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REGISTER ONLINE FOR CONFERENCE at www.emergencynurse2007.co.nz
A Word from the Coordinator/Editor:

I’m delighted to be able to include original articles from Ginette Janssen and Doug King in this issue of the journal. Their contributions resume the sharing and publication of emergency nursing practice knowledge that had a brief hiatus in the last issue of Emergency Nurse New Zealand. There are other articles “in the pipeline”, but I urge and implore all of you to stop procrastinating and start writing; especially those of you who already have work in the form of assignments that just needs a little twinking to be ready for publication. You will see from the impressively overloaded list of peer reviewers that we have a team capable of providing excellent feedback to your submitted work to enable your published work to be of a high standard. My thanks to the reviewers who have agreed to contribute by reviewing articles for the journal, and to Michael Geraghty who has devoted considerable time and effort to developing standards for review and publication. I’d like to draw your attention to the NZNO submission concerning access to acute care this is an important issue for all nurses. And finally, if you are thinking about attending the CENNZ conference in Dunedin, fill in the application form included in this issue, book your tickets, and pack your winter woollies. Look forward to seeing you there!

Regards, Lucien Cronin.

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CRISIS AROUND BLACK HOLE

A serious problem of access to acute care for South Dunedin is the situation at the Black Hole. A number of residents of the Western Bay of Plenty (regionally considered as Level 2) were reviewed as emergencies and treated in Tauranga ED each year. Approximately 36 000 people are living in the Western Bay of Plenty and Tauranga City. Tauranga Emergency Department is a level four facility, providing emergency care to 147 000 people living in the Western Bay of Plenty and Tauranga City. Tauranga Emergency Department is a level four facility, providing emergency care to 147 000 people living in the Western Bay of Plenty and Tauranga City. Approximately 36 000 people are treated in Tauranga ED each year.

Look forward to seeing you there!
The CENNZ National committee last met in May. This was a productive meeting spent reviewing several positions statements and our “Standards of Practice”. The standards require several hours more work before the revised version will be made available to the membership. We also spent some time looking at the MoH’s discussion paper “24 hour disposition tool”. As a result of this, the discussion paper was mailed out to all CENNZ members asking for comment. Thank-you to the large amount of you who submitted comments or full submissions. Some of these have been forwarded as individual submissions and others have been incorporated into the CENNZ submission. The Expert Advisory Group is meeting again on the 25th of July to wade through the submissions. I will keep you posted on the outcome of this.

The planning for our conference in Dunedin is moving into the final stages, if you haven’t registered yet check out the website www.emergencynurse2007.co.nz

Congratulations to those of you who have been fortunate enough to be awarded sponsorship to attend this conference. It is due to the success of the previous conference that CENNZ was able to offer this to members.

There are two vacancies coming up on the National Committee which hopefully will be filled at the AGM; these are for the Top of the South and Tai Tokerau/Northland regions. To be on the National Committee, you have to be a member of CENNZ and be nominated by another CENNZ member. The AGM will be held during the conference at 11.30am on September the 1st. All members are welcome.

It was great to see the new format for the journal. I have received positive feedback. What we now need is for you to provide articles to fill the journal, you may be able to win a quality Littman's stethoscope for your efforts (see details inside the journal).

The National Committee continues to work behind the scenes on behalf of CENNZ. Most of them have work, family and study commitments and still manage to contribute to CENNZ. I look forward to the two new members joining so we can share the workload and add to the expertise and opinions within the committee.

Keep safe and warm over the winter.

Justin Moore
Introduction. A seventeen year old female presents to an emergency department for the repair of a four cm linear laceration at the level of her right eyebrow following a fall. She has a fear of needles and asks if there are any alternatives to suturing the wound.

Lacerations are a common presentation in emergency departments with the principal goal of management being to achieve a cosmetically appealing and functional scar whilst avoiding complications such as infection and gaining well approximated wound closure (Hollander & Singer, 1999). Suturing is the traditional method of wound closure for lacerations, but this method can be painful for a patient, time consuming and expensive (Singer, Quinn, Clarke & Hollander, 2002). For several years tissue adhesives have been employed in the repair of simple wounds as opposed to standard wound closure such as sutures, staples and strips (Farion et al. 2005). This review will examine evidence that supports the use of tissue adhesives versus standard wound closure in uncomplicated lacerations.

Cosmetic Outcome. According to Quinn et al. (1998), the most important factor in wound management for patients and physicians is the cosmetic outcome (cosmesis). A systematic review conducted by Farion et al. (2005) examined the use of tissue adhesives versus standard wound closure for management of acute, linear, low tension lacerations in children and adults. Ten randomised controlled trials (RCTs) were analysed by two independent reviewers. Cosmesis was the primary outcome measured and determined by blinded assessors using one or more validated cosmetic scores. The wounds studied excluded bites, puncture wounds, heavily contaminated, infected, and devitalized wounds, those over joints, and patients with chronic illnesses which could affect wound healing. This meta-analysis revealed no significant differences with short or long-term cosmetic outcome of wounds repaired with tissue adhesives as opposed to standard wound closure. Not included in this Cochrane review was a large multi-centre RCT studying 924 wounds (383 lacerations, 541 surgical) comparing tissue adhesives to standard wound closure in emergency departments and community facilities (Singer et al. 2002). A physician blinded to the study assessed wounds using a validated wound evaluation scale. Cosmetic outcome, at three months for the 383 lacerations was comparable between the tissue adhesive group and the control group. Holger, Wandersee, and Hale (2002) conducted a clinical trial following the review. There was no significant difference in visual analogue grading scales comparing tissue adhesives versus nylon or absorbable sutures for the 145 facial lacerations studied. Both the blinded physician and patients’ own assessments were compared.

Patient satisfaction. Repairing wounds with tissue adhesives can considerably reduce procedure related pain for a patient eliminating the need for local anaesthetic (Singer et al. 2002). Quinn, Cummings, Callaham, and Sellers (2002) conducted a RCT comparing tissue adhesive versus sutures in 95 uncomplicated hand lacerations. Patients’ mean visual analogue pain scale rating was considerably lower for the tissue adhesive group. In further studies, patient/guardian satisfaction and preference was: 79% (Resch & Hick, 2000); 80% (Karcoglu, Goktas, Cokun, Karaduman & Mendesre, 2002); and 95% (Bruns et al 1999). Bruns et al (1999) and Osmond, Claassen and Quinn(1995) report that tissue adhesives are not only less painful, but are beneficial because of reduced procedure time and stress, as well as the convenience of not having to return for suture or staple removal. Tissue adhesives are more convenient in that they require minimal care, will slough off spontaneously 5-10 days post procedure, although the patients must be adequately informed of the need to avoid moisture and topical ointments (Singer et al. 2002).

Benefits for health care providers. Tissue adhesive repair is less time consuming than treatment with standard wound closure. Farion et al. (2005) reported a time saving of approximately five minutes per procedure when using tissue adhesives. Not included in this Systematic Review, both Singer et al. (2002) and Quinn et al. (2002) also reported significant time savings. Bruns et al. (1999) found that standard wound closure took almost twice as
Tissue Adhesive: A Literature Review
Author: Ginette Janssen

long as tissue adhesives in his trial. He commented that this was largely due to the decreased need for local anaesthesia and has positive implications for busy emergency departments with high patient through-put. A cost analysis and willingness to pay survey was conducted by Osmond et al. (1995). This study reported tissue adhesives to be a cost effective alternative to standard wound closure. Not only was the product cheaper, there were no associated costs with equipment and local anaesthesia. Tissue adhesives were found to be a more efficient use of resources than sutures due to the non-routine follow up treatment required. In a more recent study, Karcioglu et al. (2002) found tissue adhesives were cost approximately half that of standard wound closure.

Limitations. The Systematic Review conducted by Farion et al. (2005) showed no significant difference between the two groups for infection, delayed closure or discharge. In fact, erythema was more prevalent in the standard wound closure group. However, a small but significant 4% risk of dehiscence existed in the tissue adhesive group. Singer et al. (2002) also commented on the lower tensile strength of adhesives than sutures. Both authors recommend further trials into the causes of dehiscence and its cosmetic outcome, and the use of adhesives in areas of higher tension and mobility eg. joints. According to Singer et al. (2003), low viscosity and tendency for adhesives to migrate from application area is a limitation associated with octylcyanocrylate (OCA) tissue adhesives. This can be more problematic in wounds close to the eyes. His clinical trial examined the use of a more viscous (OCA) tissue adhesive compared to the standard low viscosity (OCA) adhesive. The higher viscosity adhesive resulted in less migration than the standard adhesive. Product performance was comparable and complication rates in both groups were acceptably low.

Conclusion. Multiple studies have compared the use of tissue adhesives to standard wound closure. The systematic review conducted by Farion et al. (2005) aimed to gather best possible evidence comparing wound closure methods and the effects of tissue adhesives for simple wound repair. There is sufficient evidence to indicate that tissue adhesives are an acceptable alternative to sutures, staples and adhesive strips. Cosmetic outcome, featured as the primary outcome measure in the above literature, was comparable between both groups studied. Secondary outcome measures reported were also consistent between studies. Decreased procedure time and pain plus the convenience of not returning for follow up treatment are added benefits for patients treated with tissue adhesives. Tissue adhesive application involves less time and resources, and is reported to be a more cost effective mode of treatment. Many studies have excluded complicated wounds and areas of increased mobility and tension. Farion et al. (2005) and Singer et al. (2002) agree that further research exploring treatment of such wounds with tissue adhesives is needed before treatment is advocated in this area.

References:

Ginette Janssen is a Clinical Charge Nurse in the Assessment and Planning Unit at Auckland City Hospital. She is currently completing her Post Grad Diploma in Advanced Nursing at University of Auckland.

This literature review was initially submitted as part of these studies.
Executive Summary

The College of Emergency Nurses New Zealand (CENNZ) believes that everyone has the right to health care. If a person chooses to attend a health care facility, health care should not be denied. CENNZ believes that there are barriers to health care that encourage people to choose emergency departments for health care over other available options, such as financial barriers, transport being available only in evening or after hours. There may already be a debt at their local primary provider which needs to be paid before they can access further care. They may have moved into the area recently so do not qualify for the PHO member prices or have not engaged with another provider. Many are unable to access their General Practitioners in a timely manner.

CENNZ believes the role of “Triage” is to determine urgency of need to see a registered Health Professional to commence treatment or tests and investigations, and to administer basic first aid. Any assessment or treatment beyond this is not the core function of “Triage”.

CENNZ does not agree with triaging patients away to another facility. CENNZ does not believe that person should be sent away from a health care facility until the episode of care for which treatment is being requested has been tended to, to the best level that the available skills can provide. CENNZ supports the development of robust systems to improve the patient journey, and developing emergency nurses along a pathway to expert emergency nurses, nurse specialists, and introducing the role of the Nurse Practitioner and observation areas based in the Emergency Department.

About the College of Emergency Nurses New Zealand (NZNO).

The College of Emergency Nurses (NZNO) is a professional group that represents 702 Emergency Nurses throughout New Zealand. This group belongs to the New Zealand Nurses Organisation. The New Zealand Nurses Organisation (NZNO) is a Te Tiriti o Waitangi based organisation which represents 39,500 health workers. NZNO is the professional body of nurses and the leading...
nursing union in Aotearoa New Zealand. Our members include nurses, midwives, students, health care workers and other health professionals.

CENNZ aims to promote excellence in emergency nursing within New Zealand/Aotearoa through the development of education, research and frameworks for clinical practice.

CENNZ Policy and position on the issue.

CENNZ is supportive of a more informed public who are better equipped to make good decisions related to their health care.

CENNZ believes in equitable access to health care for all people throughout New Zealand.

CENNZ acknowledges the legislation that defines boundaries around nursing practice. CENNZ does not support the “Triaging Away” of people seeking health care.

CENNZ advocates for assessments and treatment within Emergency Departments free of charge.

Consultation questions

Do you agree / disagree?

1. The College of Emergency Nurses New Zealand (CENNZ) agrees with the third principal. “People will not be denied access to services which ever of PC or ED they attend, but will be educated to assist them to access the most appropriate service in the future.”

2. The CENNZ does not agree with the proposed sorting tool for use in Emergency Departments.

Nowhere in the algorithm for the emergency patient does it mention capabilities of accessing primary healthcare once emergency care is deemed complete. This could include –

+ Inability to pay
+ Inability to make own way to Medical Centre
+ No intention of going anywhere else
+ It assumes that the patient can access their Primary Healthcare provider.

There is also a danger of increased levels of hostility from the public accessing healthcare when told their level of care is complete and they now need to go to their GP.

The algorithm does not make it explicit who would be determining when emergency care is complete. The CENNZ does not advocate “Triaging away”.

3. Guidance point Number 1

The CENNZ does agree with the development of a telephone disposition tool.

However this needs to be robust and available to all people in New Zealand. The telephone disposition tool needs to be fully aware of local facilities capabilities. It also needs to be able to direct patients to the most appropriate centre for care.

must be available through 0800 numbers, accessible through cell-phones and public phones. Computer access should also be taken into consideration. Some comments provided to CENNZ have criticised the inability to get through to the current telephone disposition tool, Healthline. Concerns have also been raised about delays for people contacting a telephone disposition tool when they should have called 111 for an ambulance.

4. Guidance point Number 2

The CENNZ agrees that no-one will be turned away from an Emergency Department and care will not be denied.

5. Guidance point Number 3

The CENNZ does not agree with this Guidance point. Determining what is Primary Care and what is Emergency Care is a subjective task.

that any two Health Care practitioners may not be able to agree to. Each patient visit requires varying levels of care and set rules are not always able to be followed.

Do you agree with the Sorting Tool?

The CENNZ does not agree with the sorting tool. Patients who present to the Emergency Department deserve to have their episode of care tended to. The CENNZ does agree that efforts should be made to ensure ongoing Primary Healthcare for those patients who require it. Emergency Departments frequently see patients due to their inability to access their Primary care provider in a timely manner. Bearing this in mind, it is not guaranteed that an Emergency patient’s care deemed completed, will be able to access Primary care as required.
OVERALL VIEW

In the questions above, you have given your feedback on each part of the proposed process. Please now give us your response to the whole:

Do you think this approach will be useful for a front-line health professional to follow? What needs to be changed?

The telephone disposition tool could be useful if developed to accommodate the various facility’s abilities and if publicised widely. This would need to be trialled and consumer comments sought.

Do you think the sorting tool will be useful for a frontline health professional to use? What needs to be changed?

The tool needs to be omitted. This tool assumes that care is available elsewhere. The sorting tool requires an assurance that care is available at another facility. The time taken to check this availability may have enabled the care to be completed within the emergency department.

The patient has chosen what they see as the most appropriate point of care for them.

A negative experience may reduce their chances of accessing healthcare in the future.

Do you think the approach suggested will be useful for Maori? What changes would you suggest?

The CENNZ believes that this is a question best answered by individual iwi.

Do you think the approach suggested will be useful for Pacific peoples? What changes would you suggest?

Again the CENNZ believes that this is a question best answered by the various pacific island community groups.

Do you think the approach suggested will be useful for rural areas? What changes would you suggest?

The majority of CENNZ members work in urban settings. CENNZ believes this question is best answered by rural healthcare providers.

Do you agree with the Algorithm as a pathway through the health system for a person who requires urgent care? What changes would you suggest?

No. Once a person has chosen a healthcare provider that episode of care should be completed to the best of that facilities abilities. CENNZ does not support the denial of completion of healthcare.

Given improvements as you suggest, are you favourable towards this approach or would you still have serious misgivings?

CENNZ is supportive of the enhancement of a telephone disposition tool and public education to make appropriate choices for accessing healthcare. It does not however support the denial of care or the denial of completion of care.

Conclusion

CENNZ supports the NZNO’s submission. If the tool proceeds in its current form CENNZ has grave concerns for the safety of the emergency nurse implementing these recommendations and for the safety of the patient. CENNZ believes that the patient has the right to choose where their healthcare is provided.

CENNZ believes that healthcare in Emergency Departments must remain free of charge to the consumer.

CENNZ advises that instead of investing in sending patients away from the Emergency Departments, resources should be redirected to the professional development of all health professionals to enable them to facilitate care as needed where it is required.

Submission prepared on behalf of the National Committee CENNZ by: Justin Moore, Chairperson, College of Emergency Nurses New Zealand (NZNO).

Literature:


Over the weekend of the 9th and 10th of June 2007 6 Registered Nurses, 2 from Wellington ED, 1 from Wanganui ED and 3 from Rotorua ED attended (and all passed) the Course in Advanced Trauma Nursing held in Rotorua...

The course is similar in duration to the ENPC and TNCC courses and is also run by the Australian College of Emergency Nurses (ACEN). The course is not a practically based course but rather theoretical, but before that puts anybody off, the concepts discussed relate directly to what we see in practical trauma situations with the idea being that we are able to apply this theoretical learning to trauma.

There is a six week pre reading phase with the appropriate text being issued. The course is based on seven aspects of trauma and the ways in which these interrelate. Some aspects covered include gas transport and diffusion, pain, ethics and consciousness. Each aspect has a chapter in the text assigned to it and each is covered again in lecture from over the two days of the course.

The testing phase (for which plenty of practice time is assigned) is an oral viva based on a trauma scenario you are given and have time to prepare for. Questions are posed and answers given must cover the aspects mentioned above but perhaps more importantly, how they interrelate to each other. For example, how might the pain this person is experiencing relate to their hypoxia and how does that affect their level of consciousness?

This is the first time this course has been offered in New Zealand and I would thoroughly recommend it to anybody involved in dealing with trauma patients.

Cormac Peirse
Report: Course in Advanced Trauma Nursing in Australia - by Amy Carroll

Amy Carroll is an emergency nurse working at Hawkes Bay emergency Department.

She successfully applied to CENNZ for funding to attend the Course in Advanced Trauma Nursing in Australia. The following report is submitted as part of the conditions of her accepting this funding.

Trauma is known to be one of the leading causes of death in those under the age 40. New Zealand unfortunately has one of the highest rates of motor vehicle related injuries and death in the western world (NZL Resuscitation Council, 2001). For trauma nurses knowledge is a core discipline that is needed. Knowledge is obtained from several sources including clinical observation, experiences and education (Emergency Nurses Association, 2000). Theory and on going education is vital for trauma nurses to remain knowledgeable, up to date with trauma care and to become experts within this field.

I am a third year Registered Nurse currently working in the Emergency Department at Hawkes Bay District Health Board.

In the last year and a half I have been able to participate and successfully pass several courses including the Trauma Nursing Core Course (TNCC). I work often within our resuscitation area and have been involved in several major traumas. I also have a great passion for trauma and trauma care. I wanted to consolidate the knowledge taken from TNCC and from experiences working within resus to the next level, to further my education and to benefit my patients and my job.

Recently I was given the opportunity to take part in the Course in Advanced Trauma Nursing II or CATN as it is commonly known as. This course is offered by the Australian College of Emergency Nursing, which was developed by an international faculty for the Emergency Nurses Association (USA). The purpose of this course is to teach patho-physiologic concepts, which help strengthen critical decision making skills for nurses who care for the injured or ill patient. The course was held in Nambour, Australia, although it has been offered in New Zealand. I applied for funding to take part in this course and was lucky enough to be granted funding from a few sources, with the College of Emergency Nurses (CENNZ) been one. I am very grateful for the financial support of these groups.

I received the course manual approximately six weeks before attending the course. It includes mainly pathophysiology but also encompasses anatomy, physiology, nursing outcomes, interventions and evaluation, trauma system development, ethical dilemmas, trauma team collaboration and interpersonal relationships, and the application of science to nursing practice.

I found it to be overwhelming and intense at times to read and found myself looking through patho books from my time studying to help refresh some of the information given to me. I was also lucky enough to call upon my clinical nurse specialist and clinical nurse educator in times of need.

An exercise is to be completed prior to beginning the course, where you have to create a cell including all cellular functions and base it around something. I chose to interpret the triage room in our emergency department. That in itself was challenging, coming up with an idea of what I could use as a cell and interpreting its functions through furniture, equipment and staff members.

Like all courses, I went feeling I didn’t know a thing and thought to myself many a times ‘what have a got myself into?’... The course was presented over two days and covered a lot of information. The three tutors who presented the course are very intelligent and knowledgeable and delivered the content in an interesting and very captivating way.

Long days are anticipated as with any course but due to the content and the tutor’s enthusiasm, the days go fast. We were given homework on the first night, which we were able to do by ourselves or with each other. Basically it was a scenario of a trauma patient with multiple injuries. Through a “concept map” you had to relate areas together and what may be going on at cell and tissue level. This is similar to what happens when you are tested at the end of day two.

There are seven areas, which are looked at when you do your “concept map”. These include:

• ventilation and gas transport
• transport and perfusion
• mobility and sensation
• host defence systems
• consciousness
• pain
• collaboration and ethics

Through your “concept map”, you can inter relate all these areas together for example:

You have a trauma where there is a chest injury. It can cause an impairment in ventilation and gas transport e.g hypoxia leads to inadequate tissue perfusion which causes a disruption in transport and perfusion as there isn’t an adequate amount of blood flow, nutrients & oxygen to supply the tissues and cells or:
A COPD patient presents with lowered GCS. They would have an impairment to ventilation and gas transport which would decrease their lung compliance and effort secondary to their altered consciousness.

The examination process was also very nerve racking, as it is an oral viva, but please don’t let that dissuade you. You are given several scenarios and opportunities prior to this. Under exam conditions you are given a scenario either on trauma or illness and you have half an hour to read and write ideas on your “concept map”. You then have approx 30 minutes with a tutor where you answer questions relating to your scenario and information you have written on your map. I felt drained by the end of day two but was relieved when I successfully completed the course.

I personally took away a lot from this course. It helped emphasise and strengthen the knowledge that I already had gained and it showed me to think outside the square. It also helped boost my own confidence and increase my passion for trauma. I came away from this course feeling re energised and knowledgeable.

I couldn’t wait to start work again to consolidate what I had learnt and to able to share with my colleague’s information I had gained.

I recommend this course to all Nurses who work within an emergency department who want to take the next level from TNCC to better understand, why the body is reacting the way it is, what’s going on at deeper level and which actions will help improve these deficits and impairments. Yes there is a lot of reading and work to be put in prior to going to this course but it is very beneficial not only to you as the nurse but also to your patient. I find myself looking at the whole process differently.

I am very appreciative that I was able to take part in this course.

References
Sports Related Concussion in the Emergency Department: Some considerations

By: DA King. BN PGDipSportMed, MHealSc

Introduction.

Watching a 16 year old female patient crying on the Emergency Department (ED) bed is nothing unfamiliar for ED staff. Watching her pointing at the lady with her saying she does not recognize her presents questions to the ED team. Knowing that this is the patient’s mother who has come in to see her daughter for her third consecutive sports concussion in a week raises some more questions. So where does the ‘duty of care’ of the sports injured patient actually finish? And what roles can the ED team play in assisting the safe return of players to their sporting activity?

Sporting activities are a growing industry in the developing world. As a result of these sporting activities, many injuries can occur and typically they present to either the GP, the physio or, invariably, to the ED. Although sports related injuries have been reported to be between 2.7% - 13% of total presentations to the ED, (Boyce & Quigley, 2004; Kelly, Lissel, Rowe, Vincenten, & Voaklander, 2001) the management of these is unique as the participants are usually fit, young and want to return to their sport as soon as physically possible. Sports related concussions are reported to be only 3% of the total sports related injuries seen in the ED environment (Boyce & Quigley, 2004; Kelly et al., 2001). Despite this, sports related concussions account for nearly a quarter (24%) or all concussions seen in ED (Kelly et al., 2001). Although the management of concussions is similar, patients presenting with a concussion from a sports related activity should be given some additional considerations.

What is concussion?

Concussion has been previously described using various definitions. Until recently there has been no universally accepted definition for concussion (Collins, Lovell, & McCaig, 1999). Following the National Symposium on Concussion in Sport (Aubry et al., 2002), a definition was proposed for the group to consider describing concussion. The same group met again in Prague, 2004, and reaffirmed that a “sports concussion is defined as a complex pathophysiological process affecting the brain, induced by traumatic biomechanical forces” (McCorry et al., 2005). Additionally it was also identified that concussions:

(1) May be caused by a direct blow to the head, face, neck, or elsewhere on the body with an “impulsive” force transmitted to the head.

(2) Typically results in the rapid onset of short lived impairment of neurological function that resolves spontaneously.

(3) May result in neuropsychological changes, but the acute clinical symptoms largely reflect a functional disturbance rather than structural injury.

(4) Results in a graded set of clinical syndromes that may or may not involve loss of consciousness. Resolution of the clinical and cognitive symptoms typically follows a sequential course, and

(5) Is typically associated with grossly normal structural neuro-imaging studies.

Primary care of concussion.

The primary care of a player with a concussion has been identified to be in need of better primary care. In 1995 it was identified that only 30% of sports participants assessed as having been concussed received appropriate return to play (RTP) guidelines (Genuardi & King, 1995). This was similar in 2001 when a survey of medical practitioners identified that many of them were unaware that actual concussion management guidelines existed (Bazarian, Veenema, Brayer, & E., 2001). Of those medical practitioners that were aware of these concussion management guidelines, many did not use guidelines in the provision of care for those patients presenting with concussion (Bazarian et al., 2001). Again in 2006 it was identified that only 20% of primary care providers surveyed used management guidelines in the provision of their care for patients presenting with concussion (Peecher, Dexter, & Heinz, 2006).

Occurrence of concussion in sports.

Research of contact sports have identified that concussions occur at various incidence rates. Studies in rugby union identified that a concussion can occur between 0.1 – 8.3 per 1000 playing hours (Marshall & Spencer, 2001). To put it in match figures you can expect a concussion to occur once for every six matches played. Similarly in rugby league a concussion is reported to occur at a rate of 6.1 – 18.0 per 1000 playing hours (King, 2006; King & Gabbett, 2007; King, Gabbett, Dryer, & Gerrard, 2006). This equates to a concussion occurring once for every two matches played.

Assessment of concussion.

Traditional assessment questions of the player who has a possible concussion have been identified and utilised throughout the medical literature. All of these assessment questions have varied in content and consequently in assessment outcome; consequently these have been identified as being unreliable in the assessment of a concussed player (Maddocks, Dicker, & Saling, 1995; Targett, 1998). Standard orientation questions (e.g. time, place, person) have also been shown to be unreliable. (Maddocks et al., 1995; McCrea, Kelly, Klaue, Ackley, & Randolph, 1997) but brief neuropsychological test batteries that assess attention and memory function are practical and effective in the assessment of concussion (Aubry et al., 2002). Two such brief neuropsychological...
tests recommended by members of the 2nd International Conference on Concussion in Sport, Prague 2004, are Maddock’s questions (Table 1) and the Sport Concussion Assessment Tool (SCAT) (McCrory et al., 2005).

Table 1: Maddocks’ Questions (Maddocks et al., 1995)

<table>
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<tr>
<th>Grade</th>
<th>Cantu</th>
<th>Colorado</th>
<th>AAN</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>No loss of consciousness</td>
<td>Post-traumatic amnesia for fewer than 30 minutes</td>
<td>No loss of consciousness</td>
</tr>
<tr>
<td>2</td>
<td>Loss of consciousness for fewer than 5 minutes</td>
<td>Post-traumatic amnesia for more than 30 minutes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Loss of consciousness for more than 5 minutes</td>
<td>Post-traumatic amnesia for more than 24 hours</td>
<td></td>
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Although these questions are more designed to assess the injured player at the sideline, these can be easily adjusted for use in the Emergency Department setting (Table 2). If the player has a member of their team present when asking these questions, they may be able to verify the answers. Ideally the player may come with a SCAT card done at the sideline providing more clinical information for the Emergency Department team.

Table 2: Amended questions for the Emergency Department situation

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<tr>
<td>1</td>
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<td>No loss of consciousness</td>
</tr>
<tr>
<td>2</td>
<td>Loss of consciousness for fewer than 5 minutes</td>
<td>Post-traumatic amnesia for more than 30 minutes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Loss of consciousness for more than 5 minutes</td>
<td>Post-traumatic amnesia for more than 24 hours</td>
<td></td>
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</table>

Recent recommendations have identified that the use of grading scales should be abandoned and that concussion be categorised by the management required to guide the return to play decisions for the individual patient (Aubry et al., 2002; McCrory et al., 2005). Where a simple concussion is defined as a concussion that:

“progressively resolves without complication over 7–10 days, and... apart from limiting playing or training while symptomatic, no further intervention is required during the period of recovery, and the athlete typically resumes sport without further problem.”

(McCorry et al., 2005 p197)

The simple concussion represents the most common form of sports related concussion, a complex concussion is one where a player:

*suffers persistent symptoms (including persistent symptom recurrence with exertion), specific sequelae (such as concussive convulsions), prolonged loss of consciousness (more than one
minute), or prolonged cognitive impairment after the injury and includes athletes who suffer multiple concussions over time or where repeated concussions occur with progressively less impact force.*

(McCrory et al., 2005 p197)

Return to play guidelines.

Similar to grading scales of concussion, the return to play guidelines also differed (Table 4). These were compounded by the severity assessment and, depending upon what assessment was used to determine the severity of concussion, the return to play process also varied.

| Table 4: Management of concussion according to severity |
|---|---|---|---|
| Grade | Cantu | Colorado | AAN |
| 1 | Athlete may return to play if asymptomatic for one week (if athlete is totally asymptomatic, return to play on same day may be considered). | Athlete may return to play if asymptomatic for 20 minutes. | Athlete may return to play if asymptomatic for 15 minutes. |
| 2 | Athlete may return to play if asymptomatic for one week. | Athlete may return to play if asymptomatic for one week. | Athlete may return to play if asymptomatic for one week. |
| 3 | Athlete may not return to play for at least one month; athlete may then return to play if asymptomatic for one week. | Athlete should be transported to a hospital emergency department; athlete may return to play one month after injury if asymptomatic for two weeks. | Athlete should be transported to a hospital emergency department; if athlete had brief loss of consciousness (i.e., seconds), may return to play when asymptomatic for one week; if athlete had prolonged loss of consciousness (i.e., minutes), may return to play when asymptomatic for two weeks. |

In the absence of scientifically validated guidelines for returning the player to sports participation, the member’s of the 2nd International Conference on Concussion is Sport, Prague 2004, (McCrory et al., 2005) recommended that a clinical construct be utilised for such a graduated approach in the return of a player to their sporting activities. Such a graduated approach has the advantage of being able to be customised to the individual player (Table 5) (Aubry et al., 2002; McCrory et al., 2005).

| Table 5: Return to play protocol |
|---|---|
| Level 1 | No activity, complete rest. Once symptom free and cognitive recovery is demonstrated, proceed to level 2. |
| Level 2 | Light aerobic exercise such as walking or stationary cycling |
| Level 3 | Sport specific training (e.g. running drills, ball handling skills) |
| Level 4 | Non-contact training drills |
| Level 5 | Full contact training after medical clearance |
| Level 6 | Game play |

(McCrory et al., 2005)

The Emergency Department nurse has a role to play in this graduated approach by primarily emphasizing that complete cognitive and physiological rest is required for at least a few days following the concussion incident. As well, once they have rested and feel better then they should undertake a supervised return to play process that should be assessed by either the team medic or their own GP.

National sporting body requirements.

Most sporting bodies in New Zealand require that any participant in their sport that has been assessed as having a concussion be reported to either their district or to the national sporting body. The New Zealand Rugby Football Union and the New Zealand Rugby League have established a reporting form in conjunction with the Accident Compensation Corporation (ACC). These forms require that the players full name, date of birth, club and injury event be reported within 48 hours of this occurring. To supplement this information, the concussed player’s medical documentation could be sent as well identifying the assessor’s evaluation of the concussion and any advice given. The responsibility for reporting these concussions should be with the player’s team manager or trainer/medic. Unfortunately not all teams playing sport have
Sports Related Concussion in the Emergency Department: Some considerations

By: DA King. BN PGdipSportMed, MHealSc

managers and/or trainer/medics attached to them that are able to do this and often these remain unreported.

As well, most sporting organizations in New Zealand have adopted the recommended three week stand down period following a concussion. This is further publicized by ACC as they have produced a wallet sized concussion information resource that identifies the guidelines and return to play process. These recommendations are that:

1. the player must stand down for a minimum of three weeks and
2. should not return to play or training until symptom free and
3. with mandatory medical clearance (King, 2005).

Sports participants are competitive people and will endeavour to try to return to their sport as soon as possible. Simple instructions put in terms that the player understands can assist in aiding the injured player to make an informed decision about their concussion rehabilitation. By describing a concussion as a sprain of the brain and comparing it with a sprained ankle may assist in enlightening the player why they should rest. As well, by describing the brain as jelly inside a concrete box and getting them to visualize it wobbling back and forward as it is shaken about as would occur when the head is injured resulting in a concussion can also assist in their understanding of what has happened.

Some future considerations.

Although most sports concussion are initially seen in the ED environment, no subsequent follow up review of the concussed player is undertaken. Often these patients are referred back to their GP’s and, unless there is a full concussion assessment supplied to the GP the initial assessment is not able to be used as base line data to gauge the recovery from the injury. Maybe a sports concussion assessment unit can be established in one area of the ED where the presenting patients on the weekend can be reassessed. Surely continuity of care in the case of sports related concussions can be considered?

There are some aspects of emergency nursing that we are excellent at yet we sit and watch the concussed athletes hospitalized for concussion.

References:


Correspondence to: Doug King | Emergency Department | Otaki District health Board Private Bag 1921 | Dunedin | New Zealand | Email: doug.king@healthotago.co.nz
KEYNOTE SPEAKER

The conference organising committee have great pleasure in announcing the keynote speaker for the CENNZ 2007 Conference – Jean Proehl, RN, MN, CEN, CCRN, FAEN. Emergency Clinical Nurse Specialist, Dartmouth-Hitchcock Medical Center, Lebanon, NH. Jean has been an emergency nurse for more than 25 years and an emergency clinical nurse specialist since 1985. She was the 1999 President of the Emergency Nurses Association and is currently the Chairperson of the Academy of Emergency Nursing. She is the editor of Emergency Nursing Procedures, 4th Edition (Saunders, in press) and co-editor of the Advanced Emergency Nursing Journal. Jean is an internationally recognized speaker and author on emergency and trauma nursing.
Emergency Care is no Accident: Conference Programme

Thursday 30 August
1600: Registration desk opens.
University ISB Link Building

1800 hours:
Conference Opening & Welcome Reception
University ISB Link Building & Exhibition area.

Evening: Delegates free to visit and dine at the many fine local
Dunedin cafes, pubs, and restaurants within easy walking
distance of the University.

Friday 31 August
0800: Registration desk opens
0830: Welcome Address – Kim Caffell – Nurse Director
Emergency & Medicine
0845: KEYNOTE Address – Emergency Nursing in the 3rd
Millennium Jean Proehl – Clinical Nurse Specialist, USA
1000: Morning Tea & Trade Exhibition
1030: Free Paper Session (concurrent sessions)

Castle One Lecture Theatre
1030:
WORKPLACE VIOLENCE IN THE EMERGENCY DEPARTMENT: ARE EMERGENCY NURSES SAFE?
Suzanne Rolls

1100:
TRIAGING PATIENTS AWAY FROM THE EMERGENCY DEPARTMENT: A REVIEW OF THE ISSUES
Lisa Blackmore

1130:
The EXPERIENCE OF MINOR ILLNESS OR INJURY AND SEEKING CARE AT A HOSPITAL EMERGENCY DEPARTMENT: AN INTERPRETIVE PHENOMENOLOGICAL STUDY
Lucien Cronin

Castle Two Lecture Theatre
1030:
RECOGNISING THE SICK PATIENT: AN EMERGENCY NURSES VIEW
Karen Blair

1100:
ACUTE HYPERCARBIA IN CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD): PRESENTATIONS TO A NEW ZEALAND EMERGENCY DEPARTMENT
Anton Brett Turnwald

1130:
DIV 2’s A CHALLENGE OR A BLESSING!
Diana Patton
Emergency Care is no Accident: Conference Programme

Friday 31 August - Cont.
1200: Lunch & Trade Exhibition
1300: Dr John Chambers - Director Dunedin ED
   “How to Save a Life…”
1330: Darryl Tong – Consultant Oral and Maxillofacial Surgeon
   Maxillofacial Trauma: Patterns of Injury & Diagnosis
1415: Jeanne Frossard – Consultant Anaesthetist
   Primary Trauma Care
1445: Afternoon Tea & Trade Exhibition
1515: Panel discussion – The New Graduate in the Emergency Department
1615: MedXus 2007 Research Award Presentation
   Michael Geraghty - Emergency Nurse Practitioner
16.45: Close

1900 hours:

Conference Dinner & Haggis Ceremony
Venue: The Otago Museum
Theme: “Dress to Kill.”
Prize for best dressed/costume

Saturday 01 September - Overleaf.
### Emergency Care is no Accident: Conference Programme

#### Saturday 01 September

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<tr>
<td>0815</td>
<td>Welcome Address</td>
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<tr>
<td>0830</td>
<td><a href="#">KEYNOTE Address – Critical Clinical Thinking in Practice</a> - Clinical Nurse Specialist, USA</td>
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<td>0900</td>
<td>Morning Tea &amp; Trade Exhibition</td>
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<td>1000</td>
<td>Free Paper Session (concurrent sessions)</td>
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<td>1000</td>
<td>ON YA BIKE! PATIENT FLOW VERSUS CARE INITIATIVES</td>
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<td>1030</td>
<td>COMPLEX PAEDIATRIC PATIENT CARE IS NO ACCIDENT</td>
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<td>1100</td>
<td>&quot;VICTA 2 SCRAMBLE - THERE IS AN INCIDENT AT 9.0&quot; THE EMERGENCY NURSES CONTRIBUTION TO MOTORSPORT</td>
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<td>1245</td>
<td>Lunch &amp; Trade Exhibition</td>
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<td>1345</td>
<td>Awards, Prizes and Raffles</td>
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<tr>
<td>1400</td>
<td>Invited Speaker - Gerard Wood – Lieutenant Colonel Royal New Zealand Nursing Corps</td>
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<td>1500</td>
<td>Jane McGeorge – Sponsored Speaker by LifeVent Medical Ltd. A Lot of Puff about Nothing: Non-Invasive Respiratory Support</td>
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<td>1530</td>
<td>Legal Issues in Emergency Nursing.</td>
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<td>1600</td>
<td>Dr. John Fountain – Medical Toxicologist National Poisons Centre. Common “Poisonings” and Gastrointestinal Decontamination</td>
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<td>Castle Two Lecture Theatre</td>
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REGISTRATION FORM

GST Number: 10 386 969 | www.emergencynurse2007.co.nz

Section A: Delegate information

To register Online: www.emergencynurse2007.co.nz

Or;

Complete this form, keep a copy for your records and forward to: Ali Copeman akB Conference Management
PO Box 994, Dunedin, New Zealand.

Surname: __________________________ First name: __________________________

Organisation: __________________________ Position held: __________________________

Postal address: __________________________ Suburb: __________________________

City / Town: __________________________ Telephone (daytime): (0 ) __________________________

Email: __________________________ NZNO Membership number: __________________________

Preferred name for name badge (if different from above) __________________________

Special requirements: __________________________

The Privacy Act 1993 provides that before your name and details can be published in the list of delegates
either for distribution to fellow delegates or any other party, you must give your consent.

Section B: Registration Fees - take advantage of the discounted fees and register early, all fees are GST inclusive

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<th>Registration details</th>
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<th>Standard Registration After 30 June - Before 22 August 2007</th>
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<td>CENNZ NZNO member</td>
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<tr>
<td>Non-member</td>
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NZNO Membership Number: __________________________

Or you can join CENNZ - membership - $25.00 / year (magazine levy)
www.emergencynurse.co.nz
REGISTRATION FORM (Cont.)

Section C: Social Functions

Welcome Reception Friday 30 August 2007
Ticket included in full registration fee NOT included in Day Registration
For catering purposes please indicate if you are attending the reception: □ Yes  □ No (Please tick box)
Number of additional welcome reception tickets: [ ] @ $40.00
Name of accompanying person(s) .................................................................

Conference Dinner 31 August 2007
Ticket included in full registration fee NOT included in Day Registration
For catering purposes please indicate if you are attending the Dinner: □ Yes  □ No (Please tick box)
Number of additional dinner tickets: [ ] @ $120.00
Name of accompanying person(s) .................................................................

Social Function Sub total: $ ...........................................................................

Section D: Method of Payment

□ Credit card  □ Cheque (Please tick box)
Make cheques payable to Emergency Nurses Conference 2007
Credit Card Authorisation: □ MasterCard □ Visa (Please tick box)
Card number:  ............................................................................................
Expiry date: /  
Cardholder Name: ....................................................................................
Signature: .................................................................................................
Date: / / 

Section E: Payment Summary

Registration fees: $ ....................................................................................
Social Functions: $ ....................................................................................
Total: $ .................................................................................................
Hi Everyone,

Winter is upon us and with it brings the usual ills and chills, not only is this obvious in the high numbers of patients presenting to the department but with unfortunate high levels of staff sickness. A timely reminder is to: "look after ourselves".

For those of you that are unaware the 2008 Annual CENNZ conference is being held in Auckland. To date there is a committee meeting on a fortnightly basis to organise this, with Mary McManaway at the helm. The committee representatives are from Middlemore, Auckland City Hospital, Starship, North Shore and Waitemata Emergency departments. The conference theme, venue and dates will be decided on by the AGM in Dunedin in September 2007.

Middlemore Emergency Care is under going a revamp in the Adult Assessment area. Staff are coping very well with hammers, saws and dust along with the high patient numbers as mentioned previously. Walls have been removed and others altered resulting in centralising the staff base and relocating the drug room. A few disruptions have resulted in the odd pizza or two being provided by the builders to soften the impact it’s had on staff. The intention is to alter the running of the assessment area with staff being encouraged to put their ideas forward to ensure a smooth transition.

There have been a few recent changes to the senior staff within the department. It is with pleasure to announce that two new Clinical Nurse Specialists have recently been appointed to the department, Heather Raynor (ex Middlemore EC Charge Nurse) and Rachael Dobson from Waikato. With Heather being appointed to CNS a new Charge Nurse has been appointed to fill her position, (Sandra King being successful). Best of luck to you all. Hope to meet a lot of new faces in Dunedin.

Glenys McSweeny

The Northern and Top of the South Regional CENNZ representative positions are currently vacant; we hope to appoint representatives for these regions at the 2007 AGM.

Mike Geraghty

Like most ED’s up and down the country Auckland City Hospital is experiencing our fair share of what has been euphemistically become known as the ‘winter work load’ but which oddly seems to extend way past the winter period and amounts to access block, long waiting times the whole year around. Once we hit red alert a cascade of calls starts with the specialty consultants and all significant others (bed managers, senior management etc) which has had some positive effects. St John’s ambulance are also called upon to manage patients we will not accept past the triage point. This is not a role which St John’s wants to own and ultimately has a negative impact on their ability to perform their primary risk in the community. It does however add to the pressure on in-patient staff to be pro-active with managing patients particularly when St John’s management put pressure on hospital management to free up their staff to do their job. Interestingly it is the nursing staff on wards who often create the biggest obstacles and who are least willing to share risk – whilst ED staff are expected to manage excessive volumes of patients ward staff will not share that risk by accepting patients to their wards (and managed in corridors if needed), employing effective discharge processes etc.

We can only continue to do our job well and ensure that the care we give is the best possible and at all times document, document, document!!

Mike Geraghty
Regional Reports

Hawkes Bay Region

Robyn Price
Hastings Emergency Department
Hastings
Contact: robprice@xtra.co.nz

Hi from Hawkes Bay.

Like everyone else, we are in the throes of awful winter weather and the winter blues. No beds, short staffed (both nursing & medical) & everyone sick of the cold, wet, miserable conditions. Only consolation is that every day brings us closer to a warmer day! We have been very busy in Hawkes Bay with patient numbers still climbing and exceeding predictions. This stretches our nursing staff numbers and stress levels climb. However, everyone has coped really well, which is possibly not good in regards to getting more staff! Just shows how great nurses are with coping strategies!

Two of our nurses recently completed and passed the CATN course.

Congratulations to them both. All of our staff are involved continually with upskilling through courses, self learning and weekly short education sessions at work. This is all good for our department and moral as a team. I admire the nurses for the hours and effort the put in to their education and advancement on top of their education and advancement on top of their work. We welcome our new Educator, Janet Atkinson, in April who is doing a great job so far. Liz Appleton, Staff Nurse, Rotorua Emergency Department.

Winter arrived in Tauranga when the calendar turned over from June to July, with the weather becoming wet, cold and miserable. However, we’re a cheerful bunch in the Bay of Plenty, and turned over from June to July, with the weather becoming wet, cold and miserable. However, we’re a cheerful bunch in the Bay of Plenty, and we won’t let it get us down. The spirit of the team has shown itself over the past six months, as we rallied around several of our nurses who have experienced some very difficult times in their personal lives, even as we cope with the various challenges faced by any ED these days.

The hospital is often crowded, leading to the new standard delays admitting patients to the wards – but there is always someone worse off than us. They are being regularly cared in the bed! The problems are certainly global, but we still work in the best area of nursing! I go to it folks, be proud and work together to help each other and your patients.

See you all at conference in Dunedin in August.

Thanks Robyn

Midland Region

Lucian Cronin
Staff Nurse
Rotorua Emergency Department

Contact: lucien.cronin@ibopdhb.govt.nz

News from Rotorua ED………on asking around this morning the overwhelming comment has been that we have never had such a busy summer and regularly have our “second board” out (patient allocation board) which means we have patients lining the corridors and Whanau room on almost a daily basis now which is unusual for us. The radiographers and laboratory technicians strike has impacted on the department’s workload too. We have a full complement of nurses still and have another two doctors from the USA who like the others from there have adapted well and are a pleasure to work with. We welcomed our new Educator, Janet Atkinson, in April who is doing a great job so far. Liz Appleton, Staff Nurse, Rotorua Emergency Department.

Winter arrived in Tauranga when the calendar turned over from June to July, with the weather becoming wet, cold and miserable. However, we’re a cheerful bunch in the Bay of Plenty, and we won’t let it get us down. The spirit of the team has shown itself over the past six months, as we rallied around several of our nurses who have experienced some very difficult times in their personal lives, even as we cope with the various challenges faced by any ED these days.

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See you all at conference in Dunedin in August.

Thanks Robyn

Contact: lucien.cronin@ibopdhb.govt.nz

EMERGENCY NURSE NZ > JULY 2007
Central Region
Janine Kereama
Palmerston North Emergency Department
Contact: seanjanine@xtra.co.nz

As I sit here typing this with cold fingers, my sympathies and “warmest” of thoughts go out to our southern colleagues dealing with the great winter snows, and inevitable car crashes and associated ills and ailments. Leaving from work after a recent afternoon duty was reminiscent of an episode of E.R with staff dressing up in scarves, gloves, hats, and Long-johns. We are soft, I hear the hardy southerners say, however winter in Palmerston North has also hit us with icy temperatures and deluges of rain. The snow “feels” close, and at times has been visible on the nearby ranges...not that I am trying to compete in any way with the beauty of the snowy south!

To keep active in this dark-season, E.D Palmerston North has just put together a team of eager and willing indoor netball players. After 3 games, although no wins, I am very pleased to report that there have been no injuries. In the current climate, I personally feel that this is indeed the greater of accomplishments. Now that the grading rounds have finished, I do anticipate a somewhat fairer competition and look forward to reporting on more favourable results in the next issue.

On a professional note, the majority of nursing staff in the department have recently been involved in a pilot study that Dr Chris Underwood (our favourite Registrar – I can say this with confidence as he is our only registrar) submitted for the research component for his upcoming Consultant exams. Chris looked at the efficiency of CPR rescuers swapping across the patient, versus beside the patient. This proved to be very beneficial in the delivery of effective CPR and decreasing hands-off time. The research was passed by the committee, and I am aware that it is to be published medically.

Canterbury/ Westland Region
Justin Moore
Clinical Nurse Specialist
Christchurch Hospital Emergency Department
Phone: 03 364 0270
Email: justin.moore@cdhb.govt.nz

Winter is well and truly upon us. The patient volumes and acuities at Christchurch Hospital’s Emergency Department are increasing. We are grateful that the flu season is only just starting, we can only hope it doesn’t take a hold like it has in previous years.

Christchurch Hospital is frequently in gridlock, which as you all know, impinges on the Emergency Department. One day recently we had three patients stay in our department longer than 24 hours.

We have been threatened with snow in Christchurch several times over the past week but luckily, the snow clouds keep bypassing us. This sort of weather always puts a smile on those skiers and boarders who work in the department.

Christchurch Emergency Department has had a new Nurse Manager appointed. Anne Esson has taken up the role permanently after filling in since December. We have recently lost two very experienced Emergency Nurses who left after many years of service, Denise Spencer has retired and is currently on an overseas trip and Angela Knight has moved to the Afterhours Clinic. Denise was given a very stylish guard of honour with bedpans and urinal bottles as she left the department after her last night shift. They will both be missed by all the staff.

Janine Kereama

Regional Reports
Regional Reports

Wellington Region

Jinty Graham
Clinical Coordinator
Wellington Emergency Department
Wellington

Contact: janetgraham@ccdhb.govt.nz
Hi from Wellington,

As I write this winter has New Zealand firmly in its grasp. Just like every emergency department Wellington has seen its fair share of busy days and overcrowding. After weeks of enduring "Code Oranges" with up to 36 hour waits for hospital beds and patients in every possible corridor space a "Code Red" was finally declared on the 19th July. Issuing a "code red" alert, Capital and Coast District Health Board management made an unprecedented SOS for qualified nurses to help out. Media was enlisted to inform the public to see their GP first.

Clinical leader Peter Freeman said winter seemed to take hospitals "by surprise" every year. "Essentially, the Government needs to resource hospitals properly to deal with winter. In the months leading up to winter Senior nurses in the emergency department has been asking for a winter plan. Management were unable to supply such a plan, hopefully they will learn from this year and make adequate plans for next year."

On behalf of my colleagues at Wellington Emergency Department I would like to thank everyone for their support during our "Code Red". We received many phone calls of support from Emergency Departments around New Zealand and knowing you were all thinking of us despite being busy yourself was great.

Meanwhile out in Lower Hutt the Emergency department is seeking record numbers of patients presenting while across the road the Accident and Medical centre run by local GPs is facing having to close at night due to limited presentations and rising costs for patients. One can only imagine the implications of this on Hutt emergency department which is already stretched on space and resources.

I hope to catch up with many of you at conference. I hope winter treats you well.

Jinty

Southern Region

Judi Van’t Wout
Nurse Educator
Dunedin Emergency Department
Dunedin

Contact: judiw@healthotago.co.nz
Hi from the Southern Region

Well conference is definitely looming on the horizon. A huge effort has been put in by a large contingent of dedicated emergency nurses to bring you the best selection of wine...... From an extensive list - a dirty job but someone had to do it. See the photo below:-

- Don’t forget to dress warmly for conference in Dunedin.
- Register for conference online at www.emergencynurse2007.co.nz

"There is no such thing as cold weather, just inappropriate clothing.” - Billy Connolly

For all you Shortland Street fans out there - don’t try to deny it - check out the staff room poster as part of the props/scenery - currently airing on TV2.

Recent local events have included:
- 100 year of nursing in Otago was celebrated in June.
- The ODHB has begun a project to look at patient flow.

See you all in Dunedin
Judi van’t Wout
College Support Directory

Triage Co-ordinator:
Position vacant:
Anne Smiley has resigned from the Triage Coordinator position. Thank you Anne, for the excellent service you provided by ensuring the provision of triage training throughout the country.
Anyone who is interested in fulfilling the Triage coordinator role should contact Justin Moore (see contact details opposite).

NZNO Nurse Advisor:
Suzanne Rolls
NZNO National Office
Wellington
Ph: 04 931 6747
DDi: 04 931 6712
Fax: 04 382 9993
email: suzanner@nzno.org.nz

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Lucien Cronin via email: Lucien.cronin@bopdhb.govt.nz
CENNZ Conference 2008
28th, 29th and 30th August 2008

Welcome to Auckland - City of Sails

Planning is well under way so mark it in your diary. See you all in 2008.

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