Name**	
Clinical Nurse Educator Network	Lauren Miller	
Charge Nurse Managers Network	Vicki Bijl	
Advanced Emergency Nurses Network	Lydia Moore	
Emergency Nurse Practitioner Network	Craig Jenkin	

Committee Regional Representatives

Committee Regional Representatives

Region	Name	Daily Role
Te Rūnanga	Natasha Kemp	Clinical Nurse Coordinator, Emergency Department, Whakatāne Hospital
Northland / Te Tai Tokerau	Amanda Harrison	Clinical Nurse Educator, Te Tai Tokerau Emergency Department
Auckland	Wendy Sundgren	Associate Clinical Nurse Manager, Emergency Department, Middlemore Hospital | Professional Teaching Fellow, The University of Auckland
Auckland	Lydia Moore	Clinical Nurse Specialist, Emergency Department, Waitakere Hospital
Midlands / Bay of Plenty	Lyn Logan	Associate Clinical Nurse Manager, Emergency Department, Rotorua Hospital
Hawkes Bay / Tairāwhiti	Vacant	
Mid Central Region	Lauren Miller	Clinical Nurse Educator - Taranaki Emergency Department
Wellington	Craig Jenkin	Nurse Practitioner, Emergency Department, Wellington Regional Hospital
Top of South	Vicki Bijl	Clinical Nurse Manager - Nelson Hospital
Canterbury / Westland	Jo Aston	Nurse Unit Manager, Emergency Department, Christchurch Hospital
Otago / Southland	Michelle Scully	Clinical Nurse Educator | Staff Nurse, Emergency Department, Southland Hospital

Chairperson's Report

Lauren Miller
CENNZ Chairperson
Contact:
cennzchair@gmail.com

One of the most significant ongoing challenges we face as emergency nurses is the issue surrounding the shorter stays in Emergency Department (ED) targets.

While this initiative has been introduced with the aim of improving patient flow and overall emergency care, it has become evident that there are several complexities affecting its full implementation and success. The sheer volume of patients presenting to EDs across New Zealand continues to rise, in my ED we hit our highest presentations to date this week- which was an increase of 7% on the previous record, which was only set in Jan 2024. This increasing demand often overwhelms our capacity to meet the shorter stay targets, resulting in extended wait times despite our best efforts. Emergency nurses understand that we have a responsibility to provide timely and quality care, but this can be incredibly difficult when resource shortages, staffing constraints, and overcrowding persist.

Moreover, the complexity of patient presentations has evolved. More patients with chronic conditions, mental health crises, and comorbidities are arriving at our doors. The increasing complexity of care needed by many patients, especially those with high acuity, demand more time and resources than ever before. For our nursing teams, this can feel like a constant balancing act between meeting targets and maintaining the high standards of care we are proud to offer. These factors and other social stressors have also led to increasing severity of violence and aggression within our EDs. CENNZ has and will continue to campaign for 24/7 Security presence in all ED's across Aotearoa. As stated in our recent media release on the subject, "we also strongly believe that the security guards should be purpose-trained to work within the ED setting and integrated members of the team".

In addition to the challenges related to patient care and workload, there is growing concern among those on the frontlines regarding the ever-changing leadership at the Minister of Health and Chief Executive levels within Te Whatu Ora. Frontline emergency nurses, and management have expressed a sense of uncertainty and frustration as leadership transitions continue to occur. This constant change at the top has led to a lack of clarity in direction and decision-making, creating a sense of instability among those of us working at the frontline. It is difficult to build momentum and trust in leadership when key positions are in flux. As a result, there is an undercurrent of dissatisfaction, which has contributed to declining morale and a growing sense of disengagement among many of our frontline staff.

Another area of significant frustration for our members is the ongoing bargaining and the subsequent strike action that has been necessary to advocate for improvements in our

Chairperson's Report Cont.

Collective Agreement. The ongoing delays and difficulties in achieving a fair and sustainable agreement for our nurses have contributed to a sense of frustration within the workforce. Nurses have consistently voiced concerns about the adequacy of current compensation and working conditions, especially given the immense pressure they face in the emergency care environment. The decision to engage in strike action, though difficult, has been a necessary step to ensure our voices are heard and that the value of the work we do is recognised. I feel that our ED nurses are highly committed to the well-being of their patients, but they must also feel supported and valued in their roles.

CENNZ have concerns regarding the CCDM pause and review, particularly when this programme is still in the process of being rolled out, and is new or still to be implemented in a number of emergency departments. Delays and lack of clarity on this critical initiative raises significant worries about its long-term impact. Without adequate staffing and effective workload management, the pressures on emergency departments will only continue to worsen. For many emergency departments, the CCDM Trendcare programme is still in it's early stages, and the freeze delays the full implementation of a system that could help us better meet the needs of patients and staff alike. What is especially concerning is that there remains a lack of commitment or clarity from Health New Zealand about the actual budgeting and funding of FTE positions once departments have completed FTE calculations and these have been approved by council. The freeze and delays in finding post calculations, undermines the progress we've worked so hard to achieve and further compounds the strain on ED nursing staff.

The new year is often a time to reflect and for me I would like to acknowledge what a privilege it is to have this opportunity to represent emergency nursing in the role of chair for this college. Year by year I'm impressed by how much work the committee achieves and the ongoing passion of those committed to emergency nursing. I would like to highlight the dedication and passion of the CENNZ triage instructors who have welcomed the changes to the Triage Course, and continue to deliver a high quality programme to increase the skills and knowledge of emergency nurses from all around NZ. I would also like to thank Brendon and Laura for their time as representatives on the CENNZ national committee.We truly appreciate all the time and energy you showed and wish you both the best for your ongoing adventures.

Ngā mihi

Lauren Miller

CENNZ Chair.

Te Tai Tokerau | Northland Region

Regional Representative

Amanda Harrison

Clinical Nurse Educator

Whangārei Hospital Emergency Department

Te Whatu Ora Te Tai Tokerau

Whangārei Hospital Emergency Department

Whangārei Emergency Department has had a reasonable summer managing some record breaking daily presentations. Like most departments we have had some struggles with staffing, saying farewell to a number of highly skilled senior nurses and unable to recruit to replace. This has put significant pressure on our team. A silver-lining is that this has opened up progression opportunities for staff into more senior nursing roles on the floor.

In November, we officially welcomed Dr Fiona Bowles into the role of Clinical Director. Her aspirations are to embed an equity focus and improve flow through the Emergency Department. With her inclusive mindset, positive attitude and respect for her nursing colleagues we look forward to working alongside Dr Bowles to achieve better outcomes for Māori and improve the patient journey through our department.

TrendCare has been our biggest undertaking over the last few months. Implemented in mid-September the feedback has been mostly positive. As predicted, it has certainly had its hurdles and challenges, but the resilience and adaptability of our team has shone through once again. It has required plenty of extra work for our crew in the background to audit, track progress, ensure reliability of data, and following up with individual staff to provide additional support. But thanks to our TrendCare Champions the team has run with it extremely well. There is still much more work to be done but essentially we will need to wait and see if it generates any benefit toward increasing the FTE for our department.

Our simulation programme celebrated its 5 year anniversary last month. Regular insitu simulation, although very low fidelity, has had a positive impact. Focusing on a multi-disciplinary approach and a no-blame-culture has our nursing staff, who initially were very reserved and unwilling to participate, now seeking out sim and enquiring when and what the next sim will be. This year we plan to expand and run more interdepartmental simulation to include other services such as Paediatrics, Intensive Care Unit, Obstetrics and Gynaecology, etc. The idea is to test interdepartmental processes, improve communication, build relations, identify and address system barriers, overall improving patient outcomes. We look forward to welcoming back NetworkZ in May.

Amanda Harrison

Clinical Nurse Educator.

Dargaville Hospital

Dargaville has seen a reduction in the after-hours GP service. Outside of their hours all these patients are now managed through our ward utilising medical cover either by telehealth or a Doctor in person, based on their triage code. These numbers have increased particularly on the weekends when the GP practice is now open 9-12pm on a Saturday only.

Our presentations have stayed similar however the acuity of our patients on presentation has also increased again with patients not always being able to see their GP due to lack of appointments.

Like everywhere else, we have faced significant staff challenges at times and continue to do so. Due to this, we have had an increased amount of local education for our nurses based around scenarios and emergency care. This will continue through 2025.

Karen Katipa

Clinical Nurse Manager.

Tāmaki Makaurau | Greater Auckland Region

Regional Representative

Lydia Moore

Nurse Practitioner

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 Waitematā,

We trust that you have all had a well-deserved and restful summer break.

There have been several noteworthy developments in the departments since our last regional report. These include the Cultural Wellbeing Days, where food was shared and teams came together to celebrate various cultures, including Kiwi, Indian, and Filipino Days, as well as the recognition of our Employee of the Month. Additionally, the department has expanded the tea area to create an outdoor space for staff. During the Christmas period, our pediatric department organized a gift collection for children on Christmas Day, an initiative that was greatly appreciated by all patients and their whānau. Furthermore, we have seen a significant increase in positive patient feedback regarding professionalism and compassion, highlighting the dedication and excellence of our staff.

Across both departments, we are pleased to welcome eight new graduates and congratulate four new Nurse Practitioners. An additional three Clinical Nurse Specialists are currently undertaking the NPTP course this year.

We are also looking forward to starting the year with more in-house simulation sessions and education study days. A new initiative in the department includes monthly themed teaching sessions during nurse handovers. This has provided an opportunity for all staff to both teach and continue learning, despite the challenges of a busy department. In addition, despite the time pressures faced within the department, the implementation of TrendCare continues, and we eagerly anticipate the results later in the year.

Much like the rest of the country, unfortunately, during the summer period, our department did not experience the typical decline in numbers seen in previous years. The increase in patient

presentations has led to full hospitals and corridor beds. Nevertheless, our exceptional team continues to deliver outstanding care to our patients and their whānau. The establishment of the flow role in the department has also significantly contributed to improving patient flow.

We wish all ED's across the motu a safe and well-staffed winter.

Lydia Moore,

Nurse Practitioner.

Auckland Region cont.

Auckland Adult Emergency Department.

This summer at Auckland ED has been eventful, providing numerous opportunities to enhance our knowledge of business continuity plans. We have successfully navigated challenges ranging from water outages to floods, power cuts, and even DIY toilet repairs.

Recent major projects have added to our cognitive load, as we've adapted to new patient information systems and temporary accommodations during remodelling work. This has impacted all staff, particularly those in triage. In brief triage encounters, we gather and record patient details, integrate assessment information, make critical clinical decisions, and manage organisational processes and information systems. Simultaneously, we strive to offer compassion, welcome, and reassurance to often anxious and distressed patients and whānau.

Despite frustrations over long waiting times and cramped conditions, safe and effective care at the 'front door' has been maintained through the extraordinary flexibility and collaboration of our emergency department staff. The presence of our dedicated health security team members is now crucial to the safe operation of our (temporarily merged) triage and ambulatory area, although their services are (sadly) in demand throughout our department.

During COVID, we gained a greater appreciation for the vital role of our cleaners. The tumultuous introduction of TrakCare and Centric has been the time for our ward clerks to shine. These always-invaluable team members have become departmental (and sometimes hospital-wide) 'IT support,' guiding clinicians, resolving errors, and finding workarounds. The proximity of senior doctors to the temporary front of house has also been beneficial. While we are mindful of the upcoming winter workload, we eagerly anticipate the opening of our new triage and waiting room areas.

Natalie Anderson

Registered Nurse.

Te Tari Rongoaa Ohorere | Middlemore Hospital Emergency Department.

Patient presentation numbers for Middlemore ED have stayed relatively high between 10,500 and just over 11,000 patients per month, which is a 6.6% increase when compared to the equivalent period last year. Better flow through Medicine in particular has meant that though the department still reaches total patient numbers in the 180s to 200s each day, it recovers through the night as patients flow to the ward. As in previous years, there is a switch from medical presentations to surgical ones through the warmer months.

Plans to increase security presence were realised at the end of January 2025 with an increase from two to five guards present in ED 24/7 established as well as a base for the security coordinator within the Adult Assessment Unit.

Another celebration for Middlemore ED is the appointment of the Charge Nurse Manager for Adult ED in December 2024 and the Charge Nurse Manager for Kidz First ED who is due to start in February 2025. This means that the structure, introduced at the end of 2023 will be fully recruited to for the first time, having all four Charge Nurse Managers in place. The aim of the structure is to provide a better staff experience and to lead in driving quality and performance across the department, both of which should lead to better patient experience and outcomes. .

Chris Chu,

Nurse Unit Manager.

Waikato | Bay of Plenty Region

Regional Representative

Linda (Lyn) Logan

Associate Clinical Nurse Manager (ACNM)

Rotorua Emergency Department

Te Whatu Ora Lakes

Rotorua Emergency Department.

After the festive season, which didn't seem to have much of down downturn in the amount of presentations we are seeing, we are back to the normal bed block and flow issues more days than we would like. This is similar to other EDs in our region. The 6 hour target seems to be the flavour more so this year, in 2025, without any further resources or changes in care delivery. There continues to be delays in speciality teams seeing their patients who are often waiting for long periods for a definitive treatment plan which further impacts on ED waiting times.

The Police and their reduction to mental health callouts is continuing with their phased approach. We have had issues, but a working group with ED, the police and mental health are addressing some of the issues and looking at ways we can work better together. The lack of an acute response team involvement overnight, due to resourcing, significantly impacts the work being undertaken. Our ED was not one of the 7 hospitals given extra funding for Security, but it is something we definitely need to review with the increasing verbal abuse and anti-social behaviour problems that we are now experiencing. This aligns with the nationwide problems with health workers being attacked in their roles, either in a community setting or in a ward setting. Health workers need to feel safe when undertaking their roles, and at present we don't. We need our employers to do more to make us safe in our workplaces as per the H&S act and the Te Mauri O Rongo Health Charter.

On a positive note, we did manage to employ 4 NEtP students this year, as we did last year. It is good to welcome these RNs to Lakes when I know a lot of graduates missed out. We are hoping to undertake FTE calcs in April, which will be a first for us, so we are hoping to gain more FTE that we so badly need. However, it will be interesting to see how long it takes to get the FTE on the floor as I know some regions have been waiting for approval to recruit to their FTE calcs from last year. As we know, everything is again 'up in the air' with the reset from Health New Zealand plus the resignation of the CEO and the change of Minister of Health. We will wait and see if any improvements occur this year after these changes.

Lyn Logan,

Associate Clinical Nurse Manager.

Waikato Hospital Emergency Department.

After a brief discussion with a couple of the team at Waikato I can report they are having similar issues to Rotorua with bed-block and flowth. Although, an increase in their FTE from the calcs last year has helped with more RNs on the floor to provide timely care. As we have seen in the news recently, cardiology delays have been a major issue, and this impacts Waikato with a huge number of hospital referrals and in-patients - this further impacts ED in their ability to see patients within the national 6 hour target.

Written on behalf of Waikato ED by:

Lyn Logan,

Associate Clinical Nurse Manager.

Waikato | Bay of Plenty Region cont.

Te Āhuru o Rehua-ariki | Whakatāne Emergency Department.

Tena koutou katoa,

The Christmas holiday period saw an increase to the annual surge of holiday makers arrive in the Eastern Bay of Plenty, our ED presentations increased on average 30%. We certainly felt the increased workload and pressures. Fortunately we have a GP service over the weekends and public holidays that runs out of the Outpatient Department, adjacent to our department. Expectedly, this service also saw a rapid spike in presentations that saw their waiting rooms also become overwhelmed. These dual services were vital for our community and our health workforce over the summer break.

Challenges we are facing include the ongoing workforce constraints. Our medical team are facing critical doctor shortages at all levels and compounded with working visa issues. Our nursing team are also feeling the strain, with recruiting freezes and professional development requests having to go through layers of approval and bureaucracy.

The Elderly group, of over 65 years, make up 20% of the population here. Over the summer period, we continued to have high numbers of elderly present with high acuity needs also. In an area that has a large number of elderly and whanau living in financial hardship, the social needs of elderly has also been evident. Our colleagues in the wards also continued to have wards full at capacity, typically this impacted on our ED with impeded bed flow and patients, often elderly staying in ED overnight.

Services that support our elderly in EBOP, such as palliative care, district nursing and primary care, are all struggling to meet the clinical and social needs of our elderly/kaumatua here. I hope the new Minister of Health is aware of these needs, as this would be repeated in other regional areas.

Successes in our team has meant that several of our nursing staff were able to attend the triage and TNCC courses over the last half of 2024, which has helped to upskill our team. Now we look forward to supporting their growth and development on the clinical floor.

As a team we continue to persevere through the challenges and serve our communities.

Mauri ora Natasha.

Nā, Natasha Hemopo.

Clinical Nurse Coordinator

Tauranga Emergency Department.

It has been a tough few months here in Tauranga, with many days seeing presentations way above those forecast. However, for the first time in a while, we have a fully recruited nursing team, which makes those busier days slightly easier for the team.

Acute flow remains an issue, resulting in long waits for patients being transferred to inpatient beds and long waits for those waiting to be seen. We have implemented the 'Flow RN' role from 1030-2300 hrs (without any increase in resource) utilising RN's within the department to expedite investigations, paperwork for admissions etc with some good results.

For some time now our waiting area has been a regular 'hot spot' due to overcrowding, and despite the exceptional efforts of our front of house nursing team, post triage assessments are often delayed. In an attempt to reduce the waiting room pressure, we are trialling the 'streaming' of ATS 4 and 5 patients to our vacant fracture clinic area after hours and at weekends. Here, they are seen by our Nurse Practioner, Clinical Nurse Specialist and Acute Care Physio team. To date, utilising this space at weekends and on public holidays appears to be more useful than weekday evenings.

John Wylie.

Charge Nurse Manager.

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

Regional Representative

Position Vacant

Taranaki/Manawatū/Whanganui Region

Regional Representative

Lauren Miller

Clinical Nurse Educator

Taranaki Emergency Department

Te Whatu Ora Taranaki

Taranaki Emergency Department.

There has been increased pressure to meet Shorter Stay Targets, leading to the reinstatement of our EDO unit. This involves a lot of ongoing work with IT, TrendCare, and our Admin team to get the process underway. In addition, we are trialing a new initiative where ICU and ED RNs swap roles for 8 weeks. Feedback is being gathered to evaluate if this will continue, with the goal of improving the relationship between ED and ICU and supporting the knowledge and skills of our Resus nurses.

Another new initiative involves trialing an RN working alongside our CNSs and NPs in our Portacom (Fast track area). The goal is to improve the throughput of our CNSs and NPs, which should also help improve our SST. While patient presentations have remained relatively consistent, the acuity level has increased with more Triage 2s and 3s. We recently experienced our highest presentations to date, superseding our previous record by nearly 7%.

Staffing remains a challenge as we are still waiting for FTE calculations. We could greatly benefit from another Resus nurse and an ambulance bay nurse, both on the morning shift. On a positive note, we have made significant progress with TrendCare and are almost ready for FTE calculations!

Therese Manning,

Clinical Nurse Manager.

Hāwera Emergency Department.

We have seen a busy few months in Hawera Emergency Department, with increased presentations in both numbers and acuity with our record day taking place in January.

A highlight was a visit from TV one news and a spotlight being put on rural health and the challenges that are faced with recruitment and retention of staff in rural areas.

Towards the end of last year, we has a sepsis month where we carried out daily teaching sessions, focus boards and celebrated the sepsis tool being used appropriately - this has led to an uptake in the identification of sepsis within the department.

The educator team has been working in collaboration to instil regular simulation training, and this is now happening monthly within the ED. Various scenarios are carried out from paediatric to adult resuscitations, as well as the deteriorating patient. In addition to this simulation-based training, a Hawera-based deteriorating patient study day is also being developed for 2025.

Hawera ED have a Clinical Nurse Specialist team of two who worked tirelessly in 2024 to gain their nurse prescribing certification. This has been an excellent addition to the department and the Clinical Nurse Specialists having the ability to prescribe significantly helps with patient flow through the department as well as department congestion. This CNS team are also developing plaster study days to run later in the year.

Shannon Drought,

Clinical Nurse Manager.

Te Upoko o te Ika a Maui | Greater Wellington Region

Regional Representative

Craig Jenkin

Mātanga Tapuhi | Nurse Practitioner

Te Pae Tiaki | Emergency Department, Wellington Regional Hospital

Te Whatu Ora Capital, Coast and Hutt Valley

Te Pae Tiaki | Wellington Emergency Department.

2025 has seen the employment of six new graduate nurses joining the Wellington Team. They will be supernumeray and supported over their inital oreintation period. These nurses have added a new energy to our department.

Our Clinical Nurse Educators have been supporting and developing new staff with innovative techniques education. Use of QR codes for tracking attendance and feedback on educational sessions. The information can be used to track professional development hours and planning of future training. The team is looking at the possibility of recording educations sessions to create a video librabry, allowing staff unable to attend education sessions to access education.

Patient and staff safety is still at the forefront of our ED. There has been improved presence and response from security services. This is been useful as there has been increased numbers of patients using the waiting room to sleep during the night, which is not appropriate. Managing the physical environment with security and orderly support is beneficial for our nurses.

Positive improvements have been seen in the triage and reassessment process. The addition of waiting room nurses and a more robust triage team has helped improve patient flow and reduce waiting times, leading to safer care for patients.

Wellington is still facing challenges with FTE/RBC approvals to recruit in designated senior nurse and registered nurse roles. There is a significant vacancy number to fill but a lack of RBC approved for this. This is compounded with capacity issues within Te Pae Tiaki | ED, with hospital bed block making treating ED pateints increasingly difficult, even prior to the winter months hitting.

Craig Jenkin,

Mātanga Tapuhi - Nurse Practitioner.

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

Wairarapa Emergency Department.

RN Staffing levels are better than they have been in years but we still have some long terms sick leave and maternity leave not filled. While this is great, it has highlighted our overcrowded and cramped working conditions. With patients in corridors on a routine basis and sharing spaces with our nursing staff who are already working in corridors, we are constantly looking at new ways in which to keep our staff and patient's safe. We have had great difficulty hiring Nurse Practitioners with a vacancy of 1.3FTE unfilled for over 18-months. On days we have no NP on, an extra SMO is rostered as the NP position is recognised as pivotal to achieving patient flow.

Our patient numbers don't seem to have increased significantly however the acuity and length-of-stay have, which is impacting on patient flow. We are trialling staffing the short stay unit attached to our ED between 1100 and 1900hrs to enable a senior ED nurse to take on secondary Triage. The idea is to support the triage nurse in the redirection of appropriate patients to GP services and help monitor and care for the, often overflowing, waiting room. It is early days yet but we have already seen an increase in our SSED targets and a decrease in our "did not wait" patient's.

We have had our first ever Enrolled Nurse complete her Enrolled Nurse Support into Practice Programme (ENSIPP), and this year, we have taken on two NEtPs. We have found this is the best way to get nurses into rural hospitals - "grow our own". Our Enrolled Nurse and one of our NEtP nurses started out in our ED as HCA's and we have supported and encouraged them while they undertook their nursing training.

Corrina Rooderkirk,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Hutt Valley Emergency Department.

Hutt Valley Emergency Department continues as status quo. Like other EDs, they are holding out for FTE calculations to see what FTE they are able to recuit into.

Like Wellington, their positive is 6 new graduates who are looking to be promising ED nurses.

Charley Gibson,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Te Tauihu | Top of the South Region

Regional Representative

Vicki Bijl

Whakatu Nelson Emergency Department and Medical Admission Planning Unit

Te Whatu Ora Te Tauihu Nelson Marlborough Health

Whakatu Nelson Emergency Department.

Tēnā koutou,

The traumatic loss of Senior Sergeant Lyn Fleming significantly impacted our ED team, Hato Hone St John, MH hospital teams and many other agencies in our region. We continue to support our team and the wider agencies that have been impacted by this senseless act.

Our presentations continue to climb with a 3.5% annual rise. December was a record month with our highest number of presentations ever and New Years day, the highest number in a 24 hour period - 133. We continue to face the same challenges as many around the motu with ongoing access block and multiple patients waiting for inpatient beds - directly impacting the hospital 6 hour target, and patients being seen within a timely manner.

Our workforce has been somewhat stable over the past 6 months. However, with the pause to review CCDM it has meant an impact in our staff fully engaging in completing TrendCare data. We are busy trying to keep traction going, to ensure when calculations are completed we have the correct data for this! We have been pretty lucky to employ two NEtPs this January. One of our NEtPs has been working in our team as a HCA, while she completed her nursing and now is employed as a nurse - a real grow your own moment.

Since my last report, Nelson ED has been fortunate enough to gain funding for our ED redevelopment. It will ensure that we can continue to deliver emergency care to our growing community. The department's footprint will grow to 28 beds, including isolation rooms that are of international standards, dedicated mental health treatment areas, a whānau room and an increase in staff areas for ED and specialty staff. We will maintain operational while the building occurs around us, which is challenging, however, worth it!. The build is expected to be completed by March 2026.

Vicki Bijl,

Tari Kaiwhakahaere Tapuhi | Charge Nurse Manager.

Westland/Canterbury - Te Tai o Poutini/Waitaha Region

Regional Representative

Jo Aston

Nurse Unit Manager

Christchurch Emergency Department

Te Whatu Ora Waitaha Canterbury

Christchurch Emergency Department.

Summer of 2025 has appeared to be somewhat delayed in Christchurch, however we enjoyed a slight reprieve over January with some days giving us lower numbers, followed by our usual rising presentations up to 400 per day. Our team continues to be committed to driving flow and supporting clinical safety resulting in our SSED target sitting at 80%. We have welcomed new staff with ED skills following the approval of some recruitment and five NEtP nurses who are demonstrating a keen interest in emergency nursing with much enthusiasm.

2024 impacted us with recruitment challenges, rising presentations, access block and overcrowding. Depite these factors the team continued to move forward creating learning opportunities with a focus on flexibility in the delivery of education and upskilling of staff to build our cohort of team leaders.

The opening of Emergency Observation with 12 beds in September 2024 has been a game changer. The collaborative planning proved sucessful as this area has functioned efficiently from day one. The environment is peaceful (most of the time), provides patients with scenic views of Hagley Park and the opportunity for clinical teams to provide patients with extended care avoiding unnecessary admissions.

CCDM calculations were completed in October 2024 with collective efforts from the TrendCare champions, TrendCare Coordinator, ACNM's and nursing staff to reach 90% IRR and consistent actualisations. We hope to see resolution in the review of the calculations to implement the uplift.

The nursing leadership team identified areas of clinical risk and areas of practise which required support and education. A program of "The Fundamentals of Care" was collaboratively developed in October 2024 with themes including : nursing care, documentation, communication, professionalism and environmental checks, this is part of an international program. This was delivered by the ACNM's on each shift with a narative to embed these themes. This work is part of a contiuum of practise which will continue to be socialised.

Christhcurch ED has been identified as one of the eight priority ED's to implement the ED Security Improvement programme training.

The purpose of this training is to provide a nationally led, locally deilvered program to strengthen security frameworks and provide additional training to clinical staff. The training is booked over four weeks commencing the 17th February, with an opportunity for some flexible refresher updates.

In March 2025, we will welcome the upcoming pilot of the Mental Health and/or Addiction Peer Support Specialists (PSS) Service, delived by an NGO. Their role in the department will include connecting with patients and whānau, advocating, supporting and enhancing the patient experience. Training has commenced for the champions, ED senior nursing team, mental health team and will extend to the wider team as the pilot begins.

Our agile roster team continue to creatively meet the needs of the department and team members. Where possible, short notice requests and spot leave are granted with staff following updated guidlelines to support his process.

The ED staff look forward to a refresh in the delivery of ED team days. This will involve team activities, mandatory training and partnering with our medical colleagues through professional development.

On a final note, we celebrate Luke Roberts who has successfully passed the Nurse Practitioner panel, and wish staff who are undertaking study in 2025 all the best!

Jo Aston,

Nurse Manager.

Westland/Canterbury - Te Tai o Poutini/Waitaha Region cont.

Acute Admitting Unit, Ashburton Hospital.

Attendances to Ashburton Acute Admission Unit (AAU) continue to be high, especially afterhours, and a very busy time over the Christmas and New Year period. Higher patient presentations remain being predominately primary care admissions, mostly triage 4 & 5's, and as a result of the inability to access Primary Care GP appointments locally.

The nursing workforce has stabilised for now, and education and training opportunities have enabled a highly functioning nursing team across all areas. Ashburton nursing also offer CORE training to staff on-site and this course has been successfully running for the last 2-years.

Nursing, Allied Health and Medical went live with the electronic patient documentation system "Cortex" on the 11th February across our Short Stay Unit (within AAU), Ward 1 and Ward 2. We are 4-days into the launch, and all is going very well. Cortex is widely used throughout Christchurch, Burwood and Greymouth hospitals, so we were excited to join our colleagues across the organisation.

A huge thank you to Stacey Simpson, Saxon Connor and the Cortex team for their expert guidance and support throughout the Project implementation phase and onward.

Jane Harnett,

Nurse Manager.

Timaru Emergency Department.

Timaru ED remains busy, with December being a largest month of presentations ever, following national trends of patients being sicker and spending longer in our department. While SSED continues to be a national focus and our performance is steady at close to 90%, delays continue as patient numbers exceed our bed spaces. Staffing resources overnight continue to contribute to length of stay and are a current focus for improved patient flow.

TrendCare continues to have excellent engagement from staff and we continue to await approval for our FTE uplift, with 90% of day and afternoon shifts continuing to have a negative variance for nursing hours. While we are still waiting for approval of FTE, it is great to have a data set to show acuity.

We continue to be fully recruited to our budgeted FTE and were excited to have a NEtP RN join our team. We are also looking forward to hosting NetworkZ trauma simulation in March.

Kathryn Campbell,

Nurse Manager.

Southern Region – Te Tai Tonga

Regional Representative

Michelle Scully

Clinical Nurse Educator/
Registered Nurse

Southland Hospital Invercargill
Emergency Department

Te Whatu Ora Southern

Southland Emergency Department.

Leadership update:

TrendCare is going well and continues to show a negative deficit monthly. We are doing work on achieving 100% actualisation. December was very busy and we missed approximately 0.6FTE in actualisations. We will go for FTE calculations in 6 months.

Presentations and acuity have increased. We are seeing about 5 less patients than Dunedin and on some days more.

We have had some challenges in recruitment and the process it takes to have RFR'S approved. Lots of candidates are applying but finding suitable applicants with ED experience is challenging. Many applicants had ICU experience. There is a lack of space in our department. We have outgrown the department and this was noted on accreditation. Our IQN staff are progressing and doing well.

In regards to education, we are hosting a TNCC course and a TNCC Instructors course in Invercargill. Staff education and development continues to be sucessful.

Concerns are the next phase of the police dropping patients and our very limited security on site, with nil in the department.

Our biggest positive is that we have four NEtPs who are enthusiastic and will be great to develop - growing our own.

Leigh-Anne Fearn Charge Nurse Manager.

Invercargill ED continues to grow and thrive. The 6 ACNMs are doing projects which breathe life into the department.

Many staff have attended the Leading an Empowered Organisation (LEO) course and the projects rolling out from this course are exciting, and often transferrable. I was fortunate to be funded to attend the course and the learning was fantastic. In spite of barriers and challenges existing in the health environment, when we are all rowing the waka in the same direction, it is amazing what can be achieved.

My personal project was to develop teaching kits so that staff....on quiet occasions....if that ever is a thing.... could grab a kit, and with a peer, revise using a machine and work through a worksheet. This is hoped to develop some self directed learning and give staff the opportunity to practice with the hopes of feeling more comfortable when expected to perform under stress.

Protected education is enculterated in this department. There is 30 minurtes of Education on Monday and Friday, and now education is often ocurring on weekends as well. The goal is to now aim to get more of the RNs teaching. Weekly insitu sims continue and the learning from these are huge. Often a process is identified as needing immediate attention, or an education need identified.

Trauma education in the department is a focus over these next few months, with a TNCC course being hosted here in Invercargill. A TNCC instructors course is also being facilitated, Dunedin is also hosting a course the following week and the new instructors will be supervised teaching at this course.

NetworkZ is returning to Invercargill for further trauma scenarios. We look forwad to the simulations to evaluate the changes we have implemented as a result of their prior visit. NetworkZ is also visiting Lakes District Queenstown. Having TNCC education locally is exciting and we are looking forward to the learnings from NetworkZ.

The themes in the Southern Region appear to be the same. These are Trend Care showing a negative deficit in staffing, accompanied by increased presentations with higher acuity. The freeze on staffing is demoralising.

The positive aspect throughout the region is the addition of the NEtPs to the team. They bring energy, positivity and hope to the environment.

The ED teams continue to be resilient and the collegiality of the ED family prevails.

Michelle Scully CNE.

Leigh-Anne Fearn

Michelle Scully,

Charge Nurse Manager Southland

Clinical Nurse Educator Southland.

Southern Region | Te Whatu Ora cont.

Lakes District Hospital (Queenstown).

The summer was busy at Lakes Hospital Queenstown Emergency Department, and the busiest part was survived with minimal safe staffing or adverse patient events.

Presentations have increased by 10% from last year with an increase in Category 1 and 2 patients. In December 2024, there were 1654 presentations, and in January 2025, there were 1658 presentations, averaging around 50 patients per day.

Challenges: All workforce planning has halted, so plans for increasing senior roles in ED have been stalled. There are increasing presentations and acuity, but no workforce planning to match.

TrendCare has been going well, but the nurses have been feeling a little despondent about it. Many shifts are showing a deficit in nursing numbers.

Lisa Friesen,

Charge Nurse Manager.

Dunedin Emergency Department.

The ongoing uncertainty of the new hospital build has affected planning. There has been increased presentations compared with last year. There has been an increase in traumas and high acuity presentations. This increases strain on resources and team morale. The flow on effect of this is, of course, bed block within the hospital. Trials of "hospital within the home" continue.

TrendCare data collection started at the end of last year. We are having difficulty maintaining it as a priority during imes of high acuity. Staff are negatively affected by Health New Zealand trying to remove CCDM obligations during current MECA negotiations. The senior nursing team is looking at ways to removing barriers to completion, such as extra computers, while giving reassurance that the TrendCare data is still relevant and required to show evidence of staffing deficits. Despite this still showing significant gaps between nursing hours required and nursing hours available.

In regards to the CPI roll out and de-escalation and restraint elimination, the unexpected roll out of an externally provided CPI programme brought in by health and safety, with rosters already out, meant staff needed to pick up extra shifts. It is a great programme with fantastic feedback from our frontline staff. The CPI Team, ESPECIALLY Koko, Kim and Darcy, were very accommodating and understanding of the complications associated with the rapid roll out. The CPI programme focussed on staff safety. They are working closely with security to increase their knowledge and education around health conditions, trauma informed care and de-escalation. They are learning new "no pain" holds and restraints, as well as working with the clinical team to ensure safe, legal, de-escalation restraint. This new approach is not just a tick box exercise, with several of our SMOs attending a few sessions and now enthusiastic about participating in June. A whole team approach is needed so that everyone is on the same page, using the same language and all having renewed knowledge around the legalities.

Three New Graduates start in March. All have been students in the department before, so great to see the ongoing progression.

One of our CNS's has completed his NP training. A big congratulations. We are starting to see a few more RNs being approved which is great as we have had a flurry of staff requiring maternity leave!!

Jenn Wilson,

Clinical Nurse Educator.

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.
- Previous copies (where digitised) of Emergency Nurse NZ are available on the CENNZ website at: https://www.nzno.org.nz/groups/colleges_sections/colleges/college_of_emergency_nurses/journal.

College Activities: Courses

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

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

For the details see the CENNZ websites at:

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

and;

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

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

Submissions Guidelines - (Brief)

Journal Submissions

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

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

Category of manuscripts

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

Format:

Title page: title, authors, abstract and keywords

Body: introduction, methods, results, discussion

References: limited to 30

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

Format:

Integrative, scoping or systematic literature reviews are preferred

Use of JBI for integrative or scoping reviews recommended

Use of PRISMA for systematic reviews recommended

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

Format:

Introduction: brief overview context / problem

Case: patient description, case history, examination, investigations, treatment plan, outcome

Discussion: summarises existing literature, identifies sources of confusion or challenges in present case.

Conclusion: summary of key points or recommendations

Submissions Guidelines - (Brief)

Journal Submissions cont.

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.

Education: Conferences

Upcoming Conferences

Organisation	Title	Date	Location	Link
Society of Trauma Nurses	TraumaCon 2025	April 23-25, 2025	Kansas City, MO	https://www.traumanurses.org/events/trauma-con-agenda
ICEM International Conference on Emergency Medicine	24th International Conference	24-28 May 2025	Montreal Canada	https://www.icem2025.com/
WADEM World Association for Disaster Medicine	Governance in the Face of VUCA: the Power of Knowledge, Courage, and Solidarity in Health Systems	2-6 May 2025	Tokyo, Japan	https://wadem.org/congress/tokyo-2025/
Global Advanced Practice Summit	24 hr online conference to bring together advanced health practitioners	13th May 2025		https://thealliedhealthacademy.mn.co/spaces/17324790/page
ICN International Council of Nurses	ICN Congress 2025	June 9-13th 2025	Helsinki	https://www.icn.ch/events/icn-congress-2025-helsinki
ANZAHPE Aus. And NZ Assoc. for Health Prof. Educators	Horizons: Embracing the Future	30 June-3 July 2025	Perth, WA	https://anzahpe.org/page-1075572
20th National Nurse Education Conference NNEC	Accelerating into the Future: Empower, Innovate, Connect.	June 18-20 2025	Sydney	https://dccam.com.au/nnec2025/Home

Education: Conferences cont.

Upcoming Conferences

Organisation	Title	Date	Location	Link
ENA Emergency Nurses Association	Emergency Nursing 2025	September 17 - 20, 2025		https://www.ena.org/events/2025/09/17/ena-annual-conferences/emergency-nursing-2025
ACNP Australian College of Nurse Practitioners	National Conference	29-31 Oct	Canberra, ACT	https://www.acnp.org.au/nationalconference2025

Education: NZ Triage Course

Statement

Triage is an advanced emergency nursing assessment skill for Registered Nurses.

The CENNZ triage course supports the proficient emergency nurse to make rapid assessments, select the appropriate Australasian Triage scale score using skilled questioning and clinical judgement, and initiate early interventions.

CENNZ Triage course is nationally recognised as foundational training in triage for the New Zealand emergency nursing practice context. Course instructors are experienced emergency nurses.

CENNZ triage course endorsement is limited to courses that are officially provided by CENNZ. The workbook resources, course materials and tools provided are copyrighted to CENNZ.

A minimum of two years emergency or urgent care experience in addition to NZRC CORE Advanced is ideal prior to completing the CENNZ triage course. Nurses who do not meet these criteria will need a letter of support from their manager or nurse educator and will be accepted at the discretion of the course co-ordinator.

Time commitment and availability for pre-course work is essential.

Components of the course:

1. Pre-reading and course work (approx 20hrs)

2. Two day course with:

- An exam on the pre-course work (pass rate for the exam is 80%)
- Practical Scenario based assessments.

The number of participants per course is a maximum of 24 and courses can be booked out months in advance.

Application Process:

Applications are accepted online only and must be received before the close off dates. We now have a credit card payment option along with an invoice option where you can pay by direct credit. Invoices and receipts are sent directly by email when booking is complete.

Please ensure you enter the correct email address and invoicing details for the person who needs to receive invoices and receipts. This is often different from the attendee information. Invoicing is automated via the website when you submit your application and cannot be changed afterwards.

Cost: $595 for CENNZ levied members, $750 for non members.

To pay the lower price:

- You must be a levy paying member of CENNZ for the financial year in which the course is being held. The CENNZ Levy is $25.00 per annum from 1st April to 31st March of that financial year.
- You must be a member of NZNO to join CENNZ

If you are not a member of CENNZ and your workplace only pays the member cost of $595.00, you will be expected to cover the extra cost of $155.00.

- Read the CENNZ Triage Course Terms and Conditions online (Includes cancellation policy)

Book early to avoid disappointment.

Education: NZ Triage Course cont.

2025 Course Dates:

The "Book Now" links will take you to the online booking for that course.There you will see if the bookings are still available.

It will either have a 'Book now' link or it will say 'Event full'. There is an option to book more than one attendee at a time and an option to invoice to one place i.e. your manager or finance department.

Region	Course Dates	Venue	Closing date for booking	Closing date for payment	Registration
Christchurch	22/23 March 2025	Manawa Building [Registration 3rd Floor] Health Education & Research Facility, 276 Antigua Street, Christchurch	24 January 2025	7 February 2025	Bookings closed
Taranaki	5/6 April 2025	Lecture Theatre, Education Centre, Building 3, Taranaki Base Hospital, David Street, Westown, New Plymouth 4310	14 February 2025 (Extended)	21 February 2025	Bookings closed
Hawkes Bay	10/11 May 2025	Hawkes Bay Hospital, Education Centre Canning Road Hastings 4120	14 March 2025	28 March 2025	Visit the CENNZ website to book
Invercargill	17/18 May 2024	The Practice Development Unit, Level 1, Learning and Research Centre, Southland Hospital, Kew Road, Invercargill	21 March 2025	4 April 2025	Visit the CENNZ website to book
Tauranga	24/25 May 2025	Tauranga Hospital Education centre, 889 Cameron Road, Tauranga.	28 March 2025	11 April 2025	Visit the CENNZ website to book
Lower Hutt, Wellington	7/8 June 2025	The Learning Centre, 1st Floor, Clock Tower Block, Hutt Hospital, High Street, Lower Hutt	11 April 2025	25 April 2025	Course full
Wellington	5/6 July 2025	Education Centre, Level 12, Ward Support Block, Wellington Hospital, Riddiford Street, Newtown	9 May 2025	23 May 2025	Visit the CENNZ website to book

For any registration issues please contact: triage@nzno.org.nz

Any questions on course content or holding a course in your area please contact: Triage Course Co-ordinator
Email: cennztriage@gmail.com

Education: Policies & Websites

Policy Documents		
Organisation	**Title**	**Web Address**
ACEM (2020	Care of older persons in the emergency department	https://acem.org.au/getmedia/bfd84f83-fcb2-492a-9e66-47b7896e5c70/Policy_on_the_Care_of_Older_Persons_in_the_ED
ACEM (2020)	End of life and palliative care in the emergency department	https://acem.org.au/getmedia/d55cb8ce-2d26-49d5-823a-f7f07b5c19cc/P455-PolicyonEoLandPalliativeCareinED-Jul16.aspx.
ACEP, AGS, ENA, SAEM (2013)	Geriatric emergency department guidelines	https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/geriatrics/geri_ed_guidelines_final.pdf

Policy Documents		
Organisation	**Title**	**Web Address**
RCEM Royal College of Emergency Medicine	Care of older people in the emergency department	https://rcem.ac.uk/wp-content/uploads/2023/10/RCEM_COP_2023_25_QIP_Information_Pack_V5.pdf
GEAR	GEAR Geriatric Emergency Care Applied Research	https://gearnetwork.org/
GEDC	Geriatric Emergency Department Collaborative	https://gedcollaborative.com/

Assessing & Managing Mild Traumatic Brain Injuries Including Concussion

CENNZ Webinar - 10th April 7- 8PM

Date: Thur 10th April 7-8PM

Presenter: **ALICE THEADOM,** Professor of Brain Health and Director of the TBI Network, Registered Psychologist and Rutherford Discovery Fellow.

KEVIN HENSHALL, Nurse Specialist, Trauma Service, Health New Zealand Te Whatu Ora, Counties Manukau

Title: **ASSESSING & MANAGING MILD TRAUMATIC BRAIN INJURIES INCLUDING CONCUSSION**

There have been a lot of recent advances in how mild traumatic brain injuries (including concussion) should be assessed and managed. The objectives of this session are to:

· Outline current research evidence on mild TBI and concussion

· Provide updates on new ACC processes, clinical management recommendations, and decision support tools.

Reg Link: https://tinyurl.com/CENNZ10APR

REGISTER NOW!

COLLEGE OF EMERGENCY
NURSES NEW ZEALAND
WEBINAR

College of Emergency Nurses NZ
Ngā Ringa Ringa Aroha NZNO

ASSESSING & MANAGING MILD TRAUMATIC BRAIN INJURIES INCLUDING CONCUSSION

Thursday 10 April, 7.00 - 8.00pm

ALICE THEADOM

Professor of Brain Health and Director of the TBI Network, Registered Psychologist and Rutherford Discovery Fellow.

KEVIN HENSHALL

Nurse Specialist, Trauma Service, Health New Zealand Te Whatu Ora, Counties Manukau

Professor Alice Theadom has been specialising in mild traumatic brain injuries for over 15 years. She is driven to improve understanding and recognition of TBI, and to discover ways to enhance recovery for those affected and their whānau. Originally trained as a psychologist in the UK, Alice moved to New Zealand in 2009 and has been leading a research programme into TBI/ concussion.

Kevin is a member of the Major Trauma National Clinical Network. A graduate of the University of Manchester, his clinical background is in critical care, and he has extensive pre-hospital nursing and paramedicine experience. Kevin has a special interest in Traumatic Brain Injury initiatives and is currently a member of the Health Quality Safety Commission (HQSC) Severe TBI working group.

There have been a lot of recent advances in how mild traumatic brain injuries (including concussion) should be assessed and managed. The objectives of this session are to:

- Outline current research evidence on mild TBI and concussion
- Provide updates on new ACC processes, clinical management recommendations, and decision support tools

REGISTRATIONS REQUIRED
Use the link:
https://tinyurl.com/CENNZ10APR

health hub

College of Emergency Nurses NZ

Ngā Ringa Ringa Aroha NZNO

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