Draft New Zealand Child and Adolescent Asthma Guidelines

Submission to the Asthma and Respiratory Foundation New Zealand

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Draft New Zealand Child and Adolescent Asthma Guidelines.

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the Respiratory Nurses Section.

3. NZNO welcomes the intent of the Guidelines to provide simple, practical and up-to-date, evidence-based recommendations for the diagnosis, assessment and management of children and adolescent asthma in clinical practice, with the aim of improving outcomes and reducing inequalities.

4. NZNO found this to be a very positive and user-friendly document with relevant information, offering a systematic framework with easier to follow processes and has made a number of suggestions for further development of ideas and strategies.

DISCUSSION

5. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Guidelines.

6. Members felt the Guidelines make a meaningful contribution in the practice setting. In particular, members were pleased to see acknowledgement of the PREDICT bronchiolitis findings identified, and the section on under 5's provided very clear guidance.

7. NZNO notes that *He Maramatanga Huango: Asthma Health Literacy for Māori Children in New Zealand* which makes a number of recommendations to address health literacy to improve asthma outcomes for Māori children, is considered the gold standard document for asthma management and suggests consideration of this in the development of the Guidelines.[1]

8. NZNO has made a number of suggestions for further development of ideas and strategies, as detailed below.

[1] Jones B., Ingham T.R., Reid S., Davies C., Levack W. and Robson B. (2015*). He Māramatanga Huangō: Asthma Health Literacy for Māori Children in New Zealand*. Dunedin: University of Otago.

Abstract

Members queried whether this document might also be of use to prehospital providers, for example ambulance personnel, and, if so, should they be specified in the intended users in order to promote inclusion?

Introduction

1.1 Inequities in New Zealand

It is appropriate to highlight that children aged 13-17 do not generally have access to free primary health care. However, even for those within the age range where this is available, access to such is not always possible due to ancillary costs such as transport, ready availability of services etc. While the statement is made regarding the role of all health professionals in improving outcomes and reducing inequities, it is also worth noting the impact of disjointed provision of services and, at times, the difficulty of achieving the ideal seamless provision of care.

Members also highlighted that this section needs referencing to demonstrate the evidential base underpinning the statement relating to Māori and Pasifika inequities. It was noted that this section reads very differently to the rest of the guide. It may be worthwhile aligning the whole guide to be similar to the adult Guidelines for wording, format and lay out so that health professionals using both guides find them more user-friendly.

1.3 Other guidelines consulted

While it is appropriate that a wide range of guidelines are referenced, it is disappointing that the decision was made, particularly given the time since the previous 2005 document, not to carry out a systematic review of the literature to develop a fully robust evidence base.

1.8 Top 10 ways professionals can help

Under “relationships”, emphasis is understandably given to the primary care setting. However, it may be worth also considering the secondary relationships, for example, those between health providers, and with schools and emergency services.

Housing

The discussion around consideration of housing is based on the presumption that housing is available. The increasing incidence of homelessness and transience as a result of poverty affecting families’ needs to be considered. Not all individuals will even be in a formal housing situation.

Income

The discussion is too narrowly focussed. NZNO urges consideration of the broader financial and other burdens – can the family physically get to the doctor (transport), are there other child care considerations? Attention should be given to factors such as what time is taken off work for the adult accompanying the child and existing unpaid bills for other services with the health care provider. In terms of adherence, a simple question may be: *what would make it possible for you to follow the plan your doctor/nurse has suggested?*

Adherence

More helpful terminology may include “we all live busy lives and forget things”. Ask questions such as *“do you ever forget to take your medication?”*

Figure 1A

Note that there are some yes and no’s missing at the top of the graph. Also, under ‘preschool wheeze’ the box below mentions Monteleukast used for flare-ups. It is suggested that this could be expanded on, on page 7, where wheezes are discussed.

Figure 1B

Note that the top box has the word Ate instead of Are.

3.1 Evaluation of asthma control and severity

With regard to monitoring healthcare use, consideration of integrated care plans should be added to facilitate the sharing of information and improve the patient journey. Monitoring medicine use is also a measure of uptake if prescriptions are not being filled and this may be a trigger for identifying inequity due to issues of access and/or poverty.

Is there a reason why the GINA assessment is being used? If so, it should be stated. The Asthma Control Test (ACT) is a good way of assessing asthma control and there are ACT's for paediatrics and adults used in the adult Guidelines which could be included in the child Guidelines for consistency.

4.1 Non –pharmacological measures

While modifications to diet are, as noted, unlikely to have direct cause and effect impact on asthma, there is a relation with general health equity of wellness status. It is important the Guidelines maintain a holistic approach and not focus on asthma to the extent that it is seen in isolation.

NZNO urges consideration of the key broader environmental factors impacting on childhood asthma rates and inequalities in Aotearoa New Zealand with which we are now familiar: poor quality housing which is cold, damp and overcrowded and poor access to primary health care. The need to address poor housing conditions has emerged as a high priority for protecting the health of vulnerable children, and is strongly associated with higher hospitalisation rates for respiratory tract infection among Māori and Pacific children and those living in the most deprived neighbourhoods[2].

[2] Baker, M and Howden-Chapman, P. (2010). Time to invest in better housing for New Zealand children. *New Zealand Medical Journal, 126*(1367). Downloaded on

NZNO therefore strongly recommends that the Guidelines demonstrate a stronger focus on prevention of asthma by addressing how people live in their houses, as a dimension of clinical practice, as well as the clinical management of childhood asthma. While health professionals cannot fix the problems of housing, poverty and barriers to accessing primary care, they are in a position to advise on and assist with preventative measures people can take in their everyday lives to reduce the impact of these broader structural influences on asthma. This is within the scopes of practice of all regulated health professionals and in Codes of Ethics for health professionals.

NZNO recommends this section includes an increased focus on simple, practical measures aimed at mitigating the impact of poor housing and barriers to accessing primary health services on asthma control, with reference to the role of nurses where possible, including:

1) referral to nurse-led healthy homes initiatives (for example, in Wellington families with high health need are referred to the Hutt-based Housing Assessment and Advice Service, where public health nurses work to prevent children's hospital admissions through assessing unhealthy properties and advising on appropriate actions to take. Also, the three Auckland DHBs plus Northland, Waikato, Bay of Plenty, Lakes, Tairawhiti, Hawkes Bay and Capital and Coast and Hutt Valley DHBs have rheumatic fever-related healthy homes programmes that people may be eligible for);[3]

5/04/17 from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2012/vol-125-no-1367/editorial-baker

[3] McMillan, V. (2 September, 2015). When houses become ill-health traps, nurses get on with the job. *New Zealand Doctor*, Downloaded from https://www.nzdoctor.co.nz/in-print/2015/september-2015/2-september-2015/when-houses-become-ill-health-traps,-nurses-get-on-with-the-job.aspx

2) how health professionals such as nurses can give practical tips for warmer and drier homes;[4]
3) how to identify and address barriers to accessing primary health services. GPs fees, cultural and language barriers, costly prescription fees, transport issues and time delays in getting appointments are all significant barriers to accessing primary health services. Vulnerable population groups experience most, if not all, of these, which is reflected in a higher incidence of asthma.

4.2 Identifying management goals

Members suggested the inclusion of a patient-focussed point under the section 'adjust treatment' in line with the other sections, for example, patient willingness and understanding.

4.5 Adolescents: Getting it right for adolescents with asthma

Adolescents aged above 16 years of age are considered and treated as adults when seen as inpatient and specialty outpatients at many DHBs. Good Transition Guidelines at each DHB and PHO will help improve the transfer from paediatric to adult services. NZNO suggests there are specific physical and social reasons for adolescents being seen as a separate group with special needs (including needs related to asthma), as outlined in the Chief Science Advisor's (2011) report Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence. [5]

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[4] http://www.nursingreview.co.nz/issue/august-2015-vol-15-4/poor-child-health-and-housing-whats-being-done/#.WOLgEfnvPIU

[5]Office of the Prime Minister's Chief Science Advisor (2011) Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence, Downloaded on 20/4/2017 from http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf

Other aspects to consider with teenagers include:

- Vaping, which is becoming increasingly popular so there is a need to discuss the issues around vaping and how glycol (found in e-cigarettes) can aggravate asthma.
- Apps, which are great to use and the Health Navigator team are currently reviewing some to see if they are appropriate for kids/adults in New Zealand (for example using an alarm on a mobile phone as a reminder of when to take a regular preventer).
- The device that the adolescent uses – will they be more compliant with a different inhaler, for example Spacer and MDI vs Accuhaler or Turbihaler).

4.8 Health systems approach

Members suggest the inclusion of advocacy in terms of policy and research.

5.1 Stepwise Approach to long-term asthma treatment

Under Practice points - stepwise management, page 22. At step 5 ..by a paediatrician (or respiratory specialist).

5.3 Initial treatment choices (when to add ICS)

There is a need to clarify whether the standard recommended daily dose of ICS for paediatric asthmas is considered low or medium dose (in the stepwise). This could be interpreted differently by different users of the guide. An alternative heading could “starting maintenance dose for paediatric asthma.” Otherwise it could be described as having a 3 charts of recommended daily dose of ICS for: under five low, medium and high does; under 12 low, medium and high doses; and over 12 low, medium and high doses.

5.4 Treatment of Acute Severe Asthma

Note that reference should be made to Table 6 rather than Table 5. Also, we query why prednisone is not considered to be effective for under 5 year olds. This should be referenced for further reading or acknowledged in the Guidelines.

Figure 7: Algorithm for management of acute asthma appears to be for greater than 5 years old – is there one for under 5 year olds?

General comments:

It was observed that figures are mentioned in the text but several pages away so it may be helpful to have the page number next to the figure discussed so people know where to look. For example, figure 4 and 5 mentioned on page 11 and the figures are on page 20 and 21.

In terms of the acute care pathway, some elements of treatment that are currently in use are no longer advocated here. Acknowledgement that they have been removed (perhaps with the underpinning rationale) would be helpful in guiding practitioners in these areas, for example the use of aminophylline.

In addition to the feedback from nursing representatives, medical staff added additional feedback that aminophylline needs to be considered in severe cases. A focus of acute response is to avoid invasive ventilation where possible, NIV (Non invasive ventilation) may also have a role. It was considered that management of life-threatening asthma may need to be separated out as a specific path within the Guidelines.

CONCLUSION

9. In conclusion, NZNO hopes the above feedback is helpful and looks forward to the New Zealand Asthma and Respiratory Foundation's release of the Child and Adolescent Asthma Guidelines.

Nāku noa, nā

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