CENNZ National Conference. Christchurch August 2009.

Topic and Contact Details for Speakers.

Due to limitations of space I am unable to provide full abstract details of all the speakers. The list below provides contact details and full abstracts, more information is available via www.cennz.co.nz and via the *conference* hyperlink.

Speaker and Title of presentation	Contact Details
Sandra Richardson *Which patients comes to the emergency department and why? The Christchurch Hospital Acute Care Opportunities Study*	

Abstract:

Aim:

- To review all patients presenting to the Christchurch Hospital ED on each of seven study days, with representative days of the week and all shifts covered.
- To identify those patients who typically present to the ED with a view to determining whether ED based care was the most effective form of service delivery in each case.

Method:

This was a collaborative study, with both hospital and community providers contributing to study design and implementation. The study took place over a five week period, during which seven 24hour periods were assessed. During this period a total of 1,262 presenting patients had data entered into the study. This represented a patient recruitment rate of 90%. Data was collected from patients, nursing staff, ambulance staff by means of surveys, short answer questions and interviews while in the ED. Community Patient Management Systems were used to identify if the study participants were enrolled with a GP and to identify when they last consulted with that GP. Assessment relating to alternative service opportunities was carried out by nurse auditors and cross checked by a senior physician.

Findings:

- This study identified a number of process and patient flow issues that impact on the patient journey, including issues around gathering ethnicity data and communication problems associated with patient referrals.

- A number of patients were identified as possibly being suitable for an actual or potential alternative pathway.
- The most commonly identified alternative service was a Primary Care Consultation.
- Patient perceptions were identified, and these were recognised as having significant impact on the patients' rationale and choice of health service.

Emergency Nursing in a Combat Environment

Captain Simon Ainsworth

Abstract:

This presentation looks at my experience of emergency nursing within the challenging environment of a military combat hospital in Afghanistan.

The New Zealand Defence Force (NZDF) has a two person medical mission in support of the Canadian led Multinational Medical Unit (MMU) based at Kandahar Air Field (KAF), southern Afghanistan. The MMU provides the highest level of medical care available within the southern Afghanistan area of operations. It receives casualties directly from the point of injury and also receives transfers from other smaller medical units who have casualties requiring higher medical intervention.

This environment gave me the opportunity to experience the unique set of clinical presentations and challenges that comes with nursing within a combat area. The unpredictability and tempo of war means that the numbers and types of injuries are not always known before arrival. The reality that some injuries are not survivable is also a lesson learned very early in your time at the MMU
The intent of this presentation is to share candidly my lived experiences and looks at the both the similarities and differences that this environment had in comparison to NZ emergency nursing. The presentation relies on photographs to illustrate the harsh and challenging reality of both combat; and the environment that is Kandahar Air Field.

Working With Domestic Violence in the Emergency Department: A Team Approach

Christine Corin and **Carolyn Harris** Emergency Department Social Workers
Christchurch Hospital, CDHB

Abstract:

This presentation will focus on practical aspects of working with domestic violence victims in the Emergency Department setting. This includes:

- identification of domestic violence
- safety of patients in the department
- risk assessment – including child protection, suicide and homicide
- documentation
- mobilizing of community support agencies to the emergency department

The overall focus is how the collaboration of the nurse, doctor and social worker can ensure victims receive a comprehensive service and thereby reduce the likelihood of repeat presentations with violence related injuries.

Intranasal Fentanyl an effective first line analgesia for children

Sally Britnell, Children's Emergency Department, Starship Hospital
Abstract:

Rapid and effective analgesia is important particularly when intravenous (IV) access is unavailable. Children present unique challenges and achieving effective analgesia and this may often be delayed due to staff skill and availability, patient and caregiver anxiety combined with varying responses to pain and difficult IV access.

Ideally analgesia needs to be easily administered utilising the least invasive route which will reduce anxiety and ensure the shortest time to achieve effective analgesia.

Pain is often underestimated and under-treated in children. Effective pain management is influenced by a multitude of factors including pain assessment, determining the appropriate route for analgesia, IV insertion and coping with a child's varying responses to pain.

Fentanyl is a rapid acting medication which takes 2 minutes to reach serum therapeutic levels. This makes it a viable choice of analgesia while longer term pain relief options are considered. The decision to utilise the IN route and administration of Fentanyl is nurse initiated on triage in CED in collaboration with medical staff who prescribe the medication, this is commenced at triage to decrease the time to analgesia.

A first dose of IN Fentanyl of 1.5 micrograms/kg is effective. This may be followed up with a second dose after 10 minutes of 0.5 micrograms/kg.

Conclusion
IN Fentanyl is an effective analgesic in children when compared with IV morphine. It reduces time to analgesia and gives an alternative route to IV. It also provides time to enable topical anaesthetic cream to be used prior to IV insertion for the administration of ongoing opiate analgesia

Clinical Pathways in ED – Friend or Foe: How they can help you practice and your documentation

Polly Grainger, MN (Clinical), RCN (NZ), RN (UK), Dip HE (adult) Nursing Studies
Nurse Coordinator – Clinical Pathways

Abstract:

Pathways were designed for industrial purposes to: standardise practice – to reduce waste in time and effort, and to increase productivity and safety. In recent years clinical pathways have been developed internationally in a variety of health settings aimed at an diverse range of clinicians.

Since 2005, Christchurch ED has begun to develop clinical pathways. To facilitate this, in January 2008 a dedicated nurse liaising with a senior medical officer was appointed with the intent being the development of a number of new pathways and the redevelopment of the original pathways.

The pathways selected for development were chosen from the top twenty presentations to our ED and also from areas identified as needing a documented process. The new pathways address not just the tasks necessary for certain conditions but also:

- Support the practice of nurse initiated therapies
- Allow the practice of safely stopping the triage clock which helps to demonstrate nursing practice that is otherwise hidden
- Reveal and support critical thinking and clinical judgments.

In addition they can replace what is normally written in full with a tick, a time and a signature – thus facilitating documentation, leaving more space on the assessment record for the clinical assessment and allowing the clinicians to spend more time with their patients.

This presentation discusses the processes involved in their development, the links with specialty teams to connect with their work, the barriers to implementation and the benefits to both the patient and the clinicians.

The Emergency Department … the new graduates perspective

Chelsea Gannon-Willmott, RN Dunedin ED

Abstract:

This presentation aims to provide the perspective of new graduates on the highly debated topic of whether new graduates should be allowed to start their nursing career within the emergency department.

The results of a literature review, survey and interviews with new graduate nurses working in the ED setting are included. I feel it is important to ask what the challenges for new graduates in general are and how new graduates can be supported within the emergency department.

I feel very passionate about newly graduate nurses working within this area, however I do want to provide a well rounded perspective that considers historical and contextual factors and contains on the practicality of this area for new graduates.

Older people's perceptions of elder abuse, and the identification of elder abuse in the emergency department setting

Dianne Hudson

Abstract:

Identification of elder abuse in acute health care settings such as the Emergency Department (ED) is an internationally recognised approach to the detection of elder abuse. The aim of this process is to provide health professionals with the opportunity to offer assistance and provide support. However, the reality of the situation is that few cases of elder abuse are detected and few reach the stage of referral. Related to

this, is that the majority of research studies guiding the practice of identification of elder abuse are from the perspective of health workers. There are few studies that examine older people's perceptions of elder abuse or the processes for the identification of elder abuse. One World Health Organisation (WHO) study that does address this problem succinctly describes this phenomenon as the 'Missing Voices'.

In the form of a dissertation I have therefore endeavoured to address this gap in research by exploring older people's understanding of elder abuse and their points of view on how they would prefer to be approached about this problem in an acute health setting such as the ED. The research study I designed uses a qualitative research approach for this purpose. This involves focus group discussions with two groups of older participants, older women and older men, from the community and a third focus group of ED nurses. The aim of including this third group is to provide insight into nursing perspectives of elder abuse, therefore broadening the knowledge base of the study.

A significant finding from the study is that elder abuse in the domestic setting remains hidden and generally under recognised by older people and ED nurses. The older participants viewed elder abuse as something that happened to other people, but not to them. Ageism was a central theme and viewed as a form and cause of abuse. Both older participants and ED nurses viewed ageism as a major barrier to the identification of elder abuse.

This study suggests that if health professionals are to be successful in improving the process of identifying elder abuse, older people's views, opinions and perceptions must be considered. Underlying values and attitudes of health professionals and wider society towards older people must change. Nursing practice in the ED needs to be guided by protocols and standards and supported by education in order to adequately address this significant problem. The establishment of safe and effective practice in this area has the potential not only to support change but also to establish a precedent prior to any introduction of identification programmes into routine ED nursing practice.

Urgency or emergency… that is the question!

Rebecca Fenn, Eastcare Accident and Medical Clinic

Abstract:

I have always thought that the only place where emergency nursing can be effective is in the hospital in an emergency department.
However, when I moved out of the hospital into the community and began working in an Accident and Medical clinic I was surprised at the amount of "emergencies" that can be and in fact are managed out there in the real world…the world outside of the hospital.

A busy clinic we see approximately 45,000 presentations annually.
We send a considerable amount to hospital for further management but of the 45,000 people we see 5,000 of these people who require hospitalisation are managed in the clinic under what is known as POAC or Primary Options for Acute Care.

POAC as we call it has been running since 2001 and is an innovation in practice which keeps people out of the emergency department and allows them to be managed at home.
It is funded by the district health board and the clinic has a management contract which allows them to offer POAC as one of their services.

This presentation will look at:

- Admission criteria: who is eligible for treatment under the POAC care
- The patient: who are we keeping out of hospital and what are their common complaints!
- How do we treat them
- Funding: who pays for what, how we are saving the emergency departments time space and money whilst effectively reducing hospital admissions
- Case study: from start to finish for one POAC patient

Primary options for acute care are an efficient, organised care option for independent patients who meet the criteria for admission.
This is an opportunity to increase awareness of this innovation in practice.

Emergency Department re-presentations following intentional self-harm

Silke Kuehl Clinical Advisor, NZGG

Abstract:

Repeat intentional self-harm (ISH) episodes are strongly correlated to suicide. Intentional self-harm for this thesis includes suicide attempts, deliberate self-harm and suicidal ideation. The aim was to describe what factors contribute to people re-presenting to the emergency department (ED) within one week of a previous visit for ISH. Objectives identified were to describe the people using demographic and clinical features; describe and evaluate ED management; and identify possible personal or system reasons as to why people re-present to ED within one week.

A retrospective observational design was selected for a period of one year. The data was collected from electronic clinical case notes. The sample consisted of 48 people with 73 presentations and re-presentations. Descriptive and inferential analyses were undertaken using the Statistical Programme for Social Science (SPSS). Missing data limited the number of inferential analyses. Outcome measures were divided into information regarding the person and the presentation.

This study made several discoveries: many re-presentations (55%) occurred within one day; the exact number of people who re-presented many times to ED is unknown, but is far higher than reported in other studies; fewer support people were present for the second presentation; the documentation of triage and assessments by ED staff was often minimal, though frequently portrayed immense distress of this population; cultural input for Maori was missing; physical health complaints and psychosis were found with some intentional self-harm presentations; challenging behaviours occurred in at least a quarter of presentations; and the medical and mental health inpatient admission rates were approximately 50% higher for second presentations.

Recommendations in regards to the use of a triage assessment tool, the practice of reviewing peoples' past presentations and the need for a mental health consultation liaison nurse in ED are made. Staff education, collaboration between services with consumer involvement and further research of this group are required. This study supports the need for holistic and expert care for people who present ED with ISH. Such care needs to be provided in a safe way with the intent on reducing the distress experienced by people who intentionally self-harm.

People at risk of suicide in Emergency Departments – a collaborative approach

Silkie Kuehl, Clinical Advisor, NZGG
Karen Blair, Hutt Valley DHB

Abstract:
The Self harm and Suicide Prevention Collaborative Whakawhanaungatanga aims to provide timely and appropriate services for people at risk of self-harm and suicide. Since 2005 New Zealand Guidelines Group (NZGG) has been contracted by the Ministry of Health to implement recommendations from the 'Assessment and Management of People at Risk of Suicide' (NZGG & MoH, 2003). Thirteen of New Zealand's 21 DHBs are currently participating in Phase Two of the 18 month Collaborative.

The three main objectives are to:

- Improve the care of people presenting to the Emergency Department with self-harm or suicidality
- Increase collaboration between Emergency Departments, Mental Health Services and Māori Health/Mental Health Services. It includes consumer and family representatives
- Share an improvement methodology that can be used for other services.

Implementation of best-practice recommendations is achieved by process mapping, Plan-Do-Study-Act cycles and National Targets are used. The four National Targets cover access, assessment, discharge and follow-up. The Maori concept of 'whakawhanaungatanga' is incorporated - for this project services are committed to working together with respect, aroha and shared responsibility. Outcomes from the first Phase in 2006/2007 included increased collaboration and communication between services, decreased waiting time and increased consumer satisfaction.

"After 10 years of nursing, I now know what questions to ask. I feel much more confident caring for these patients" (Emergency Department Staff Nurse)

"Consumers used to complain a lot about having to go to the Emergency Department and the care they received. Since being part of the Collaborative, I have not heart any complaints". (MH team manager)

Currently the NZGG team is providing support to participating DHBs through site visits and teleconferences. A website is available for DHBs to input data in order to measure progress on their improvements; it contains resources and a discussion board where DHBs share their knowledge. Using a collaborative approach with other DHBs, a consumer focus and strong emphasis on supportive relationships provides an excellent basis to implement an evidence-based guideline, and ultimately improve the consumer experience.

The Clinical Advisor from NZGG will present highlights and challenges. A DHB project coordinator (ED Nurse Educator) will also share her experience.

Cardiac Arrest at 12,000ft

Kathryn Dawson RN, Dip Nursing, BN, PG Dip Business

Kathryn Steel RN, PG Dip Advanced Nursing
Abstract

Any nurse will tell you that a patient in Cardiac Arrest and their subsequent resuscitation would be considered a challenging situation. But when you are 10,000 feet in the air – working out of a backpack in a confined space with only one other medical colleague, the challenge is only escalated. This presentation looks at the case study of a cardiac patient who arrested mid flight, how the situation was managed by the team and what it was about the flight environment that may have contributed to an arrest that may not have occurred on the ground.

Massive Pulmonary Embolus (MPE) and Thrombolysis.

Margaret Anderson, RGON
Abstract:

A case study presentation of a patient with a clinical diagnosis of MPE being thrombolysed successfully. The presentation outlines the demographics of the mid Canterbury region and the difficulties associated with rural health and how we manage with the restricted services available after hours and ensure the best possible outcomes for the patients.
This case study commences at admission to the Acute Admissions unit, outlines the clinical observations, graphing vital signs (clearly showing the deterioration in the patients' overall condition) and input from the medical staff. It then goes on to explain the thrombolysis performed and them demonstrates the effectiveness of this for the patient and a positive outcome.

Change is as good as innovation for the care of children with fever

Eleanor Heard CCN Starship Children's Hospital, Auckland
Abstract:
A very common presentation to Emergency Departments (EDs) is children with fever. Nurses in EDs have an important role in the care of children who present with fever as they, (ED Nurses), lead and guide care for the parents and caregivers. The knowledge required for ongoing fever care and management needs to be up to date, and reflect evidence from both the literature and current practice.
This presentation, on the care and management of children with fever, will discuss some recent literature by Beasley, Clayton, Crane, von Mutius, Lai, Montefort, and Stewart (2008) which examines the association between paracetamol use and the development of atopic conditions in childhood. This has precipitated a review of the how we assess and care for children with fever.
There is also an examination of some of the literature on nurses' knowledge of the care and management of children with fever. It was apparent in the Children's Emergency Department (CED) that Nurses' knowledge of the care and management of fever in children needed to be updated to support a new clinical guideline for Fever in Children under 2 years of age. The literature suggests ongoing education is required to ensure good fever care and education is given to parents and caregivers.
In conclusion, the presentation will provide information on the reviewed Starship Guidelines for the management of fever in paediatrics over 3 months of age (Richardson and Lakhanpul 2007, Starship Clinical Guideline for Fever under 2 years of age).

From neonate ICU to “frequent flyer” in ED: Improving the transition to care

Chantal Stevens
Sharon Payne

Abstract:

Many nurses identify that caring for acutely unwell children is challenging and a source of anxiety. This is especially so when nurses are exposed to critically unwell children infrequently. Increasing numbers of paediatric patients with complex health needs are presenting to emergency departments with serious and often critical illness. These children are most often cared for by parents with expert knowledge and they do not seek help until the care of the child condition has moved out of the threshold of their knowledge and skill. Often the conditions they suffer from are complex, unusual and health professional have very limited knowledge of the condition.

We will present the case study of Child M, discussing his care and the multidisciplinary approach to paediatric care in a regional emergency department. Child M was born at 29 weeks, and following many weeks in the neonatal intensive care unit, was discharged to the care of his parents with extensive input from a multidisciplinary team. Child M was to become a regular attendee to the emergency department, bringing some interesting challenges to provide the expert care he required. Along with his complex health needs there are significant social issues that must be acknowledged in the provision of his care.

The New Zealand Ambulance Strategy

Donaleen Shiell

Abstract:

In 2008, a draft New Zealand Ambulance Strategy was developed by the Ministry of Health and ACC in consultation with the Ambulance Sector and other stakeholders. The Strategy was taken to consultation in late 2008, and was released by the Minister of Health on 4 June 2009, on behalf of Health and ACC. This presentation outlines the Strategy initiatives, the formation of a new joint ACC and Ministry team to manage ambulance service purchasing by the Crown, and where to from here.

How to have a difficult conversation

Brian Dolan

Abstract:

In 2009, the US Joint Commission identified that rude language and hostile behaviour pose serious threats to patient safety and quality of care. The *Silence Kills* study, conducted by VitalSmarts and the American Association of Critical-Care Nurses, reveals that more than three quarters of caregivers regularly work with doctors or nurses who are condescending, insulting, or rude.

How an individual handles difficult conversations can have a profound influence on their work and personal relationships. Based on the work of Kerry Patterson et al (2002), this session will provide tips for succeeding at crucial conversations including;

- Recognising when you're having a crucial conversation
- Holding the right conversation

- Starting with your intent, not your content
- Starting with facts, not feelings
- Learning to doubt your feelings
- and ending with clarity.

The Christchurch Hospital Experience

Anne Esson BA (Educ), Adv Dip Nursing, Post Grad Cert Intensive Therapy Nursing, RGON. Nurse Manager Emergency Department Christchurch Hospital.

Abstract:

In May 2007 ‘Project Red’-an ED, Clinician Led action orientated project was launched. The project, under the streams of People, Plant and Processes was designed to address issues in a unified way by prioritising activities and assigning clear responsibility and accountability. In collaboration with the greater hospital’s ‘Improving the patient’s Journey (IPJ) project the Christchurch Emergency department has reduced crowding and seen a marked improvement in Triage 2 and 4 hour Length of Stay performances. This presentation outlines the actions taken to achieve these results and the challenges which lie before us.

Report on residential flight school

Karen Hathaway
Janet Barker

Abstract:

Aeromedical Post Grad Study with Otago University / 2009 Residential School Report

This year's school was held in historic Stirling in Scotland, UK and attended by Aeromedical, Aviation and Occupational Medicine students from all around the world. A mixture of site visits and stimulating lectures ensured a fantastic week which proved to be of great benefit to everyone who attended.

This presentation outlines the key components of the course and gives an overview of Aeromedical Post Graduate Study as a Distance Learning Student with Otago University.

Managing spinal injuries from a flight nurse perspective

Delwyn Rattray RCpN
After registering in 2000 I began working at the Burwood Spinal Unit caring for a range of spinal injured patients including ventilator dependant tetraplegics. This developed my interest in ventilation and after 3 years at Burwood saw me move to Christchurch Intensive Care where I have worked since 2003 minus a two year period in the United Kingdom. I began my flight nursing career in 2005 and have transferred many spinal injured patients of varying neurological disability. Unfortunately I don’t have any exciting stories of mishap and drama to share but instead wish to present some complications and consideration when dealing with spinal injuries and the best way to package and post without causing further secondary injury and ensuring a drama free transfer.

“Pigs do fly” or “Transporting the patient with H1N1”

Fernah Peacey

Abstract:

The patient with an infectious disease such as H1N1 poses extra issues for the flight nurse to consider when transporting patients between hospitals. Some of these issues and how they should be addressed will be discussed during this presentation.

Does EWS have any place in assessing the patient who requires aeromedical transport

Garry Robinson

Abstract:

Working in the Aeromedical environment has its unique challenges. Assessing patients prior to transport and gaining accurate information via phone can be challenging. I will present data about an assessment tool that could possibly aid in the pre flight assessment of patients. This topic will be interactive with open discussion.