# AIRWAYS


## NEWSLETTER OF THE (NZNO) RESPIRATORY NURSES SECTION MARCH 2013 EDITION

## Inside this Issue:

## *Note from the Chairperson*

Welcome to the first issue of "Airways" for 2013. Hard to believe it is already March, especially as we are still experiencing this prolonged summer weather.

The Respiratory Nurses section AGM was held in February in Christchurch in conjunction with the South Island Respiratory Educators Forum (SIREF). SIREF always provides a very good value forum with informative speakers and highly relevant topics. If you were unable to attend, then read on as this issue of 'Airways' has reviews of some of the presentations, plus the poster from SIREF.

At the AGM I presented my chairperson's report which detailed a review of the activities we as a section have completed over the past 12 months. This report is available on the website for you to read, plus a shortened version will be in the April edition of Kai Tiaki.

*"To help us understand the implications of moving from a section to a College, we have included an article in this issue of 'Airways' by Lorraine Ritchie, NZNO PNA".*

With no remits to discuss at this year's AGM, we had the opportunity to gauge the views of members at the meeting regarding our move from a Section to a College. We also explored the views of members of whether we should stay as a 'Respiratory Nurses College' or if we should join with other sections of NZNO and become a 'Long Term Conditions College'. To help us understand the implications of moving from a section to a College, we have included an article in this issue of 'Airways' by Lorraine Ritchie, Professional Nurse Advisor, NZNO.

The AGM is the time when retiring committee members are farewelled, and new members are welcomed. Heather Thompson our very hardworking secretary for 5 years has completed her term. Thank you Heather for all the work you have done for the section! We formally welcome onto the committee Chris Rothman being seconded onto the committee in 2012, and elected on at this AGM. Sara Mason was also welcomed onto the committee. Janis Warburton has recently moved to Timaru from Wellington, ensuring that we have representation on our team from all over New Zealand. I look forward to working with the new committee over the next 12 months.

As always please let us know if you have any comments or questions, we value your ideas, contributions and feedback for only through this sharing can we truly represent you. Thank you.

**Nicola Corna**
ncorna@middlemore.co.nz
**Chairperson, NZNO Respiratory Nurses Section**

## *Update on Transitioning from Section to College*

***Lorraine Ritchie - NZNO Professional Nursing Advisor***

The NZNO Respiratory Section National committee has gained approval from the wider respiratory section membership to work towards the achievement of College status by 2016.

There are many benefits of becoming a college. These include a pooling of resources, an expansion of expertise and skills and a 'louder' political voice for nursing issues. Members will be able to belong to 2 colleges like they can belong to 2 sections now.

There are various ways of 'becoming' a college. The amalgamation of member groups is actively encouraged and a section may join up with an existing NZNO section/s or join with an existing NZNO college. It is not possible however for a NZNO section to merge with non NZNO groups, for example Australian wound and continence groups, to become a College. For this to happen, the members of those external groups would need to become members of NZNO to join up with the existing college or section.

When sections merge, core funding is calculated as a percentage of the college or section reserves. If 2 sections merged then there would need to be some consideration given to how the funds held by each section are disseminated. A new college would only be able to have one set of rules, one education policy, one Knowledge and skills framework and so on. The new college would need to work carefully and collaboratively on these documents and come to an agreement on how the documents contain the needs of all parties.

Another option is that a section can move to a college by itself (e.g. respiratory section to respiratory college), but they would need to give consideration to the amount of work involved and whether they have sufficient members to assist with that work. The section to college transitioning involves a lot of work and is probably best served by a small dedicated working group. These are the sorts of decisions the committee is currently making and will be able to report on in the next newsletter. Several other sections have started the journey and will be able to act as role models to guide the way.

**Lorraine Ritchie**
**Professional Nurse Advisor**
**NZNO**

# *Poster Presentation: South Island Respiratory Educators Forum (SIREF) 2013*

## *Advance Care Planning and Palliative Services for Patients with Chronic Pulmonary Disease: Supporting our Patients from the beginning .*

**Author: Sara Mason, RN, Hawkes Bay District Health Board**

Chronic Pulmonary Disease encompasses a variety of life limiting conditions such as Pulmonary Fibrosis and Chronic Obstructive Pulmonary Disease. Despite the differences in their pathology, Chronic Pulmonary Disease profoundly affects a person's physical, mental and emotional status. Often patients suffer with breathlessness, anxiety, pain, nausea, loss and fear. Many die suddenly unable to communicate with their loved ones.

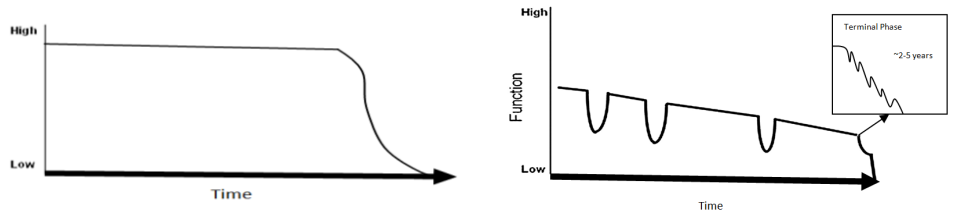
*"In Australia 70% of people who died were receiving active treatment right up until the moment of their death" (Hillman, 2009).*

Often with chronic disease, treatment is focused on the outcome of a cure, looking at the symptoms as the process of the disease, not as symptoms that can be managed. Treatment can go hand in hand with symptom management but many times the patient is left to suffer and the treatment continues. In Australia 70% of people who died were receiving active treatment right up until the moment of their death (Hillman, 2009).

Palliative care services and advance care planning at specific points in the chronic disease trajectory will support the patient from the beginning at diagnosis. This will provide an understanding and exploration of services throughout their disease process. Advanced care planning is a voluntary discussion that is recorded verbally or in written form that articulates an individual's wishes medically, spiritually and emotionally if they were unable to speak for themselves (Mason, 2012). The document that is created is an Advanced Care Plan. It is directed toward people who have life limiting conditions but can be generated before an illness arises if a person has strong beliefs and wishes that they want conveyed.

Advanced Care Planning provides a way for health professionals to introduce expectations and outcomes surrounding life limiting conditions and offers an opportunity for individuals to explore their options when they are at the end of their life. Palliative Care provides supportive management of physical, emotional, mental and spiritual symptoms of life limiting conditions, providing comfort care (Mason, 2012). Palliative Care services are unique in each region from Physician lead to multidisciplinary teams. They have historically been used with cancer patients at the end of life.

***Functional Trajectory (adapted from Haga, 2011)***



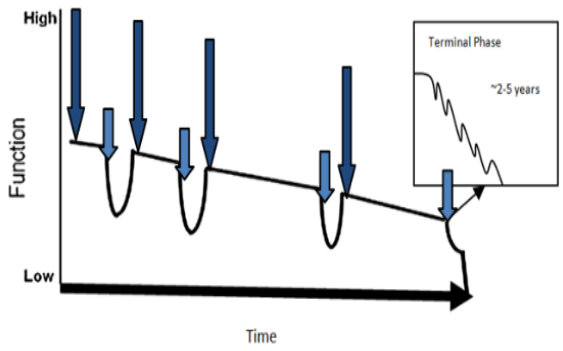
## *Poster Presentation: SIREF 2013 Cont.*

Unlike most diagnosed with cancer, patients with Chronic Pulmonary Disease typically present at diagnosis with a lower functional ability and then slowly decline with several acute exacerbations of their illness that may result in hospital admissions (Haga, 2011). These patients may live for a long time in relatively poor health, tipping on the edge of death for years. Each exacerbation leads to functional decline, never fully gaining where they were before. A common theme in an acute setting is a one sided direction of the medical team on treatment and cure and a failure to mention the impending death by any member of the team (Coventry, Grande, Richards, & Todd, 2005).

Communication is further complicated when patients have multiple co-morbidities and are using several health services. A balance of disease directed care with symptom management that is dependent on patient values and goals will provide health professionals with the support that is needed to work in partnership with their patients. This will improve service quality in all sectors of health care and put in place steps that can help manage acute demand and chronic disease.

The Trajectory model provides a visual reference of the typical functional health status of a patient with Chronic Pulmonary Disease from diagnosis to death. This can provide predicted opportunities for intervention to help support the patient along their journey. It is a fluid model where involvement of services is dictated by the trajectory of the individual's health status. It is important to note that the Trajectory Model is a tool, a point of reference, not the focus of care. Advance care planning is patient led and Palliative services are part of the supportive picture (Mason, 2012). The arrows represent opportunities for intervention starting at the point of diagnosis. Each dip in the trajectory is the hospital presentation with the subsequent arrow being the follow up in primary care.

***(Adapted by Haga, 2011)***




**Diagnosis**
In Acute or Primary Care, diagnosis is when the first mention of symptom control and Palliative Care services should occur. Advance care planning begins and a formal written Advance Care Plan is offered.

**Hospital Presentation**
The Advance Care Plan should be reviewed at each hospital presentation and alternative options of care explored. Increased support is offered from Palliative Care services.

**Primary Care**
After each hospital admission a debriefing should occur surrounding the patient's hospital experience Advance care planning should be reviewed and the Advanced Care Plan updated. In the acute setting the Respiratory Team will be able to offer symptom management alongside definitive management strategies as they draw on Palliative Care knowledge and expertise. Palliative Services can also help by providing support and insight to help determine when cure is not obtainable and offer alternatives that are in line with the patient's goals and values.

As the patient improves Palliative Care services become a more supportive role for the patient and their primary health care provider. Palliative Care will align medical treatment with the patient's wishes and the tool for communication will be an Advance Care Plan.

## *Poster Presentation: SIREF 2013 Cont.*

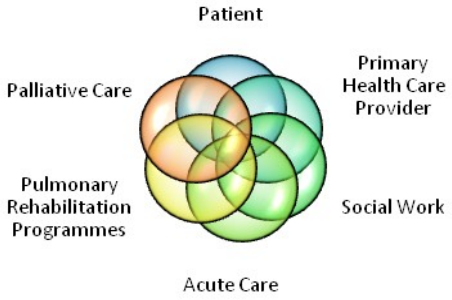
Palliative care services and advance care planning can provide support as patients explore and come to terms with their progressive disease. These services become the normality of their treatment where their experiences will be regarded as just as important as the response to the medical intervention.

Advance care planning will increase communication and understanding between health care professionals and their patients (Taylor, 2012). This will provide an opportunity for conversations about the disease, treatments and realistic outcomes that may be offered in the future and encourage conversation surrounding a person's health.

*"PROVIDING PALLIATIVE SERVICES"... WILL "EMPOWER THEM TO BE ACTIVE IN THEIR OWN HEALTH CARE AND END OF LIFE" . (MASON, 2012)*

**(Mason, 2012)**

Opportunities for Advance Planning Review




Providing Palliative services and advance care planning at the beginning of diagnosis and at specific points throughout the disease process will provide the support and symptom management that is missing for many patients. It will assist in helping individuals to have their wishes heard in a mainstream service and empower them to be active in their own health care and end of life (Mason, 2012).

The current models that are used focus on managing the condition, but do not help the person manage the impact this condition has on their lives (Schraeder & Shelton, 2011). There is a need to move away from the curative approach to chronic disease into an integrative approach that involves participation from the patient in the process of their own health care.

**References:**

*Coventry, P., Grande, G., Richards, D., & Todd, C. (2005). Prediction of appropriate timing of palliative care for older adults with non malignant life threatening disease: A systematic review. Age and Ageing, 34(8), 218-227.*

*Haga, K. M. (2011). Identifying community based chronic heart failure patients in the last year of life: A comparison of the Gold Standards Framework Prognostic Indicator Guide and the Seattle Heart Failure Model. Heart, 98(7), 579-583. doi:10.1136/heartjnl-2011-301021*

## *Poster Presentation: SIREF 2013 Cont.*

Hillman, K. (2009). *Vital Signs: Stories from intensive care.* Sydney, NSW, Australia: University of New South Wales Press LTD.

*Mason, S. (2012). Advance Care Planning: Integrating Chronic Conditions into Palliative Care. 20th Hospice New Zealand premier clinical Palliative Care. Auckland: Hospice New Zealand.*

Schraeder, C., & Shelton, P. (2011). *Comprehensive care and coordination for chronically ill adults.* Oxford, UK: Wiley-Blackwell.

*Taylor, R. (2012). End of life care for patients with chronic disease: The need for a paradigm shift. BPJ (40), 9-13*

## *Conference Report: South Island Respiratory Educators Forum (SIREF)*

**Reviewer: Elly Grant, RN, Kaupapa Maori & Pasifika Shared Services Clinical Co-ordinator - NGO Collective (Ōtautahi based)**

Kia ora: It was my very great pleasure to have been able to attend the latest SIREF, held in Ōtautahi along with three nurses working in a Kaupapa Māori NGO, a Pasifika NGO and the Aranui Neighbourhood Community Trust. All managed to gain funding to attend through the NZNO Respiratory Section Scholarships.

All sessions presented within SIREF proved interesting and stimulating commencing with a Mihimihi and Tai Chi (to centre us all) and then to the speakers. For me personally the two sessions most meaningful - were *Brief effective intervention, are we really preaching to the Converted!* - By John Hewitt (CNS, CDHB) and *Non compliance or do they not understand?* - By Teresa Chalecki (RN, CanBreathe).

**Non Compliance / Adherence/ Concordance – what is this all about?**
Personal experience tells me – patients do not understand or are not given the information in a format to which they can relate. Both audits presented to us, clearly demonstrated we have still not got this right. So whose responsibility is this? Or is this Health Literacy?

**John's question "Do we enrol patients or do we empower people?" begs thought.**
Health literacy is a major issue globally let alone in Aotearoa. In simple terms health literacy refers to a person's ability to obtain process and understand basic health information and services in order to make informed and appropriate health decisions. A recent report found that overall the majority of NZ'ers have low levels of health literacy and Māori have much poorer health literacy skills than non-Māori. This is likely to have a negative impact on their health status.

When I look back at the report (November 2012 Edition – 'Airways' newsletter) written by Kate Cooper, I note the 2006 Census stated 56% of Māori are illiterate, indicating they have less knowledge regarding health and treatment. In the same report only 9.5% of Māori diagnosed with COPD receive treatment compared to 77.8% of Pakeha. In a six year study on 89,000 New Zealand patients, Māori were 16 per cent more likely to be readmitted or to die than were NZ Europeans.

We have the assessment tools for Asthma e.g. the Asthma Control Test (ACT) and the tools available for COPD e.g. Spirometry, and yet we fail to diagnose early in order to have effective outcomes.

## *Conference Report: (SIREF) 2013 Cont.*

When we refer to the GINA guidelines (Global Initiative for Asthma) we can see clearly that someone with well controlled asthma:

- Should not experience any daytime symptoms
- Should be able to have a full night sleep without symptoms
- Should not be limited during any activities
- Should not require the use of a reliever
- Should have normal lung function

The presentations at SIREF and the statistics on respiratory health leave us with many questions.

*"THERE ARE MORE QUESTIONS THAN ANSWERS — THE MORE WE LEARN THE LESS WE KNOW".*

- We know asthmatics should be able to live a normal life, but how many do?
- How do we look at COMPLIANCE / ADHERANCE / CONCORDANCE? (The audit Teresa shared with us tells us we have much work still to do)
- Do we TELL rather than SELL? And does this result in effective BUY IN?
- HOW DO WE ACHIEVE this EMPOWERMENT?
- Do we need a multitude of different approaches - to address the disparity data between Māori and Pacific populations and Non Māori mainstream populations**?**

I believe the key remains - effective individual / Tangata Whaiora and Whānau empowerment! As with all things – *There are more questions than answers – the more we learn the less we know.*


***Elly and her team - Purapura Whetu staff (Kaupapa Maori NGO) working in new ways after the earthquake.***

**References:**

*Robson B, Harris R. (eds). 2007. Hauora: Māori Standards of Health IV. A study of the years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.*

*Ministry of Health. 2010. Kōrero Mārama: Health Literacy and Māori. Wellington: Ministry of Health.*

*Holt, S., Beasley, R. 2001. The Burden of Asthma in New Zealand. Published by the Asthma and Respiratory Foundation*

*Rumbell-Smith, J., Sarfati, D., Hider, P., Blakely, T. 2013. Ethnic disparities in the quality of hospital care in new Zealand, as measured by 30-day rate of unplanned readmission/death. International Journal of Quality Health Care 14 February online*

*Global Initiative for Asthma: A Pocket Guide for Physicians and Nurses: Updated 2012: http://www.ginasthma.org/documents/1/Pocket-Guide-for-Asthma-Management-and-Prevention*

First of all I would like to thank the NZNO Respiratory Section for the scholarship and Elly Grant for facilitating my attendance to SIREF. It was good to learn new and relevant information to assist Pasifika clients with Respiratory conditions. Without this scholarship I would not have been able to attend. Some topics were particularly interesting including fungal lung infections; pulmonary arterial hypertension; and the COPD project.

After the SIREF conference I visited one of my clients, she asked how the conference went and I responded by explaining what I had learnt about fungal lung infection. The client responded that she had been admitted to hospital last year due to this condition which gave her shortness of breath, fever, and a productive cough.

Aspergillosis, a cause of fungal lung infection, is a common fungus in the environment. It is frequently found in the respiratory tract and can cause a wide spectrum of diseases. The symptoms are fever, shortness of breath and chest pain, the same as my client had described.

I also learnt that there are different kinds of fungal lung infections such as Invasive Pulmonary Aspergillosis, commonly found in immunosuppressed patients; chronic necrotizing aspergillosis; allergic broncho pulmonary aspergillosis (ABPA); and aspergilloma, a fungal ball that grows in a pre-existing cavity such as a cavity from TB, Cancer, Sarcoidosis and Bronchiectasis.

Another interesting topic was Pulmonary Artery Hypertension (PAH) presented by Dr Lutz Beckert. In PAH the lungs have an elevated blood pressure. It is a rare condition, only 120 patients are found to have been admitted with (PAH) and it is difficult to diagnose. This condition is more common in young women but can affect anyone at any age, sex and race. Although the cause is unknown, it can be caused by smoking; diastolic and systolic dysfunction; COPD; interstitial lung disease; and sleep disorders. Symptoms include shortness of breath, fatigue, dizziness and early systolic ejection click.

I found this interesting as a client may complain of shortness of breath but spirometry, ECG's and Chest X-rays can be normal. Treatment may include oxygen therapy, anticoagulants and specific pulmonary artery dilators. Dr Beckert stated there are few treatment options available.

It was good to hear Dr Mike Epton presenting the Canterbury COPD project. He suggested that COPD should be diagnosed early and interventions such as smoking cessation; changing attitudes with patients, the health system and society; and management of co-morbidities will lead to a more effective health care for these patients. He referred to the use of wellness models for early identification of diseases and stressed the importance of managing co-morbidities and for health professionals to focus on wellness. This approach appeals to me as it is a holistic approach to health care.

Overall, a fantastic conference.

**Faafetai lava**

*Reviewer: Alo Collins – Mobile Community Pacific Disease State Management Nurse - Tangata Atumotu Trust*
*Reviewer : Maree Leather, RN, He Waka Tapu, Christchurch*

# *It's Bad Enough Having COPD Without Worrying About It All The Time As Well*

## *Can a person's state of mental health affect COPD or can COPD affect your mental health?*

**Presentation by Dr Jaki Horn, Psychologist**

That is the question I asked myself as Dr Horn began to speak. It is a health issue which is easily missed when discussing chronic diseases such as COPD. Her presentation was brilliant, and easy to understand and I was pleased this topic was included in this year's SIREF.

*"PEOPLE WITH CHRONIC DISEASE HAVE HIGHER RATES OF DEPRESSION AND ANXIETY THAN THE GENERAL POPULATION".*

It is a known fact that poor Mental Health is a barrier to self-management and health outcomes. People with chronic disease have higher rates of depression and anxiety than in the general population. All those with COPD are at different stages in their journey and feel the psychosocial burden of their disease. The psychosocial burden includes fear of dying; altered body image; altered role in the family; loss of independence; feel they are a burden; loss of dignity; loss of intimacy; panic; anxiety and depression.

Summary of some of the topics discussed included:
*General tips how to manage anxiety attacks*

1) **RETREAT (Early Panic)**
   - Recognise early warning signs
   - Keep still
   - Lean against a wall

2) **DISTRACTION (Mid Panic)**
   - TV/music
   - phone a friend
   - focus on an object
   - Medication

3) **GIVE IN (full panic attack)**
   - keep calm
   - breathing exercises
   - use relaxation CD
   - imagery
   - tell yourself it will pass

*Cognitive Behavioural Therapy*

1) **RELAXATION TRAINING**
   - Breathing
   - progressive muscle relaxation

2) **COGNITIVE PROCESSES**
   - taking charge of your thinking
   - identify automatic thoughts and associated feelings

## *It's Bad Enough Having COPD Without Worrying About It All The Time As Well Cont.*

**3) EXPOSURE BASED TECHNIQUES**

- imagine situations and identify the related thoughts and feelings
- identify distorted thinking patterns
- challenge the thought
- replace the thought
- change the action

Anxiety and depression can lead to more hospital visits. Action plans created in partnership with the person who has COPD, which includes both the physiological and psychological factors, will improve health outcomes and health management for the individual and their whanau.

**Thank you Dr Jaki Horn!**

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**Reviewer: Jenny Herring, RN, Aranui Community Trust Inc Soc (ACTIS)**

When I was offered an opportunity to attend the SIREF conference at short notice I had no problems saying YES and arranging time away from work. Working in Primary Care for a Community Trust, in isolation from General Practice and the Primary Health Organisations these opportunities do not come my way often. My role means you need to know a little bit about everything but every so often you need to know a lot about something.

Respiratory health and smoking are huge health issues in the population I work with. Therefore attending SIREF gave me the opportunity to net work with other nurses, reinforce my existing knowledge and learn the latest in Respiratory health, particularly aspergillosis.

I have worked as a Primary Care Nurse in Aranui for five years am employed by the Aranui Community Trust Inc Soc (ACTIS) which was formed twelve years ago. Our Mission is "Changing minds, to change lives and break cycles".

**My role involves:**

- Working in collaboration and partnership with families who are struggling
- Families and individuals who appear to fall through the gaps
- And who as a result - see their health as the lowest of priority

Referrals are received from Medical Centres, Schools, Preschools, and outpatient, inpatient services from our local District Health Board. Education on health issues forms a huge part of my role. Therefore attending SIREF to net-work, to consolidate and learn new things was extremely important and valuable to me.

## *Events for your Calendar*

## CONFERENCE

**TSANZ – Annual Scientific Meeting**
**23-27th March 2013**
**Darwin, Australia**


**For further information about this meeting contact: dehart@middlemore.co.nz**

The main speaker for Respiratory Nurses Section programme is Alistair Story, a nurse who set up the 'Find and Treat' programme in the UK. This programme is aimed at finding and treating homeless destitute clients who have TB in London. He will also be speaking in the main TSANZ meeting.

**TSANZ – NZ Branch Meeting**
**7, 8 & 9 August 2013**
**Queenstown, New Zealand**
**For further information about this meeting contact: dehart@middlemore.co.nz**

**Asthma Foundation - New Zealand Respiratory Conference**
**19 & 20 September, 'Making a Difference'**
**Wellington, New Zealand**

the asthma foundation
*Better respiratory health for New Zealanders*

**For further information about this conference contact: www.asthmafoundation.org.nz**

## COURSES

**Respiratory Course - Asthma**

This one-day course provides nurses with an overview of the management of asthma
Dates: 16th May 2013
Venue: Hutt Hospital, HVDHB
Cost: $115
Enquires to: Melinda.mcginty@huttvalleydhb.org.nz

**Respiratory Course – COPD**

This one-day course provides nurses with an overview of the management of COPD
Dates: 11th April & 20th June 2013
Venue: Hutt Hospital, HVDHB
Cost: $115
Enquires to: Melinda.mcginty@huttvalleydhb.org.nz

## *Events for your Calendar Cont.*

## *REGIONAL MEETINGS*

**Auckland**

Respiratory Nurses in Auckland
Next meeting: 25th March 2013 at 4-5pm
Venue: Lecture Room 54152, Level 5, Building 4, Greenlane Clinical Centre
Contact: KarenSt@adhb.govt.nz

**Bay of Plenty**

REPS (Respiratory Educators Peer Support)
March 6th, June 5th, September 4th, December 4th
Contact Reception Desk: Ph: 07 577 6738
Email: Lyn Tissingh at lyn@asthmabop.org.nz

**Wellington**

Wellington Regional Respiratory Nurses Forum
Next meeting: 18th April 2013, 6th June 2013
Venue: Hutt Valley DHB (April meeting) Capital & Coast DHB (June meeting)
Contact: Betty Poot , ph 04 5709771
Betty.poot@huttvalleydhb.org.nz

Editors Note - If you have regular meetings for Respiratory Nurses in your area, email me with the group's name, place of meeting, date and contact person and I can put the information in the next newsletter. Betty.poot@huttvalleydhb.org.nz

## *Your Committee 2013*

| ROLE | NAME | E-MAIL |
|---|---|---|
| Chairperson | **Nicola Corna** | Nicola.Corna@middlemore.co.nz |
| Vice Chairperson & Newsletter Editor | **Betty Poot** | Betty.poot@huttvalleydhb.org.nz |
| Treasurer National | **Judith Quinlan Logan** | Judith.quinlan-logan@bopdhb.govt.nz |
| Secretary | **Steph Parker** | Steph.parker@gmail.com |
| Membership Secretary and Web Site Editor | **Liz Fellerhoff** | Elizabeth.fellerhoff@wairarapadhb.org.nz |
| Committee Member | **Janis Warburton** | jwarburton@scdhb.health.nz |
| Committee Member | **Chris Rothman** | Chris.rothman@wdhb.org.nz |
| Committee Member | **Sara Mason** | usnursenz@hotmail.com |
| NZNO Professional Nursing Adviser (Liaison) | **Lorraine Ritchie** | lorrainer@nzno.org.nz |