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Emergency Nurse NZ

Editorial Committee

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A Word from the Editor:

Welcome to the first journal of 2009.

For those discerning readers you will have noticed the difference in the print quality this time around. Slowly but surely we are improving the quality of the journal both in terms of its content and appearance whilst endeavouring to be cost effective. Any feedback on the current issue is most welcome!

As part of the goal to improve the face of NZ emergency nurses the journal will 'soon' be available via the Cumulative Index Nursing and Allied Health Literature (CINAHL), the international database of nursing literature. The value to the College is in increasing our profile internationally and this is clearly of benefit to any one who chooses to contribute as well. As a successful contributor to the journal, you will be acknowledged as the author and your name / publication available to anyone in the world. If you are writing an assignment as part of your study or know of others who have something to contribute please do not hesitate to forward to me.

The New Year has also seen a number of initiatives from the Ministry of Health aimed at improving health and some of these proposals should have a positive benefit for emergency service delivery. The new minister seems very keen to develop and support clinical leadership, the maxim from the ministry is health care delivered better, sooner and more convenient. In discussions with Mark Jones (Chief Nurse) this opens the doors for nurses to put forward ideas, concepts they believe will improve care delivery and in his opinion the Ministry is currently very receptive to new ideas. Some of this is discussed in the journal under 'general news' and also in a summary of the recent MOH publication Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments as précised by Lucien Cronin.

Also under the general news section is a list of those members who have received awards from the committee over the past few months, we are very keen to offer financial support to members attending conferences and courses and encourage members to make use of this. The types of awards, application process and criteria are available via the website.

Michael Geraghty

Editor

Emergency Nurse NZ

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Letters to the Editor are welcome. Letters should be no more than 500 words, with no more than 5 references and no tables or figures.

College of Emergency Nurses New Zealand - NZNO

Emergency Nurse NZ

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Submission of articles for publication in Emergency Nurse New Zealand.

All articles submitted for publication should be presented electronically in Microsoft Word, and e-mailed to mgeraghty@adhb.govt.nz. Guidelines for the submission of articles to Emergency Nurse New Zealand were published in the March 2007 issue of the journal, or are available from Michael Geraghty at: mgeraghty@adhb.govt.nz or Lucien Cronin at: croninfamily@xtra.co.nz. Articles are peer reviewed, and we aim to advise authors of the outcome of the peer review process within six weeks of our receipt of the article.

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Chairperson's Report.



Welcome to the first journal for 2009. Since our last meeting in November-2008 the CENNZ committee has prepared the Annual Business plan which was submitted by its due date to the NZNO national office. The CENNZ committee responded to calls for submissions following the release of the draft document from the working group for achieving quality in Emergency Departments to the Minister of Health prior to Christmas. We have recently reviewed the final report and made further submissions on the Recommendations to improve Quality and the measurement of Quality in NZ Emergency Departments. We have also assisted with submissions to the after-hours care discussion paper. We have appreciated the input from those CENNZ members who took the time to read these documents within very short time frames and at such a busy time of the year for us all. Despite the time constraints placed on us by the submission process, I do think it is advantageous to take every opportunity that arises to provide good feedback and advocate for patients, families and staff. Our Knowledge of the behind the scenes work certainly enables us to explain to the public when faced with criticisms that we are trying to make improvements to the systems and processes that do cause everyone frustration.

Managing heavy workloads and Safe staffing issues continues to be problematic and as many of us can attest we certainly did not see any reduction in acuity or numbers over the summer. We are all constantly looking for ways to any improve the patient journey. The CENNZ committee are meeting with Chief Nurse Mark Jones at our next meeting and these issues will be again raised.

We have welcomed the recent news of the appointment of Jane Lawless to the position of Director, Safe Staffing and Healthy Workplaces Unit. Jane has a broad background in clinical nursing, most recently

in Emergency Nursing. As well she has previously been involved in the CENNZ Committee and is a past chairperson. She brings significant knowledge and expertise in safe staffing and nursing work to this role.

At the end of last year we received notification from our long standing supporter Medxus of a significantly reduced sponsorship package due to the world economic downturn. They have advised us of their intention to continue with sponsoring our Medxus education grant for 2009. We would like to thank them for their ongoing support of CENNZ.

CENNZ members received a "Happy New Website" mail out advising of the new CENNZ Website. Thanks to Doug King for all his work in getting it to this stage and I hope you find it useful. We will continue to add our policy statements and guidelines as they are reviewed and any information you may find useful. Please contact your local representative with suggestions or comments.

Kate Cooper our Canterbury/ West Coast Representative was successfully nominated onto The Accident & Medical Clinic standards scoping project for Standards NZ.

Since our last meeting we have received the resignation of Judi Van't Wout, our southern Representative. Judi has done a sterling job with the Treasurer's portfolio. Rosie Simpson from Dunedin who has been a long standing CENNZ member and Triage course instructor has also resigned. We would like to acknowledge and thank them both for all the work they have done for the College over many years and wish them well in their future endeavours.

Denise McGurk | Chairperson

denise.mcgurk@nmhs.govt.nz

General News.

Awards.

1. Sharon Kingsbury was nominated to receive the first time journal presentation for her case study on the management of a hand laceration published in the Summer 2008 edition. She received a Littman's stethoscope
2. Sandra Richardson was nominated to receive the MedXus Research Award 2009. She will receive \$1000 towards her research topic: *DETERMINING CONSENSUS AROUND THE INAPPROPRIATE ATTENDEE*. Sandra is a nurse researcher / lecturer based in Christchurch.
3. Dyanne Atkinson (Staff Nurse, Hutt ED) applied for and received \$700 towards a TNCC course she will attend in 2009. This money came from the CENNZ Education Fund - details are available on the website.
4. Gabby Harsveld (Charge Nurse, North Shore ED) and Lynette Baines (Nurse Specialist, Waikato DHB) received \$3500 funding via the Pacific Grant to run a modified triage course at the South Pacific Nurses Forum held in Fiji. A report by Gabby can be found in this journal and was a condition for receiving financial support.

MedXus.

For almost ten years MedXus has been the unconditional sponsor of CENNZ providing substantial financial support for the both the journal and the annual conference. Unfortunately as a result of the current economic downturn they have had to re-evaluate this relationship and are now unable to continue as our primary sponsor. We are delighted that they will continue to support the annual research award. More details of this are available on our website.

If any CENNZ member knows of any companies who would be willing to offer sponsorship, advertise in the journal / website please do not hesitate to contact me in the first instance: mgeraghty@adhb.govt.nz

Membership Renewal Process.

In order to streamline the administrative process of membership renewal the national committee has endorsed a proposal by Glenys McSweeny to change the renewal process to one date, once per year. As of 2010 all members will be invited to renew their memberships in March, in moving to this schedule no member (old or new) will be expected to pay more than once in any 12 month period. The current membership fee of \$25.00 per annum remains the same and in these days of economic instability we believe this still remains a very competitive rate and particularly given that the cost used to be \$40.00 per annum.

Financial support for CENNZ members to attend conference 2009.

The CENNZ national committee will again offer financial support to ten NZNO / CENNZ members to attend the annual conference being held in Christchurch this year. Those successful applicants will have their conference registration fee's paid in full. In accepting this award you must agree to attend the AGM and you must not have been a recipient of this award in the previous 12 months. Applications in writing to:

The Secretary

CENNZ Conference 2009,

PO Box 2128, Wellington. NZ

Cont. overleaf...

General News.

Meeting with Mark Jones, Chief Nurse, Sector Capability and Innovation Directorate. Ministry of Health.

The national committee met with Mark at our last meeting (February 2009) and took this opportunity to reflect on some of the feedback from members at the 2008 AGM. Members concerns regarding issues of clinical safety, access block and staff stress were discussed. It was clear from Marks reply that these issues are being taken seriously by the new Minister of Health, the Honorable Tony Ryall and that emergency department performance is a key performance indicator that the Government intend to monitor. The Minister has put out two significant publications in their first 100 days of governorship both inferring that access block particularly is a systemic problem, not exclusively an emergency department issue and that the Minister intends to put significant pressure on Boards / CEO's to fix this problem 'from above'. One particular initiative that the Ministry clearly supports is the six hour ED length of stay using the 3-2-1 model. In this model the six hours is broken down to 3 distinct time periods.

3-2-1 model	Intent
1st three hours	A three hour period allowing ED staff to either treat and discharge a patient or 'work them up enough' to discern that they require admission
2nd two hours	A two hour period allowing in-patient specialaty review or acceptance to admit the patient
Final one hour	A one hour period in which the patient should be moved out of ED and into an in-patient bed.

The following link provides some further detail about this model (please note the article refers to a model developed in New South Wales and may not reflect policy development in NZ):

http://www.archi.net.au/documents/e-library/blocks/models/emergency_care/3_2_1/321.pdf

A number of ED's are already beginning to collate data using this model and the principle findings show that whilst ED tends to get phase 1 right, phase 2 and 3 are where the failing exists. It is anticipated that this sort of data will allow for appropriate pressure to be born on clinical directors and in-patient specialists to move their patients out of ED in a timely manner which will make significant improvements in ED over crowding. The 3-2-1 model is one that seems to work well in larger hospitals but is not thought appropriate for a number of smaller ED's / hospitals.

National Committee Vacancies 2009.

Due to the resignation of Judi Van't Wout (Southern region) and Janine Kereama (Central region) who has completed her four year term there will be two vacancies on the national committee this year. Judi's position will be open for nominations in the next month and Janine's position becomes vacant at the next AGM. For those people interested in either standing or nominating another CENNZ member in these regions please contact either Judi or Janine in the first instance.

Contact details for Triage Nurse Coordinator.

The contact details for Gabby Harsveld has changed to the following:

Gabby Harsveld

Triage Course Co-ordinator

PO Box 35705, Browns Bay,

North Shore City, 0753, Auckland

Mob: 021 279 3581

email: triagefirst@gmail.com

Major report recommends approaches to solving ED overcrowding.

Author: Lucien Cronin.

The Working Group for Achieving Quality in Emergency Departments (2008) reported to the Minister of Health late last year, and their report, entitled *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments*, was published at the end of January. The report reviews the current state of emergency departments in New Zealand, and presents various recommendations to address the following issues, which are of course very familiar to emergency nurses, i.e.

- Overcrowded EDs
- Use of informal spaces to treat and house patients
- Long patient stays in ED
- Long patient waits for treatment or analgesia.

The causes of ED overcrowding are categorised according to the 'patient journey' - the growth in presentations and workload (input); sub-optimal patient pathways within EDs (throughput); and access block (output). Perhaps the most significant aspect of the report is the clear recognition that "The underlying causes of these ED problems span the whole health care system" and that "solutions to ED problems will need to address the underlying causes, and therefore span not only the ED, but the whole of the hospital and indeed the whole acute care system" (p5).

The report makes fourteen recommendations, including the introduction of a six hour target for admitting, transferring or discharging patients from the ED. This target is to be a key performance indicator for EDs and a letter from the Minister of Health to district health board chief executives clearly states that they are responsible and accountable for achieving this target (Ryall, 2009). This challenges the previous assumption that overcrowding in EDs has been an ED problem which should be solved by emergency clinicians. ED overcrowding should be addressed by implementing planned escalation procedures which shares the clinical risk currently carried by the ED with inpatient facilities. Holding patients in 'informal' spaces such as the ED corridor is unacceptable. The role of the ED in providing emergency care is emphasised; for example stable GP referrals should, following triage, be assessed and treated in an in-patient facility rather than the ED.

Another significant recommendation is to extend mandatory reporting and benchmarking of triage waiting times from Australasian triage categories (ATS) 1 - 3 to ATS 4 and 5, thus providing a far more complete picture of the ED workload.

One suggestion that may not find favour from a government who are determined to cut bureaucracy is the establishment of a unit ('locus') within the Ministry of Health for the performance management of the quality of ED services, and for facilitating the recognition and sharing of good practice across the sector.

Although ED overcrowding is redefined as a systemic issue, the report also suggests that emergency care clinicians can improve processes within the emergency department. For example, more senior medical staff and improved access to diagnostic testing may improve patient flow within the department. As ED nurses, it is tempting to attribute our problems to external agencies. However, we need to be prepared to review our own practices to identify how we can improve what we do to facilitate delivery of what the Minister refers to as Better, Sooner and more Convenient healthcare (Ryall, 2009). To this end, all ED nurses with an interest in the issues associated with providing emergency care should access and read the report, available via the Ministry of Health website: www.moh.govt.nz.

References:

Ryall, T. (2009) Letter of Expectations 2009/10. Office of Hon. Tony Ryall, Minister of Health.

Working Group for Achieving Quality in Emergency Departments (2008). *Recommendations to Improve Quality and the Measurement of Quality in New Zealand Emergency Departments*. Wellington: Ministry of Health.

<http://www.moh.govt.nz/moh.nsf/indexmh/recommendations-quality-nz-emergency-depts?Open>

Lucien Cronin - Staff Nurse, Tauranga ED.

NZNO Submission Website: http://www.nzno.org.nz/Site/Submissions/Recent/Quality_in_Emergency_Departments.aspx

ACC Fall Prevention Programme.



Standing up to Falls

Research shows that each year, one in three people aged 65+ will fall. This increases to one in two people, over the age of 80. ACC is the lead government agency for the National Falls prevention Strategy (NFPS) and has implemented two evidence-based exercise programmes - modified Tai Chi and the Otago Exercise Programme.

Modified Tai Chi programme.

This commenced in 1998 with a pilot programme that has since been extended throughout New Zealand. It was delivered to over 6000 people aged 65+ in the last year. Modified Tai Chi for falls prevention has the best results in those aged 65 years and over. It is a community-based group programme that consists of gentle flowing exercise. Modified Tai Chi also has other health benefits such as for hypertension, respiratory and cardiac conditions, prevention of type 2 diabetes, stress and relaxation as well as psychological benefits and social isolation.

The ACC funded programme is held twice a week for 20 weeks, after which the participants are encouraged to self fund either by continuing with modified Tai Chi or by choosing another type of exercise, depending on what is available in their area. Some people have set up their own walking groups after attending the programme. Training for instructors is provided through an ACC contracted Tai Chi Master trainer.

The Otago Exercise Programme (OEP).

This was developed in New Zealand by Professor John Campbell and associates from Otago University and has most effect in the over 80 age group. It is a 'one on one' programme that requires a physiotherapist or nurse (trained in the programme) to visit the person at home to deliver exercises tailored to the persons needs. OEP continues for one year, consisting of five visits and follow up phone calls. Walking is also encouraged.

Who is eligible?

Both programmes have entry criteria that require the prospective participant to live in the community, to have had a fall or have been identified as being at risk of falling by their health professional, along with meeting the age criteria. They are suitable for referral after having had a fall, to help prevent a reoccurrence. If health professionals are aware of the programmes, they can be offered to people who are treated in the Emergency department or Short Stay Unit. Referrals can also be made by other health professionals, on discharge from any admission that has been fall-related, or where a person has been identified as a falls risk. While the OEP is required to have a health professional referral, people can also self-refer to the modified Tai Chi programme.

Preventing falls with Vitamin D supplementation.

Another area of interest for ACC is Vitamin D supplementation. Approximately 27,000 older adults currently live in residential care facilities in New Zealand. Based on current fall rates, up to 18,000 of these residents are likely to fall over the next 12 months. Research shows that Vitamin D supplementation could help prevent around 5000 of these falls. That makes it a valuable intervention for ACC to support in order to help minimise the impact of falls on care facilities, and improve the quality of life for residents.

Resources available.

ACC has a variety of fall prevention resources available. More information on these resources can be found at www.acc.co.nz by clicking on the publications section.

Ann Rose and Mooch Williams

Programme Managers Injury Prevention - Home Safety

ACC

Preventing cardiac arrest before they die: recognition and management of the acutely deteriorating patient. Author: Roy Pryor.

Any situation that results in a hospital adverse event can have far reaching effects for both the client, their significant others and the hospital staff. Such events are not always sudden and unexpected and up to 70% are preventable (Considine & Botti, 2004; Smith & Nolan 2002). Despite this, the incidence of adverse events internationally has been estimated to be 3-4% (Considine & Botti, 2004) and in The Quality in Australian Health care Study in 1995 (Wilson, Runciman, Gibbard et al 1995) the incidence was reported as 16% of all hospital admissions.

The likelihood of an adverse event occurring increases with age as well as the potential for mortality or permanent disability following such an event. The incidence of permanent disability or death following an adverse event is less than 1.6% for those under the age of 44 years while those over the age of 65 years have a 3.8% likelihood of disability or death (Considine & Botti, 2004).

The pressure to move clients from the ED to the in-patient environment, combined with the ever-increasing demands on hospital beds means clients are often placed where a bed is available. This can sometimes mean that clients are inappropriately placed in areas where the condition they are admitted for may be sub-optimally managed. The effects of an inappropriate placement in the hospital environment can result in longer in-hospital stays further compounding the availability of hospital beds. These factors can increase the risk of an avoidable in-hospital adverse event by up to 13 times (Castle, Kenwood & Hodgetts, 2003).

Attempts to recognise these adverse events have been undertaken through the use of peri-arrest teams and the use of physiological assessment forms (Considine & Botti, 2004; Castle et al, 2003; King, 2006). Despite these attempts, the use and recognition of these activities is sporadic and often not supported throughout the hospital system. In an attempt to address the problem of in-hospital adverse events, the Hutt Valley District Health Board (HVDHB) has implemented a one-day course for all adult in-patient staff to attend.

The HVDHB is a medium sized second level hospital in the Wellington region providing district general and specialist services to both the local and regional population, as

well as a busy 24-hour Emergency Department. In late 2005 a project was started to introduce a programme of education around the recognition and subsequent early management of the acutely unwell patient, both in the general ward and Emergency Department (ED) areas.

The project was based on anecdotal evidence of patient deterioration in the general areas, supported by international literature that showed in-hospital arrests were often preceded by specific changes in patient observations (Hillman, Bristow, Chey, et al, 2002; Hodgetts, Kenward, Vlackonkolis et al, 2002; Kause, Smith, Prytech, 2004). It was also felt, that any tools to recognise and manage the medically sick patients that present to the ED would be beneficial especially out of hours when often junior medical staff are on-call for the medical and surgical specialities.

The Acute Life-threatening Events, Recognition and Treatment (ALERT™) course, originally created by Portsmouth Hospitals NHS Trust in the UK, was chosen as the preferred educational component to accompany the introduction of a physiological track and trigger or Early Warning Score system (EWS). As a multi disciplinary course, the ALERT™ is suitable for junior and mid level medical and nursing staff, as well as allied health professionals. The course includes components of teamwork and communication that were considered essential if reliable and repeatable improvements in patient management were to be achieved.

This one-day course comprises pre-reading, interactive case studies and lectures, and looks at simple management of airway compromise, respiratory support and oxygenation, circulatory compromise and subsequent support, as well as early involvement of senior or specialist staff. The interactive case studies allow the participants to talk through the management options for patients presenting with acute shortness of breath from asthma as well as exacerbation of COPD, hypotension, and a reduced conscious level.

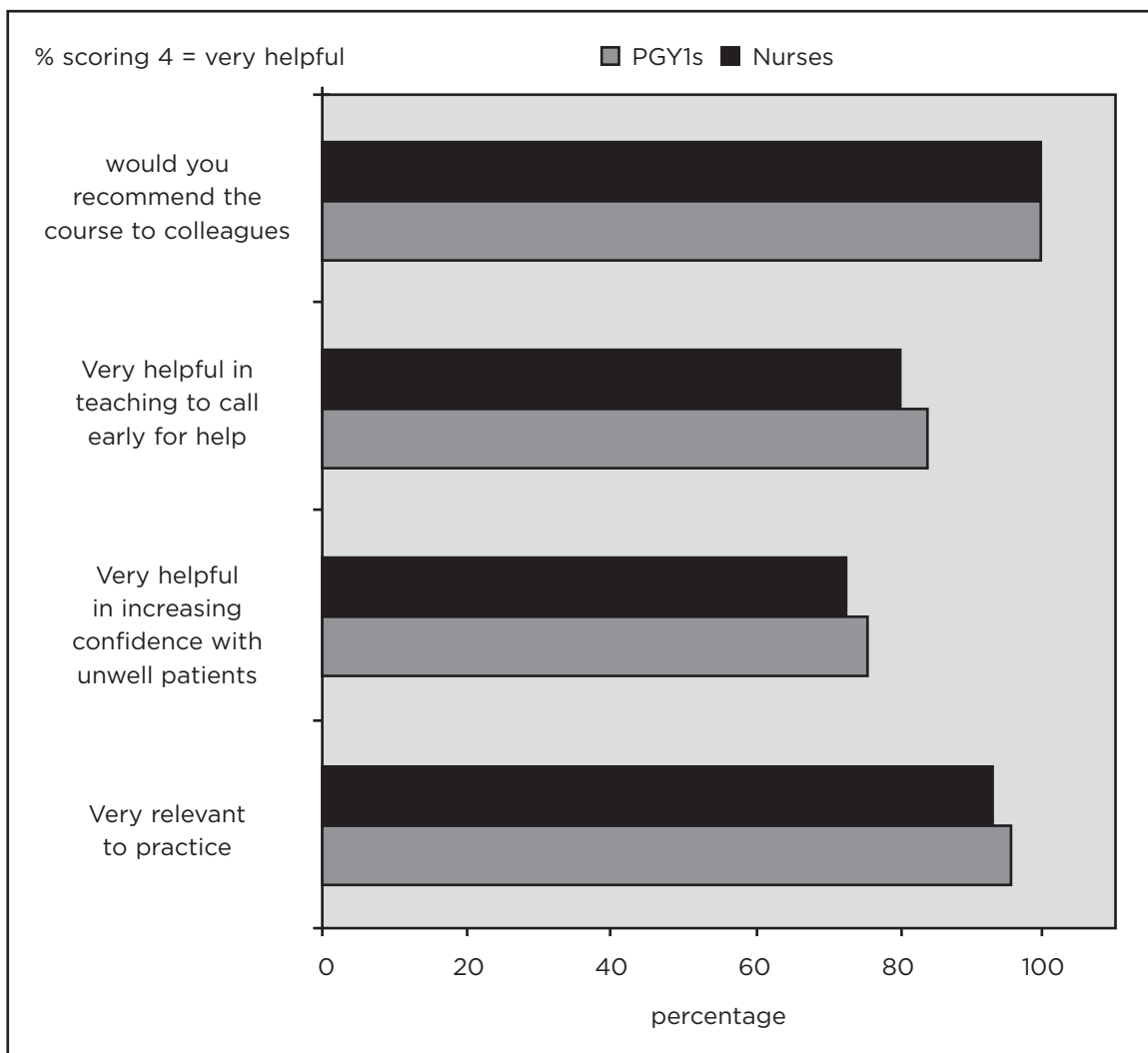
Practical scenarios allow the participants to work through the assessment and intervention model that the course teaches, with the early involvement of senior staff and good communication skill development, both verbal and written, being emphasised throughout the day.

Preventing cardiac arrest before they die: recognition and management of the acutely deteriorating patient.

The course has a degree of validation from studies in the UK, with an increase in both confidence and competence in junior doctors taking the course (Smith & Poplett; 2004), and the same has been seen in the HVDHB from an initial breakdown of the feedback results showing that

most candidates have found the course to be helpful and relevant to practice (see Table 1).

Table 1: Responses from 149 ALERT™ participants on usefulness of course to workplace environment (122 nurses 27 Post Graduate Year 1 doctors[PGY1])



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Preventing cardiac arrest before they die: recognition and management of the acutely deteriorating patient.

The introduction of the ALERT™ course supported the introduction into the hospital of an Early Warning System (EWS) and a nurse led Outreach Service. The EWS system is a physiological track and trigger system that allows staff to allocate a number to each of the standard patient observations and then total the score for that patient at that time (Table 2). The higher the total score the more serious the patient's condition and the faster and more senior the response required.

The nurse led Outreach Service is designed to support and help the ward nurses and junior medical staff in the management of these acutely unwell patients. Following this introduction, usage of the EWS and referral to the Outreach nurse increased as the number of staff in the ward areas attending ALERT™ increased. EWS is used routinely in the ED to both identify sick patients and also benchmark a start point for the ward staff when a patient is admitted.

Table 2. Early Warning Score calculation table.

Version 5	Value						
	3	2	1	0	1	2	3
Temperature (oC)		≤ 35.0	35.1 - 36.0	36.1 - 38.0	38.1 - 38.5	≤ 38.6	
Pulse (bpm)		≤ 40	41 - 50	51 - 100	101 - 110	111 - 130	≤ 131
Systolic BP (mm Hg)	≤ 70	71 - 80	81 - 100	101 - 179		≤ 180	
Respiratory Rate (bpm)		≤ 8		9 - 14	15 - 20	21 - 29	≤ 30
CNS Level: Patient responds to:			New agitation / confusion	Alert	Voice	Pain	Unresponsive
Urine output (ml/hr) for 3 consecutive hrs	≤ 9	10 - 30		≤ 31			

Preventing cardiac arrest before they die: recognition and management of the acutely deteriorating patient.

The ED senior nursing staff have all been through the ALERT™ course, and many now return to teach, passing on their experience of managing acutely unwell patients to the general area staff that may not have the exposure to these patients that the ED teams do. The ALERT™ course is also now firmly established as part of the ED development programme, with new nurses joining the ED team attending this before moving on to the New Zealand Resuscitation Council level 6 course.

Recent high profile cases of patient safety that have identified the failure to recognise the severity of a patient's condition on admission from ED to a general ward have further increased the importance of ensuring that the process of recognising and then managing the acutely unwell patient begins at the front door (HDC Panui, 2008; Seddon, 2007). The ALERT™ course is seen to be helping the HVDHB to ensure that staff are able to recognise the potential adverse event, or perhaps more importantly, recognise when they need help and then call for it.

Whilst feedback on the course is encouraging, further work is needed to assess the impact of the introduction of the ALERT course in conjunction with the EWS and Outreach teams on reducing the incidence of in-hospital adverse events relating to physiological abnormality.

The HVDHB was the first ALERT™ provider centre in Australasia, and is now the New Zealand Training Centre for the course. The ALERT™ courses are run for both internal and external staff, and the HVDHB also run Trainers Courses that will allow other District Health Board's (DHB) to set up their own provider centre running courses for their own staff as well as local health professionals.

Recently the Auckland DHB established the ALERT™ course for their employees in April of this year. Other centres are undertaking to establish the course for their staff, the Capital and Coast DHB (October 2008) and Mid-Central DHB should be set-up in the near future. As well as in New Zealand, the ALERT™ course has been established in Australia at the Joondalup Health Campus in Perth in March 2008.

References.

- Castle, N., Kenward, G. & Hodgetts, T.J. (2003). Avoidable cardiac arrest: Lessons for an A&E department. *Accident and Emergency Nursing*. 11 196 - 201
- Considine, J. & Botti, M. (2004). Who, when and where? Identification of patients at risk of an in-hospital adverse event: Implications for nursing practice. *International Journal of Nursing Practice*. 10(1): 21 - 31
- Hillman, K.M., Bristow, P.J., & Chey, T. et al. (2002). Duration of life-threatening antecedents prior to intensive care admission. *Intensive Care Medicine*. 28(11) 1629 - 34
- Hodgetts, J., Kenward, G., & Vlackonkolis, I. et al. (2002). Location and reasons for avoidable in-hospital cardiac arrest in a district general hospital. *Resuscitation*. 54(1) 115 - 123
- Kause, J., Smith, G., & Prytech, D. et al. (2004). A comparison of antecedents to cardiac arrests, deaths and emergency intensive care admissions in Australia and New Zealand, and the United Kingdom - the ACADEMIA study. *Resuscitation*. 62(3) 275 - 282
- King, D.A. (2006). In-hospital cardiac arrest: Risks and opportunities. *Emergency Nurse NZ*. 4(7) 21 - 27
- Smith, G.B., & Poplett, N. (2004). Impact of attending a 1-day multi-professional course (ALERT) on the knowledge of acute care in trainee doctors. *Resuscitation*. 61(2) 117 - 22.
- Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD (1995). The Quality in Australian Health Care Study. *Medical Journal of Australia* 1995; 163: 458-471
- HDC Panui. *Learning from mistakes, a nationwide patient safety initiative*. [http://www.hdc.org.nz/files/hdc/publications/hdc-panui-dec07-\(english\).pdf](http://www.hdc.org.nz/files/hdc/publications/hdc-panui-dec07-(english).pdf) accessed 10th September 2008.
- Seddon M. (2007). Safety of Patients in New Zealand Hospitals, a progress report. 6th October 2007 <http://www.hdc.org.nz/files/hdc/publications/seddon-review.pdf> accessed 10th September 2008

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Lower Hutt,

New Zealand.

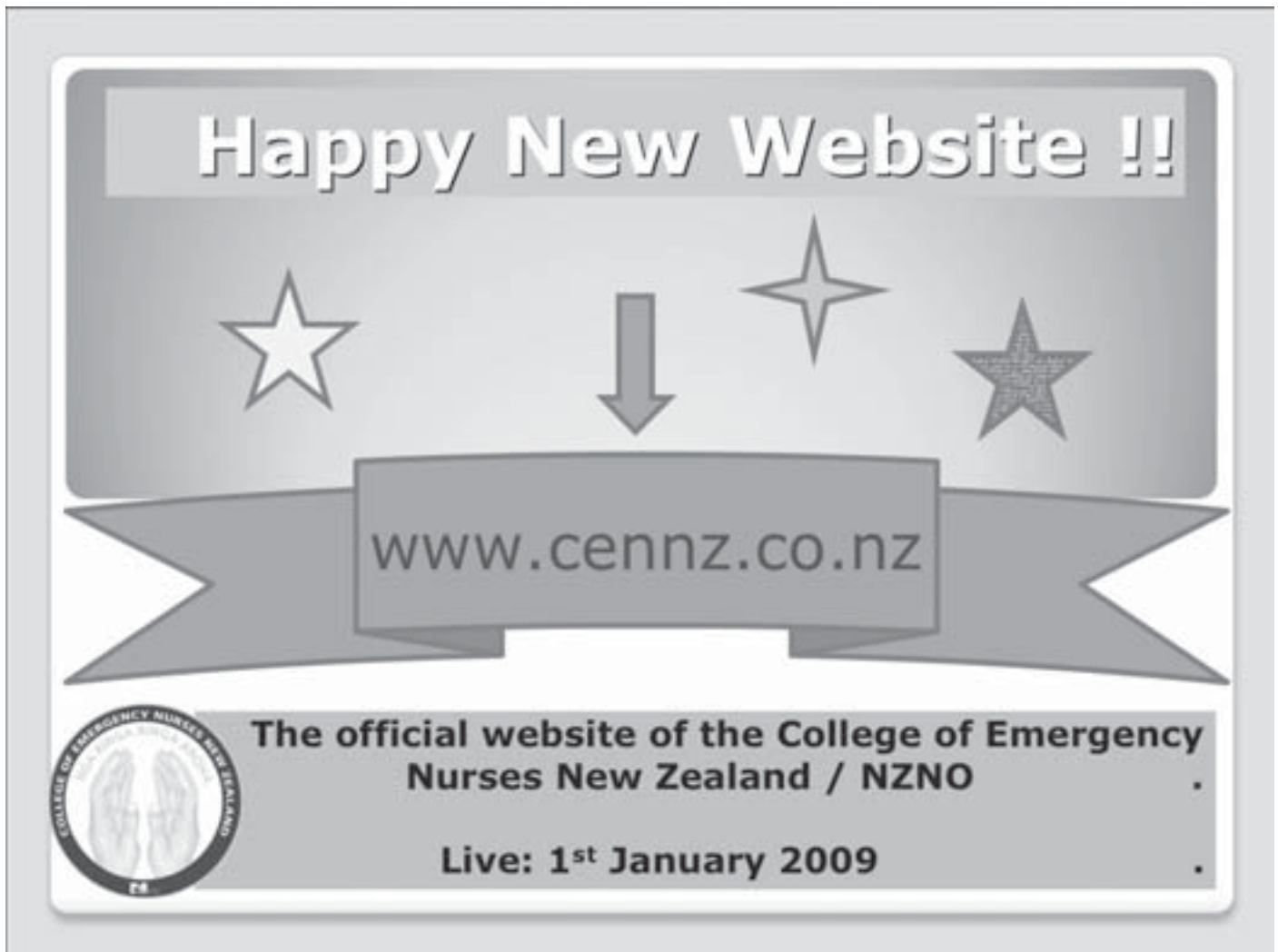
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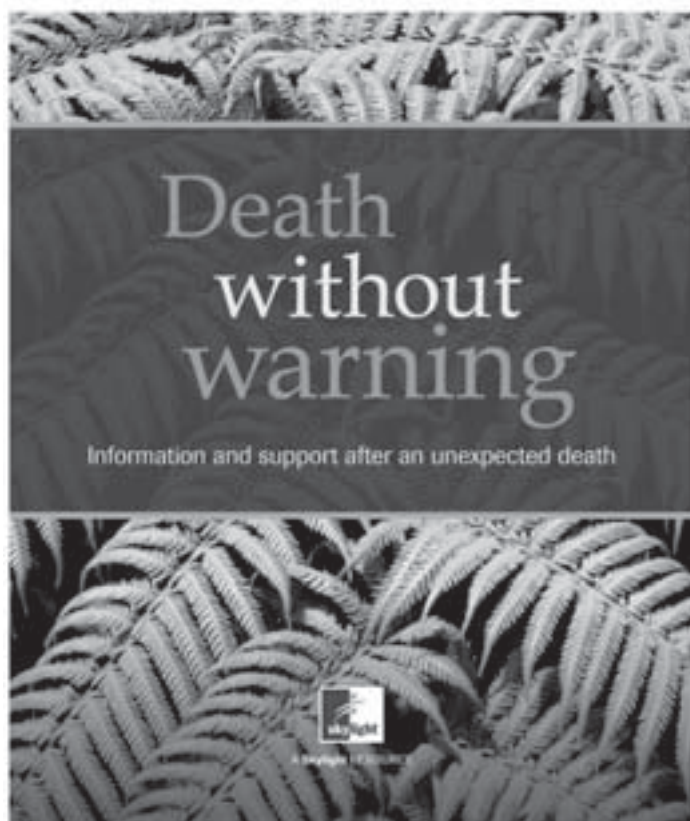
Conflict of interest; Hutt Valley District Health Board has a financial interest in the ALERT course as the New Zealand Training Satellite, and in the production and sale of ALERT material.

New CENNZ Website



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It will also assist professionals in learning more about what happens after a sudden or unexpected death in New Zealand, and about the grief that follows.

See contents list overleaf...

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Skylight - www.skylight.org.nz

Authors:

Lynne Ewart, Hazel Nesor & Tricia Irving Hendry

ISBN:

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Clinical Case Study Showing Prescribing Practice: Asthma.

Author: Michael Geraghty.

Clinical Presentation.

Miss P is a 21 year old Iranian woman who has lived in New Zealand for the past six years.

She has a previous history of asthma, eczema and seasonal rhinitis.

In early November 2008 she presented to the emergency department with a primary complaint of exacerbation of asthma as indicated by increased use of her salbutamol inhaler (Ventolin™) and shortness of breath. She had been symptomatic for 24 hours, and felt that this episode had been triggered by a sudden deterioration in the weather. By the time she presented to the emergency department she had run out of her Ventolin inhaler.

She was initially seen by the triage nurse and allocated as a triage four.

Her normal medications were:

1. Ventolin 100mcg/dose MDI PRN
2. Beconase™ 50mcg MDI PRN

She did not smoke.

She had no allergies to prescribed medications

Examination.

Vital signs:

Temp: 36.1. Respiratory rate: 24. B/P: 110/ 80. HR: 109. SaO₂: 100%

PEFR: 330. She was unclear of what her best peak flow was.

She was speaking in full sentences and appeared undistressed but complained that her chest felt "tight" and she could not take an adequate breath

She had equal air entry bilaterally with no overt wheeze but increased bronchial sounds.

She had a non productive cough.

There was no evidence of cyanosis or use of accessory muscles.

Other assessment considerations:

Miss P reported;

1. daily use of her reliever medication (Ventolin),
2. night time waking to use her pump and
3. she was unable to engage in any physical activities (sports, gym) without relying on her inhaler.

These are all indicative of poorly controlled asthma (British Thoracic Society 2008).

It was also apparent that Miss P had little knowledge of her condition and would require further follow-up on being discharged from the emergency department.

The impression was of a mild / moderate exacerbation of her asthma.

There was no indication for the need for any further investigations such as an arterial blood gas, chest x-ray or other routine bloods (NZGG 2002).

Clinical Intervention.

1. Nebulised Salbutamol 5 mg with three doses spaced at 30 minutes apart.
2. Nebulised Ipratropium bromide 500mcg stat dose.
3. Prednisone 40 mg orally stat dose

Her ongoing response to this medication was monitored by taking a full set of vital signs, including her PEFR and most importantly her subjective reports on how well she felt she was responding to the medication.

Her PEFR improved to 480 and whilst she had no previously recorded best PEFR this was deemed reasonable given her size and weight. She reported feeling able to breathe more easily and was discharged to the care of her partner. She was observed in the emergency department for three hours and deemed fit for discharge.

Clinical Case Study Showing Prescribing Practice: Asthma.

Treatment Rationale.

Inhaled salbutamol is superior to a metered dose inhaler (MDI) by virtue of the larger dose given, the supplemental oxygen and the fact that the medication is delivered directly to lung tissue. Salbutamol is a beta agonist which relieves bronchospasm and is the first line drug for asthma treatment.

Ipratropium bromide provides anticholinergic activity and alongside a beta agonist provides better bronchodilation than a beta agonist on its own. The combined dosing leads to a faster recovery and shorter periods of hospitalisation.

Steroid therapy (prednisone) given orally is proven to be as effective as inhaled steroids or those given intravenously in mild to moderate asthma. Best practice guidelines support the use of higher dose therapy (30 - 60 mg in an adult) but for short dosing periods only (5 days). They can be stopped suddenly without any adverse effects and are usually replaced during this period with an inhaled steroid. There is no indication for the use of an inhaled steroid in mild to moderate asthma (NZGG 2002).

Outcome.

Miss P was discharged to the care of her partner and with the following medications:

1. Fluticasone propionate, 125mcg/1dose. Metered Dose Inhaler. Two puffs, twice a day
2. Prednisone 20mg Tablets, 2 tablets daily, 5 days
3. Salbutamol sulfate, 100mcg/1dose. Metered Dose Inhaler. Two puffs as required, 2 inhalers

She was observed and deemed to have a good inhaler technique but at this stage declined the use of a spacer. Miss P was given specific education on both the expected effects and expected side effects of the drugs she was prescribed and advised to see her GP within 48 hours of discharge. She was further advised on the signs and symptoms of deterioration in her condition and how to manage this appropriately. It was important to

educate both her and her partner on clinical symptoms and appropriate use of emergency services.

It is estimated that 15% of the New Zealand population has asthma and the cost in terms of health care, loss of earnings the impact on the family is conservatively around \$370 million dollars per year. The majority of this cost is due to poorly controlled and under treated asthma (NZGG 2002) and it was clear that Miss P had very poorly controlled asthma and this was having a negative impact on her life. Miss P was referred to respiratory nurse specialist (ADHB) and seen in clinic a month later and seen in conjunction with a respiratory specialist. Their impression supported my initial findings of poorly controlled asthma and she was continued on the inhaler regime I had prescribed with a review at two months for repeat spirometry and expired nitric oxide measurement.. The review at two months showed she had a marked increase in her expiratory volume as measured via spirometry but more importantly was hardly using her Ventolin inhaler, was able to exercise without any limitation and had no side effects from the medications prescribed. As a consequence she had no time off work during this period and was sleeping through the night undisturbed,

Summary.

In respect to asthma the knowledge of the disease process plus the increased sophistication of medications has led to a marked reduction in mortality in NZ but a large proportion of the population continue to suffer from poorly controlled and under treated asthma.

Miss P presented with an acute but mild to moderate exacerbation of asthma and it is the emergency departments' responsibility to treat these presentations appropriately. Education and prevention should be part of that treatment package and in this particular case the positive outcome was profound. We should not always assume that any person with a chronic illness who has repeated presentations to any ED service is fully aware (and educated) of their illness or that their current treatment regime is optimal.

Clinical Case Study Showing Prescribing Practice: Asthma.

References.

1. British Guideline on the Management of Asthma. A national clinical guideline British Thoracic Society / Scottish Intercollegiate Guidelines Network May 2008.
2. The diagnosis and treatment of adult asthma New Zealand Guidelines Group September 2002.
3. Asthma in New Zealand - time to get control. Richard Beasley and Matt Masoli New Zealand medical Journal. 16th May 2003. Vol 116. No. 1174

Michael Geraghty is an emergency nurse practitioner and works at the adult emergency department at Auckland City Hospital.

Living la vida locum. Author: Iona Bichan.

Love 'em or loathe 'em, locums are part of the healthcare landscape. Our ED has lived with lots of locum doctors for the best part of a year. They included:

- house surgeons trying to pay off their student loans
- registrars moonlighting from other DHBs for extra cash
- GPs
- doctors on parental leave from their regular work
- random doctors begged from other places round the hospital
- FACEMs and registrars from other EDs who took mercy on us in our plight

Who knows? One of your own doctors may be a secret locum!

Once they're in their scrubs, locums blend into the scenery –they look like any ED doctor. But lurking beneath that uniform exterior is a wide range of skill, knowledge, and enthusiasm. The patients can't necessarily tell the difference, but the nurses can. The sight of a new locum strikes a mixture of delight and dread into the heart of the most hardened ED nurse. Here are some tips from a department with months of experience in living with locums.

Grasp the locum by the horns. Introduce yourself and welcome them to your department. Find out where they're from, how much ED experience they have, and most importantly, how long they are going to be working in your ED. The length of time they are going to be with you will determine how much energy you will put into training them. The longer they are going to spend with you, the more effort should be put into the ground work on arrival, as follows.

One or two days: These locums require minimal input. If you can't remember their name, just call them 'doctor'. Do any unavoidable computer work for them. Watch them carefully to catch major glitches early. Show them where to put their bags and where the toilet is. Remind them how to get back to their hotel and where the airport is prn.

Several days: If they're going to be with you for up to 10 days, they need moderate input. On day one, show

them the basic equipment, the staff room, the café, and teach them the computer access codes. Check on them frequently to prevent any glitches. Clear up any confusion they create as they blunder around an unfamiliar department. Learn their name.

More than a week: As above, but learn their name and some personal details. Take them to the next level of the workings of the computer system. When they pretend helplessness, tactfully remind them that you have taught them that procedure already. Share the newspaper with them in your break. Remember their name without having to check the roster.

Over a fortnight: As above, but expect them to know how to get round the immediate vicinity of the ED. Be less than tactful when they pretend they can't do something you have taught them five times already. If they're any good, show them the secret coffee stash in the staff room and start pressurising them to stay longer. Expect them to recognise 'frequent fliers', and to know your name.

Over a month: As above. Also, invite them onto the department's indoor soccer team. Tell them off when they pretend they can't work the computer system. Fight them for the crossword in the paper. Coerce them into buying morning tea when they leave. Give them a nickname.

Getting the best out of your locum.

Just like ordinary people, locums have strengths and weaknesses. Identification of these helps nurses to use locums to improve patient flow. For example, forcing a locum who is an internal medicine registrar to see all the paediatric presentations could be regarded as cruel and unusual punishment. Rather, they can be directed to see all the 'collapse query cause' patients, leaving other doctors to get on with everyone else. It should be remembered, though, that allowing a locum the right to self-select patients can lead to ill-feeling among the doctors. Careful management enables you to play to the locum's strengths while minimising the effects of any weaknesses they may have.

Living la vida locum.

Beware of over-confidence. Judge their work by what you see, not what they say. Confidently expressed opinions are not necessarily correct. Stick to your hospital's policy if there are any disagreements. Don't be lured into bizarre or unfamiliar procedures just because they say they "do it all the time".

Make some allowances. Adapting to a new environment can be stressful. Some locums work in multiple locations and have become skilled at rapid orientation. Other locums are less practiced, and may struggle to settle in. Treat them kindly, and remember that any repetitive questioning is not because they are trying to annoy you.

Having said that, avoid the temptation to let problems with their work slide because they are only with you briefly. You never know when they might be back. A small irritation with a short-stay locum can turn into a major issue when you have to deal with it for days or weeks on end. Think of the greater good of the health system- they will be working in other hospitals too!

Don't talk dollars. The exorbitant hourly rates for locums are public knowledge. It doesn't engender good team spirit to go on about it. Remember that while they may be earning more than the entire shift of nurses, it's not actually their fault.

Having said that, expect them to pull their weight. It's not fair for your regular doctors (if you're lucky enough to have some) to do all the grotty shifts as well as the difficult patients. Especially when they're being paid less.

Running an ED on locum doctors brings unique challenges. Wise management of your locums involves exploiting the positive aspects of the situation and minimising the drawbacks. Follow our advice and you might find yourself enjoying living la vida locum.

Iona Bichan, ED Charge Nurse, MidCentral Health.

No offence is intended to any individuals or groups.

No locums were harmed in the writing of this article.

CENNZ / NZNO Pacific Grant - 2008.

I was really excited to learn that I was to receive the College of Emergency Nurses Pacific Grant last year. The intention was to organise and run a triage workshop alongside the South Pacific Nurses Forum 2008 to be held in Suva late last year.

With an emergency nurse background and an Instructor on the New Zealand triage course I was excited to have the opportunity to share my knowledge and experience within at this forum.

Although in liaison with the Fijian Nurses Association we were unsure how many participants were going to attend it only added to the excitement and the decision was to plough ahead.

I decided to enlist the services of a fellow triage instructor Lynnne Baines from Waikato Hospital to assist with teaching. We arrived into busy Suva amidst political tension pending the supreme court hearing decision in relation to a hearing that questioned the legality of the 2006 military takeover. We were blissfully unaware at first of the potential outcomes pending the decisions of the courts but never the less became aware of the growing number of road blocks and the increasing visibility of the military forces around town. Ignorance is a good thing I guess however all came crashing home when on the first morning of the workshop we were collected by one of the nurses from the Fijian Nurses Association who gave us a little background of what was going on and then proceeded to tell us that all would be ok as she had sought our personal protection from the president himself should things become unstable! We felt so reassured as we rumbled through Suva town past are 3rd road block wishing we had decided to bring our passport out with us!

Out at the Tradewinds Conference Centre set amongst lovely rockery and palm tree gardens along side a lagoon we settled into our little conference room which had been prepared for us by the conference organisers with lovely Fijian cloth dressing the tables and a little air-conditioning unit to keep us cool.

Lynnne and I had modified the current triage module we offer here in New Zealand to concentrate on essential emergency assessment and the triage decision. As the day proceeded we heard amazing stories and experiences

the Fijian nurses have had within their hospital and clinic settings and found out quickly we needed to again adapt the workshop over the day to best to meet their needs within their current practice.

We found that triage is not practised on the whole throughout Fiji but the nurses were keen to take this learning back to their work places.

I loved every minute and learnt heaps about the generosity and warmth of the Fijian nurses. We were welcomed and looked after and at the end of the workshop every participant got up and shared what they had learnt as is their custom but with so much warmth and sincerity that it touched me.

I was honoured to share this time with the Fijian nurses and have been so enriched by this experience that it is hard to put into words. In total 20 nurses from Fiji and the outlying islands attended the courses.

Having met some wonderful people I hope to return again. I thank the College of Emergency Nurses New Zealand for the opportunity and the Fijian Nurses association for their hospitality.

Gabby Harsveld.

Clinical Charge Nurse

North Shore Hospital.



Regional Reports.

Northern Region

Jill Mortimer

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Adult Emergency Dept.



Hope you have all had a safe and happy summer, and work has not taken too much of a toll.

It is a challenge to write this as I am at present on holiday! The weather has been, from my perspective, absolutely wonderful – such that I have HAD to spend time at the beach. I'm concluding the rest of my holidays with packing house to move, although I am remaining in the same area.

The biggest news from Whangarei this issue would have to be the employment of our first ever Graduate nurses in the Emergency Department here. I am very excited to report that two Graduates started with us this month. It has not been necessarily the most optimal beginning – one started straight on to night shifts, and due to losing a few senior staff members it has been difficult to ensure their preceptors can be working in appropriate areas – but the journey has begun! We look forward to continuing to support these newest team members as they flourish, developing their capabilities, knowledge and caring.

My holiday mood has been a little shaded with sadness, due to the bleak event of the fires affecting our Australian neighbours. I'm sure your hearts go out to them, just as mine does. What a time of tragedy!! I was reminded again of how caring nurses are, as I listened to the report of their immediate response, giving up holidays and days off to come in and help the victims of the fires.

What an honourable profession we share!

Jill Mortimer

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Auckland Region

Mike Geraghty

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As the editor of the journal I receive all the other regions reports and have a quick read, I then try to find something a bit different and original in to mine but once again I seem to fall back on the fact that Summer has been busy. Auckland ED / ADHB has some fairly robust and sophisticated cascade policies for dealing with access block in our ED but despite these we have had some very scary shifts in the past months.

On 25th February the senior nursing and medical staff had an 'away day' to discuss issues of patient care, patient flow and other issues that might improve overall quality. I am not at liberty to go into detail about outcomes at this stage but I personally came away feeling we had achieved a number of creative and constructive changes and look forward to there implementation in the near future. Watch this space.

Waitakere.

Waitakere ECC have made a strong commitment to the development of a clinical nurse specialist service at their ED and will look to employ 3-5 CNS's early this year. Training for the role will include in-house lectures provided by nursing and medical colleagues plus mentoring at other regional ED's who already run similar services.

No reports available for NorthShore and Starship ED's

Regional Reports.

Auckland Region

Glenys McSweeney

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Emergency Care
Middlemore Hospital



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So what's been happening at Middlemore.....

EC would like to extend their congratulations to Vanessa Thornton as she was announced as Emergency Care's new Clinical Director replacing Bhavanni Peddanti shortly after my last report was submitted to the journal for publication. Congratulations is also extended to Michelle Pepperkoon, Milly Macks and Renita Antonio who have been accepted and commenced on the internship for Nurse Specialist, working towards the roles of Clinical Nurse Specialists with in EC.

A trial has been running now for a few months with a change of duty hours for the Associate Clinical Nurse Managers, they have gone from doing 12hr shifts during the day to 10 and 8 hours. This allows for an overlap from 11am to 5pm with having 2 on duty. Presently the ACNM that starts at 11am concentrates solely on patient flow, based in the Assessment area of the dept. One of the positives of finishing duty early is that we still feel human!

A huge amount of time and effort has been placed on patient flow and the maximum 6 hour time frame for patients to be in the dept. A noticeable decrease of time the corridor spaces have been used is very evident. Such a positive for the staff working in area's where this was a common occurrence. The "Flexi Ward" (as mentioned in previous reports) continues to be opened as a means of moving patients out of EC to a 'holding' ward until beds in the hospital become available for them. There have been occasions where bed block and demand for beds has been so great the Flexi ward has remained open over night.

It's that time of the year where 'Uni' is about to start, best of luck to staff that are doing Post Grad studies.

Glenys McSweeney

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Midlands / Bay of Plenty Region

Lucien Cronin

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Hello CENNZ members and ED nurses, how's everybody doing? Actually, having just attended the CENNZ committee meeting, I already know the answer to that question, more or less. (1) You are busy. (2) There aren't enough of you. (3) If you are one of the dwindling numbers of senior staff, you are buddying new grads, nurses new to ED, paramedics, military nurses. (4) If you are a new grad or new to ED, you're thinking "wow, this really is like ER!"* (5) You might be in, building, or planning a new facility. (6) Your ED may well have newly appointed Clinical Nurse Specialists. Heck, you might even be one yourself! (7) They might be building or planning some kind of acute planning unit to improve the patient journey. (8) And finally, if you've been paying attention, and depending upon your disposition, you might be saying "Go Tony!" or "Yeah right, Tony." In other words - same old story, but we do have a Minister of Health who is very forcefully saying that the same old story isn't acceptable.

Here in Tauranga (which, as it happens, is more or less Tony Ryall's home turf) pretty much all of the points made above apply. We have a brand new acute care area consisting of 3 resuscitation bays, half a dozen acute care beds, and an isolation room. However, we have resisted opening this area until we have recruited enough new nurses to safely staff the expanded department - so if you'd like to come and live in the lovely city of Tauranga, dust off your C.V. and let's be hearing from you. We continue to stoically endure refurbishment of the existing department. Our pseudo-three bed treatment areas which were originally designed as two bed areas, but then had another bed squeezed in, have been converted back to two bed areas with a wall dividing the two bed spaces. Now we don't have to worry about someone's bum knocking our elbow through the curtain just as we're about to insert a cannula. Next project: conversion of the old resuscitation rooms to standard treatment areas (once we've opened the new acute care area)

Cont... overleaf

Regional Reports.

Midlands / Bay of Plenty Region Cont...

We anticipate trialling CNS positions from May onwards, which is an exciting development for the department as a whole, and one which we anticipate will enable us to provide a better service to the people of the Western Bay of Plenty.

I had a chat the other day with Wendy Sinclair, one of the clinical nurse specialists at Waikato ED. Waikato are planning a new emergency department and APU. The ED is long overdue; one of the biggest and busiest EDs in the country badly needs a new facility. Aside from this news, Waikato faces much the same challenges as we all do. I've not been in touch with the other EDs in the region to see how they are faring.

A couple of milestones: we sadly farewelled our dear Ange (Angela Russell), who has gone to pursue her flight nurse career in Hawke's Bay. Ange has been a ray of sunshine in the department for the past decade or more. Sorry to see you go, Ange, but you know we wish you all the best! And in early March, we raise a glass and toast Neil Adams, who has been a stalwart of Tauranga ED for twenty three years. In that time, Neil has watched the department grow with the city as Tauranga has evolved from a small town to New Zealand's fifth largest city. Congratulations Neil, and we look forward to celebrating your quarter century in ED in 2011.

Cheerio for now.

Lucien Cronin

Staff Nurse

Tauranga Hospital Emergency Department.

*OK, this one might not be entirely true.

Hawkes Bay / Tai Rawhiti Region

Robyn Price

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The drought has finally broken in our region with widespread rain and cooler days. Unfortunately this is at a time when the region is busiest with all the outdoor concerts.

The mission concert is this week with bad weather forecast. Good luck to all those working!! We know it is part of our job but these events do put an extra strain on our resources as it must for all regions. We know we need extra staff for these days but where do we get them from?

The ED waiting room has now been refigured and we are about to alter the triage system so that the triage nurse will be the first person the patient sees as they come in the door and not the receptionist as it has been until now. No doubt there will be teething problems, but they will get ironed out and things should go well. This also frees up a room where hopefully a lot more minor injuries and the like can be sorted. This will then free up the waiting room a bit more, we hope! Of late we have been regularly having over 20 patients waiting to be seen!! Not good practice.

We have had some arrivals and departures over the last 3 months. The lucky ones leaving to travel overseas! Nursing is such a good career to have to travel the world with. New arrivals are very welcome and bring new skills. We only have the one new graduate this year. She is showing great enthusiasm for ED nursing. I wish her well.

A lot of our staff are doing tertiary studies this year. This also strains a department but is of great benefit to us all. Good luck to you. Please bring your knowledge back to ED and share it with us all!

Numbers over summer have not slackened. This is a nation wide problem that hopefully the new government will address!! We are regularly short of beds in the hospital and physically in ED. If this continues, I see a lot of nurses burning out and leaving which will make the problem worse. We all need to be vocal to our MP's and also flood the system with incident reports.

Cont... overleaf

Regional Reports.

Hawkes Bay / Tai Rawhiti Region Cont...

I believe that the problem must be addressed from the discharge process back, not starting in ED. ED does draw the short straw often and I am amazed by the resilience and capabilities of our staff, both nursing and medical. It is great what good team work in the department will achieve.

For all the problems that as a nation we seem to have in ED and nursing in general, I still love my job! The satisfaction in making a difference to someone in the acute stage of their medical problems is immense. Even the little things matter!

Go forth all you ED nurses. You are a legend!

Robyn Price

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Central Region

Janine Kereama

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Emergency Department

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It is not surprising that 2008 saw the largest presentation rates for ED and the highest number of annual admissions for Mid Central Health. Sort of nice to see that in this economic climate we are involved in a growth industry, however, it is unfortunate that the resources needed to ensure the effective delivery of this service are unable to be “flexed up” to accommodate the industry demands. December saw an uncharacteristic busy time in Palmerston North, perhaps a regional delay in the exodus to warmer, sandier pastures. We had our usual roster gaps that I am thrilled to report are getting gobbled up in the New Year, with a steady stream of new staff joining our team. It is a really good feeling to see enthusiastic nurses wanting to train in emergency care, the challenge to us all is to support their practice and ensure nurses stick to this speciality. It is of interest to note at the nurses who left ED most recently have done so for roster issues, and the desire to work Monday to Friday.

The CENNZ national committee meeting in Wellington in February welcomed Mark Jones (Nurse Advisor to the Minister of Health). We discussed a directive that the Minister of Health has sent to all DHBs holding them accountable for the delivery of patient care, and that a whole systems operational plan should be in place to ensure this. Irrespective of ones personal political alliance, this is great news to the emergency nurse in that CEOs have been instructed to take a stance on the delivery of effective care in its entirety. This in practice should ensure the entire patient journey becomes a priority and EDs may actually have a chance to achieve nationally set targets.

Words like “working smart” plague some companies but are very hard to incorporate in daily operational plans as few options are available to ED nurses when issues outside of the department effectively block them. My hope is that directives from board level may alleviate the burden on departments and ensure patient responsibility and care becomes a DHB, not just a departmental focus. I am confident that this in turn will produce happier nursesbecause it is about us too!!!!!!!

Regards

Janine Kereama

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Regional Reports.

Central Region Cont... / Wanganui

Mark Quin

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We have had a great summer in Wanganui, which translated into a much calmer December / January period with patient flows being more even and therefore manageable although on paper the numbers were higher than normal. It was also pleasing to see a decrease in the presentations of overdoses & attempted suicides over this period compared to other years.

With the new year, our new general manager led the drive to finally address the staffing model discussion that has long plagued and overshadowed the re-development of Wanganui Hospital and in particular the ED. ED had extensively argued and provided submissions regarding staffing levels over the last 12 months as the most dramatic reductions were in the ED. At this time this has been successful, with the FTE required to maintain current staffing levels being accepted by the senior management team.

In the new year, ED has also increased the pressure on the senior management team for the DHB to replace our very old and paper base patient management system for a dedicated purpose designed ED system, as from our perspective the risks are becoming too high and further validated in an article in the Dominion Post in late November by Ron Jamieson commenting on the risks EDs carry still using such systems.

Staffing movement has slightly increased, with 2 of our senior nurses stepping up into Bed manager & duty manager roles, which has been useful due to their ED background, but a big thanks to Rotorua ED for providing us with a new CNE, Cormac Peirse, who is proving to be an asset. New initiatives being started shortly, is starting the education of the 6 hour rule to not only ED staff but the rest of the hospital, as like many other EDs, we suffer the effects of "capping" and other such excuses for not being able to shift patients from the ED.

We are also developing a dedicated paediatric assessment form as a result of feedback from peer reviews and our paediatric team and conducting a survey on playground accidents in conjunction with the local city council.

That's all from us

Cheers

Mark Quin

Wellington Region

Karen Blair

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Hi all from the Wellington region. The silly season is hopefully over and now it's the lull before the winter season. Or if you're like me the last few years have not been as well defined and it all seems to roll into one.

I was lucky enough to attend the Optimising the Patient Journey seminar held in Wellington at the end of February and caught up with a few others from the Wellington region. It was great to hear how all these lean thinking principles can be applied to our workplace and potentially improve that dreaded patient flow through our increasingly overloaded emergency departments. Capital and Coast DHB have started on the 3:2:1 target across their hospital and reports to date show the ED are having less corridor patients which is promising. Wairapapa DHB have introduced a Triage/coordinator role across their acute floor which includes ED, APU and ICU which to date has been well received and means now that people coming to ED see a Triage nurse on arrival well done. At the Hutt there are a number of initiatives underway to optimise the patient journey the one presented at the seminar was a change in how inpatient beds are booked. Instead of ED being responsible for finding beds for patients the ED staff are trialling handing over to the service concerned leaving them the task of finding a bed. If there isn't one available on the ward then involves the bed manager. All these initiatives show a willingness of the nurses and DHB's in our region to share the responsibility of fixing ED overload which is great. Keep up the good work...

Despite the hard work I am constantly amazed at how motivated ED nurses are. All the best for all those nurses who have enrolled in post graduate study for 2009 and for those who are attending TNCC and Triage courses around the country. It's your motivation and commitment to providing quality care that makes ED's not always such a bad place to be.

After the 100 days of a new government I leave you to ponder how we as Emergency Nurses can take on board The Rt Hon Tony Ryalls key health message.

BETTER, SOONER, MORE CONVENIENT.

Karen Blair

Regional Reports.

Top of the South Region

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We have had quite an interesting time hosting many visitors to the region. During the holiday season we felt we had become a tourist destination at times and one staff member suggested there may have been a brochure at the local visitors centre describing the benefits of our emergency department! As well our local regional rescue helicopter seemed to be a preferred mode of travel to the emergency department with increased flights to our door. With the usual rush to get to our gorgeous region to enjoy a holiday, traffic volumes on roads increase, distractions from the fabulous scenery and with tiredness added into the mix, then the inevitable road traffic injuries occur. Many young people also travel to this region to welcome in the New Year, partaking in the many festivals with the help of many substances. You know where I'm heading here! For the second year running in Nelson, an alcohol audit was taken over the holiday period of everyone presenting with alcohol related injuries. Numbers had increased. This year a second step was introduced with a referral to an alcohol and drug counselling service for follow-up. I hear they were overwhelmed with referrals.

We have magnificent beaches that provide a watery playground for many locals and visitors. Severe sunburn has been the usual worry here. This summer stingrays have become the new most feared creature of the oceans along Nelson beaches. Beaches were cleared when alarms were raised that suggested a shark had attacked a third beach goer. A stingray was again the culprit and reports that stingrays have been seen so thick off Tahunanui Beach they were like paving stones, adds a new dimension to sea swimming and education to ED staff on injury treatments. Increasing patient presentations and heavy staff workloads continue with little respite. A trial of two extra shifts over Christmas and the holiday season utilising existing staff has made a noticeable improvement to staff workloads on the days when those shifts are filled. We are hoping that staff numbers can be increased in the future to meet the continuing demands placed on us.

Projects being undertaken by members of our nursing team including a nurse initiated pathway for fractured neck of femur patients and a thrombolytic audit over the 2008 looking at our performance from door to needle time.

Top of the South Region Cont...

Murchison Hospital & Health Centre

Carolyn Walker reports

We have a small team here who provide a 24/7 emergency service as well as PRIME response. There are four PRIME trained regular staff members and one more booked for training in May. We also have two casual staff members who are PRIME trained. Between 1 December 2008 and 31 January 2009 we had 19 PRIME call outs to accidents and one PRIME medical call out. This although sounding a lot, actually reflects the care drivers are taking on roads as we are on State Highway 6 and cover a huge geographic area which encompasses the Upper Buller gorge, St Arnaud, the top of Hope Saddle and approximately 10 kilometres north of Springs Junction on the Lewis Pass road.

We are all registered ACC providers and during this period there were also 202 in-house ACC consultations. During this time there were also 75 instances when the on-call nurse was called up to the hospital. By the way there are a couple of jobs going!!

Wairau Hospital ED Report

Sharon North reports.

We are busy with the new hospital rebuild. It is looking good. We have had a busy Christmas and New Year with some interesting paediatrics cases.

Denise McGurk

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Regional Reports.

Canterbury/ Westland Region

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The health system is featuring in the news media each day. Emergency Departments are at the forefront of this publicity.

The Christchurch Press. "Hospitals brace for killer flu.", yet another piece "Drunk patients worry hospital".

I find myself wondering how most of us feel when we read another article; does it give us a sense of foreboding? I prefer to think of it as a challenge and a chance to look forward to SOMETHING with change. Christmas in Christchurch Hospital kept to the national trends with increasing presentations - our predicted growth in 2009 is in the vicinity of 5 - 7% growth per annum.

Now the silly season is over I am planning some travel to the Coast and South, although I know that each of our departments have many of the same issues, it will be good to meet in person. Our new department is functioning well, but we continue to have the same issues that occur nationally in our departments - difficulty in getting inpatient beds, gridlock, difficulty meeting triage times and long waits for low triage codes.

KPI (key performance indicators) are becoming daily conversation. We have weekly graphs and figures for our nursing hand overs.

The number of new staff requiring orientation and needing buddies does put strain onto our existing staff, but we need these new nurses. Recruitment is an ongoing process and most areas in the hospital are below their FTE numbers. New graduates are working well in the department. It is a new beginning, and it is great to see them blossom and learn. New Graduates bring challenges as does the continued mentoring of new staff. Our experienced ED staff numbers are declining and it is great to grow our own.

Our boy racers are causing the city stress. It has had less of an impact for our department. It is however, hair raising driving home and getting stuck in a bunch of 200 cars!! It is a bit like being the triage nurse on a Sunday afternoon...

Happy and safe shifts,

Kate

Southern Region

No report available.

Judi Van't Wout has resigned from her position as nurse educator at Otago ED and also from her role as treasurer for the CENNZ committee. Judi has been an invaluable member of CENNZ and a national committee member for almost four years.

We wish her well in her travels.

Her resignation leaves a vacancy for the Southern region and CENNZ members from this region can expect a mail out soon inviting nominations to fill this post.

Jill Mortimer (Northern region) has taken over as treasurer.

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