AIRWAYS

NEWSLETTER OF THE (NZNO) RESPIRATORY NURSES SECTION APRIL 2014 EDITION

Inside this Issue:

Note from the Chairperson

Welcome to our first issue of 'Airways' for 2014.

'Reaching Out – from hospital to community' is the theme of our symposium and annual general meeting (AGM), which is fast approaching. That theme is reflected in this current issue of 'Airways'. I really enjoy learning from the experiences of my colleagues in all areas of New Zealand. I believe that we can combine their experiences with our own, to improve the care we provide in our communities. Ultimately, this ensures the best quality of care for respiratory patients wherever they are in New Zealand.

Each article in this issue of 'Airways' demonstrates innovative thinking and illustrates new solutions to issues we each face in our daily practice. I salute the nurses who have shared their personal experiences, and the teams who have assisted and encouraged them in these new endeavours.

"EACH ARTICLE IN THIS ISSUE OF 'AIRWAYS' DEMONSTRATES INNOVATIVE THINKING AND ILLUSTRATES NEW SOLUTIONS TO ISSUES WE EACH FACE IN OUR DAILY PRACTICE".

Please consider joining us on 11 April 2014 in beautiful Whanganui. We have an interesting and varied programme aimed at both hospital and community nurses alike. One of our speakers is Josephine Davis Wheaton, nurse practitioner in Taupo, who will be speaking about telehealth in rural practice. I am looking forward to meeting many of you there.

I would like to thank Steph Parker (Tauranga), Liz Fellerhof (Masterton), Janis Warburton (Timaru) and Judith Quinlan-Logan (Whakatane) for their significant contributions to the Respiratory Nurse section committee. They are all stepping down at the forthcoming AGM. Each of these ladies has volunteered many hours of time ensuring that symposia were organised, funding arranged, memberships kept updated and promoted, submissions analysed and submitted and all the minutiae that keeps the respiratory nurse section relevant and contributing to improving patient care across the whole of New Zealand. I wish them well in their future endeavours.

Finally, I am stepping down from the Respiratory Nurses Section NZNO committee at the AGM in April. It has been a genuine privilege to be part of the respiratory committee for the past five years. I have met some incredibly inspiring nurses during this time, and have gleaned many insights from them. I love the fact that we are bound together by our common passions of providing excellent holistic care to the communities we work in, and striving to improve our practice. Thank you for the opportunity I've been given and I certainly encourage you to consider being part of the team, as vacancies arise.

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

Improving our Respiratory Service - A Learning Experience

The Canterbury community pulmonary rehabilitation programme aims to provide exercise and education for people who suffer functional breathlessness from lung disease; predominantly for those people who have a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The service has moved from one central venue to seven venues throughout Canterbury and has the ability to accept 304 participants each year.

Following a recent evaluation of the community pulmonary rehabilitation programme it was identified that we needed to include consumer representatives in our decision making processes. The team believed they were doing a good job based on the validated international outcome measures used, but the experiences and expectations of participants had only been explored using programme evaluation forms. We wanted more in-depth information and a thorough evaluation of the service. We were keen to explore using a consumer group to help inform our decisions about the future of the service and agreed to present a proposal to the pulmonary rehabilitation working group (PRWG).

Method

As I had no experience of setting up a consumer group, I contacted anyone I could think of within the organisation who could give some guidance. Although a chaotic method, it proved invaluable as it ultimately led to getting the proposal started. For guidance I also obtained a copy of the Canterbury District Health Board (CDHB) Consumer Focus Group Policy which was an excellent framework.

Proposal

The writing of the proposal was arduous and time consuming due to my lack of IT skills and to my lack of knowledge of consumer groups. I decided upon one small group of 6-8 previous participants of the pulmonary rehabilitation programme. Additionally as I had no previous experience facilitating a group like this and all the literature supports having an experienced facilitator, I believed it was essential to have a health professional with the appropriate skills to facilitate the meeting.

Writing the proposal has enabled me to consolidate my thinking in a more logical manner and following the first draft I asked a colleague, who did not know anything about my work, to review the information. I actually found this quite difficult! However the critical analysis of the proposal in an informative and constructive way was a huge help to me.

The aim of the proposal was:

> *"To obtain consumer feedback from previous participants who have attended and completed a community pulmonary rehabilitation programme in Christchurch during the last two years and to use this information to guide and formulate future programmes".*

The final report was circulated amongst my own team and then presented to the PRWG. The proposal was accepted and all the previous participants who were contacted accepted an invitation to join the first meeting. I had not expected people to be so overwhelmed to be involved, but they were excited to have been considered and one participant stated:

> *"It's an honour to be included in this group and I'm keen to give back and help in any way I can".*

Improving our Respiratory Service A Learning Experience Cont.

Reflection

I had underestimated how time consuming and demanding this piece of work was. Although I was willing to learn and put ideas into practice, without appropriate support and guidance this can be difficult. It is good to be enthusiastic about a project, but having the necessary skills to deliver it are essential for success.

I had not identified this as a major piece of work and my organisation skills needed enhancing. On the positive side it has been an opportunity to network with people within and outside my organisation, this has proved to be invaluable.

I am looking forward to working with our consumers, to learn from their experiences and to incorporate their thoughts and suggestions into the pulmonary rehabilitation programme to enhance the service we provide to our participants.

"I had underestimated how time consuming and demanding this piece of work was." Although I was willing to learn and put ideas into practice, without appropriate support and guidance this can be difficult."

Author: Louise Weatherall
Community Respiratory Nurse
Canterbury Clinical Network

References

1. Canterbury CDHB-Consumer Focus Groups. (2006) Volume 2. Legal and Quality.
2. Kitzinger J. Qualitative Research in Health Care. 3rd edition 2006. Focus groups with users and providers of health care. Chapter 3, Page 21-29. BMJ Books
3. Professor Dee Mangin and Dr. Lynley Cook. Nov 2012. Pegasus Health Guide to Programme Planning, Research and Evaluation (Draft). Volume 3, page 29.

Integrating Respiratory Care

Background

Over the past year Hawke's Bay DHB has been working towards redesigning respiratory services in order to integrate primary, secondary care, and non-government organisations (NGOs). As part of this project, we examined other models around the New Zealand, in particular Canterbury, which helped shape our project. It was agreed early on that we would 'share' the knowledge throughout primary care, rather than only having a few key sites.

We began with an audit of 'what was happening', great variations were found with regard to spirometry, asthma and COPD management. Three areas stood out in our audit; nurses did not have any training in spirometry, asthma and COPD patients were treated using the same pathway and respiratory disease was not seen as a priority. Apart from smoking cessation, no respiratory targets have been enforced by the Ministry of Health.

A nurse led service appeared to be sensible, as long as sufficient funding could be provided.

Working with Primary Care

Key GP practices were approached as to whether they were keen to be involved as pilot practices. An agreement was reached and spirometry training was provided by the respiratory team including a respiratory scientist for identified practice champions. The training to these practice champions included the history of spirometry, theory and practical aspects of spirometry. Follow-up and support continues to be provided by the respiratory scientist, in the nurses own practice. A competence certificate is granted once the nurse has demonstrated a good understanding of the process, and a yearly update is designed to ensure continued competence.

Meanwhile a respiratory diagnosis and management tool was developed, offering diagnostic support to nurses performing spirometry with screening as a pre-requisite for all who are at risk of chronic respiratory disease. The algorithm behind this management tool draws from already entered classifications within Medtech, e.g. smoker / ex smoker, known obstructive respiratory disease and encompassed the MRC dyspnoea scale. The NHannes III algorithm supports the calculation within the form and pre-population was available for height and weight. Once spirometry with reversibility had been performed, a classification is suggested. The form then directs the user into a long term care plan, which has a list of tasks that the user can work through, depending on the severity of the COPD. If the person is classified as asthma the user is directed to the GASP tool (Giving Asthma Support to Patients).

Interestingly our experience so far using this system has found that many who were classified as having COPD / asthma had never had spirometry performed, but were being treated for the suspected disease process. We found during this process that the nursing staff needed extra support with the management of COPD and asthma. Education sessions were provided, and the Respiratory CNS from the hospital, and Respiratory Nurse Educators from Asthma Hawke's Bay worked alongside the practices providing the support as needed.

Each health care consumer is offered spirometry. If the screening tool decrees it necessary a care plan is commenced, and the education continues for a further 3 appointments. The COPD Assessment Test and / or the Asthma Control Test should be completed at each appointment. The aim is for the patient to demonstrate an improvement in quality of life. Unless there is a specific contra-indication, a self management plan should be generated by the clinician in consultation with the patient. They should also be provided with a back pocket script for use when exacerbating. Alerts are being added onto Medtech that highlights that the patient should be seen that day if they ring for an appointment after commencing their management plan.

Integrating Respiratory Care Cont.

Improving Communication

Secondary care acknowledged that there was room for improvement in our communication with our primary care colleagues. To assist with this a respiratory nursing transfer form (Nurse 2 Nurse transfer) is generated when a person with respiratory disease is admitted. This form encompasses such things as observation of inhaler technique, sputum clearance, and healthy homes to name a few. This is filled in by the multidisciplinary team throughout the admission and sent electronically to the practice when the health care consumer is discharged home. This has proved to be another way of identifying clients who are having difficulty self managing their condition.

"THIS EXPERIENCE HAS BEEN A JOURNEY INTO THE UNKNOWN IN MANY WAYS."

Reflection

This experience has been a journey into the unknown in many ways; however practices which were initially slightly dubious are now welcoming our input in identifying clients who need the support with managing their respiratory disease and getting an accurate diagnosis. It is hoped that with the support available to these clients, eventually we will see many more being treated in primary care, and not in the revolving door of the emergency department. Whilst this project is in the early stages, it has identified that we are only scratching the surface at the moment; the services which follow on from diagnosis, for example pulmonary rehabilitation and long term condition programmes will need the financial support to be able to grow to meet the need of this previously under recognised cohort. It is hoped that by continuing to work towards integration of services, using evidenced based practice that the respiratory health of Hawke's Bay residents will improve in the future.

Author: Sue Ward
CNS, Respiratory
Hawke's Bay District Health Board

Why Multi-Condition Rehabilitation instead of Pulmonary Rehabilitation at South Canterbury District Health Board?

Pulmonary rehabilitation is recognised as improving quality of life for patients with COPD as well as reducing number of hospital admissions, length of hospital stay, and a number of other benefits. (1) (2) . Pulmonary Rehabilitation programmes are shown to be effective if 6 weeks or longer, and contain both an exercise and an education component (1). Pulmonary rehabilitation courses traditionally include a pre and post assessment session to ascertain patient progress throughout the course, and a variety of assessment tools are used in these sessions such as quality of life questionnaires and 6 minute walk test (1).

South Canterbury District Health Board (SCDHB) is one of the smallest DHB's in New Zealand (NZ) and covers a population of 55,000. The main town centre is Timaru, and SCDHB covers a large rural area, including Twizel, which has the most remote medical centre in NZ.

Why Multi-Condition Rehabilitation instead of Pulmonary Rehabilitation at South Canterbury District Health Board? Cont.

Pulmonary rehabilitation was commenced in SCDHB in 2007, and 21 full courses plus refresher courses were completed between 2007 and 2012. Concurrently there was the development of the Community Health Team comprising of respiratory, diabetes, and cardiac Clinical Nurse Specialist's (CNS) plus smoke free facilitators, dietitians and physiotherapists. The decision to commence multi-condition rehabilitation (MCR) programmes instead of a pure pulmonary rehabilitation programme was to ensure patients received a 'wrap around' service from all the members of the community health team. It also allowed specialist staffing resources within a small DHB to concentrate on one rehabilitation programme.

The first MCR programme started in 2012. It is open to patients with long term conditions (LTC) such as COPD, diabetes, cardiac disease and arthritis. It is 'physio led' and the framework is consistent with pulmonary rehabilitation. There is a pre and post assessment session and then 12 classes that run over 6 weeks. There is one hour of exercise followed by an education session for the patients delivered by a member of the community health team. There are also sessions from the occupational therapist, community pharmacist and chronic pain CNS. The programmes are held in Timaru, Waimate and Temuka consecutively depending on demand.

The outcomes for the MCR programme are compatible with outcomes for pulmonary rehabilitation programmes. Additionally patients report improved self management for all their LTC's not just the one that led to the referral to the rehabilitation programme. There is also an increase in self referrals to members of the community health team from the patients participating in MCR.

Moving forward, the pre and post assessments are being streamlined to involve all members of the community health team. There is also discussion to see how a MCR programme can be completed in the more remote areas such as Twizel.

In summary, MCR programme has the positive outcomes that pulmonary rehabilitation has, and in addition improves self management of other LTC's. MCR also means maximum utilisation of specialist staffing resources within a small DHB.

Author: Janis Warburton, RN Comp, BN, MN
Respiratory CNS, South Canterbury District Health Board

References

1. Lacasse Y, Brosseau L, Milne S, et al. 2002. Pulmonary rehabilitation for chronic obstructive pulmonary disease. Cochrane Database Systematic Review: CD003793

1. Ries AL, Bauldoff GS, Carlin BW, et al. 2007. Pulmonary Rehabilitation: Joint ACCP/AACVPR Evidence-Based Clinical Practise Guidelines. Chest: 131: 4S-42S

Conference Report: - 'The Air Is Out There'

SIREF: 20-21st February 2014, Copthorne Commodore Hotel, Christchurch.
A joint forum organised by Canterbury District Health Board (CDHB) and Canbreathe.

The South Island Respiratory Educators Forum (SIREF) conference presentations were interesting and varied. Dr Mike Epton, community respiratory physician (CDHB), presented 'New ways of looking at COPD severity' which was an excellent introduction to the new GOLD guidelines, and classification methods. It provided the concept that a person may not necessarily have severely impaired lung function to be at risk of deterioration, and that increased exacerbations impact greatly on the health dollar and on patient experiences.

"The South Island Respiratory Educators Forum (SIREF) conference presentations were interesting and varied."

We were also treated to a humorous but thought provoking session from Ronnie Ellis, a practice nurse, about life in a general practice providing respiratory monitoring. This showed us that the chief need for a practice nurse is to have at least 4 pairs of hands! Her juggling act provided some thought provoking truths.

The 'Collaborative Care for Long term Complex patients' from Donna Hahn who as a Clinical Liaison for the Collaborative Care Programme run by the Canterbury Clinical Care Network, demonstrated how Canterbury is working towards the vision of one health system. An integrated record will enable all those involved in a patients care to view and/or contribute proactively towards the care of that patient.

'Community based spirometry' by Teresa Kilkenny, Louise Weatherall, community respiratory nurses from the Canterbury Clinical Network, and Josh Stanton, respiratory physiologist from CDHB, showed us how successful working across the boundaries of primary and secondary care can be. There has been a move to introducing approved providers for spirometry, with the emphasis supporting this service. A respiratory physiologist informed us that on average he spends 35 hours with each practitioner in a mentoring and support capacity.

The presentation on 'Restless leg syndrome' elicited many questions of Judy Jones, a Respiratory Facilitator from the Canterbury Clinical Network, and a few in the audience commented that they experienced these symptoms, let alone the patients!

Tackling long term condition management in sleep was next from Sally Powell, a CNS from Sleep Health CDHB. She introduced a new model of care to manage ongoing needs of people with obstructive sleep apnoea. This is essential when managing 3000 people with CPAP in the service and 500 new people trialling therapy each year.

Don't forget to breathe; a book addressing pre-diagnosis through to dying with COPD was presented by Sue Ward, CNS respiratory and Carole Donnelly, senior physiotherapist from Hawke's Bay DHB. The book is available free of charge from the website: http://dontforgettobreathe.org.nz/

In the future an exercise video will also be available from this website. An electronic tour of the book was presented.

Conference Report: - 'The Air Is Out There' Cont.

The second day commenced with Jenny McWha and Donna Thompson, CNS's from the CRISS CDHB, sharing with us the home oxygen service in Canterbury. They explained the criteria for receiving home oxygen, provision and the impact of having domiciliary oxygen on people's lives.

Next up was Dr. Alistair Humphrey a public health physician and medical officer of health, who made us sit up and take notice when talking about the post earthquake asbestos issue in Christchurch. An often overlooked and mini-mised disease, globally with 107,000 deaths yearly, Alistair showed us that we really need to be alert to potential increase in the future.

Jenny McWha was back, giving us an overview of tuberculosis (TB) in Canterbury, and the service provided by the TB team including daily observed treatment (DOT) something that was new to most of us in the room! The myths of TB being a disease of the past were rapidly dispelled as identification and contact tracing were discussed.
Dr. Lutz Beckert, respiratory physician CDHB, finished off the forum with an update on recent research in asthma and discussing the asthma control test (ACT) use. He also highlighted that 16% of children in NZ use an inhaler, and 9.2% are using 2 or more!

He finished with "Breakfast at Glenfield"; a parody of Deep Blue Something's 2009 song, which had us all in fits of laughter.

This was my first time at SIREF and will definitely not be my last. It was refreshing to see so many people who work at the coal face, both in wards and general practice. The cost of crossing the Cook Straight is never cheap, however it was extremely worthwhile and I would highly recommend this forum to others. There is great work happening in Canterbury and this is an excellent opportunity to share it with the rest of the country.

Report author: Sue Ward
CNS Respiratory, Hawke's Bay District Health Board

Events for your Calendar

CONFERENCES

Respiratory Nurses Section NZNO Symposium

Venue: Wanganui Race Course, Purnell Street, Whanganui
11th April 2014, 9:00am – 4.30pm
Topics include: Respiratory Assessment; Pulmonary Rehabilitation; Telemedicine; Nurse Prescribing; Oxygen therapy; Obesity hypoventilation
Contact: Judith Quinlan-Logan, Treasurer Respiratory Nurses Section (NZNO).
Email: Judith.quinlan-logan@bopdhb.govt.nz
Link to flyer: http://www.nzno.org.nz/groups/sections/respiratory_nurses/rns_conferences

Thoracic Society of Australia and New Zealand – 2014 Annual Scientific Meeting

4-9th April 2014 in Adelaide, Australia
Theme: Rare Lung Diseases
Nurses special interest group meeting: 5th April. International speaker for the Nurses Day is Kathy Lindell, CNS Interstitial Lung Disease, Pittsburgh USA.
Contact: Diana Hart, Nurse Practitioner Respiratory, Convenor TSANZ nurses special interest group.
Email Diana.Hart@middlemore.co.nz
Registration Information: https://secure.tcc.co.nz/ei/getdemo.ei?id=938&s=_8Y40PR94G

Thoracic Society of Australia and New Zealand – NZ branch Meeting

6th - 8th August 2014, Queenstown New Zealand
Contact: Meg Goodman
Email: Meg.Goodman@middlemore.co.nz

Events for your Calendar Cont.

REGIONAL EVENTS

Auckland

Respiratory Nurses in Auckland
Next meeting: No meeting scheduled at time of print
Venue: TBC
Contact: Karen
Email: KarenSt@adhb.govt.nz

Bay of Plenty

REPS (Respiratory Educators Peer Support)
Next Meeting: March 26th; June 25th; September 24th; December 3rd
Contact Reception Desk: Ph: 07 577 6738
Contact: Lyn Tissingh
Email: lyn@asthmabop.org.nz

Wellington

Wellington Regional Respiratory Nurses Forum
Next meeting: 5th June 2014
Venue: Wellington Hospital
Contact: Betty Poot, phone: 04 5709771
Email: 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

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