AIRWAYS

Newsletter of the (NZNO) Respiratory Nurses Section

Inside this Issue:

Note from the Chair

"'the focus for us as your committee is the transition from Section to College".

In this edition of our newsletter we want to introduce a new flyer to you. We will be using this flyer to attract your attention to any important announcements, advertisements or other items of interest. This flyer will be used more than once, so when you see the familiar picture, look down to the text box to read the announcement or topic for your attention. This issue we have used the flyer (see next page) to announce our 2016 Symposium.

We are holding our next symposium in Hamilton on the 15 April 2016. Our theme is 'Bridging the gaps in COPD care' and we believe we have put together an interesting programme for you. In the programme we have allocated a session for YOU to present what you are doing to 'Bridge the gaps in COPD care'. If you have some interesting innovations or research that you would like to share, send us your abstract for the conference to peter.cole@bopdhb.govt.nz. The information required for abstract submission is on page 2 of the Registration Form.

http://www.nzno.org.nz/groups/sections/respiratory_nurses/conferences

Abstract submissions close at 5pm Friday 18th November 2015, so get writing.

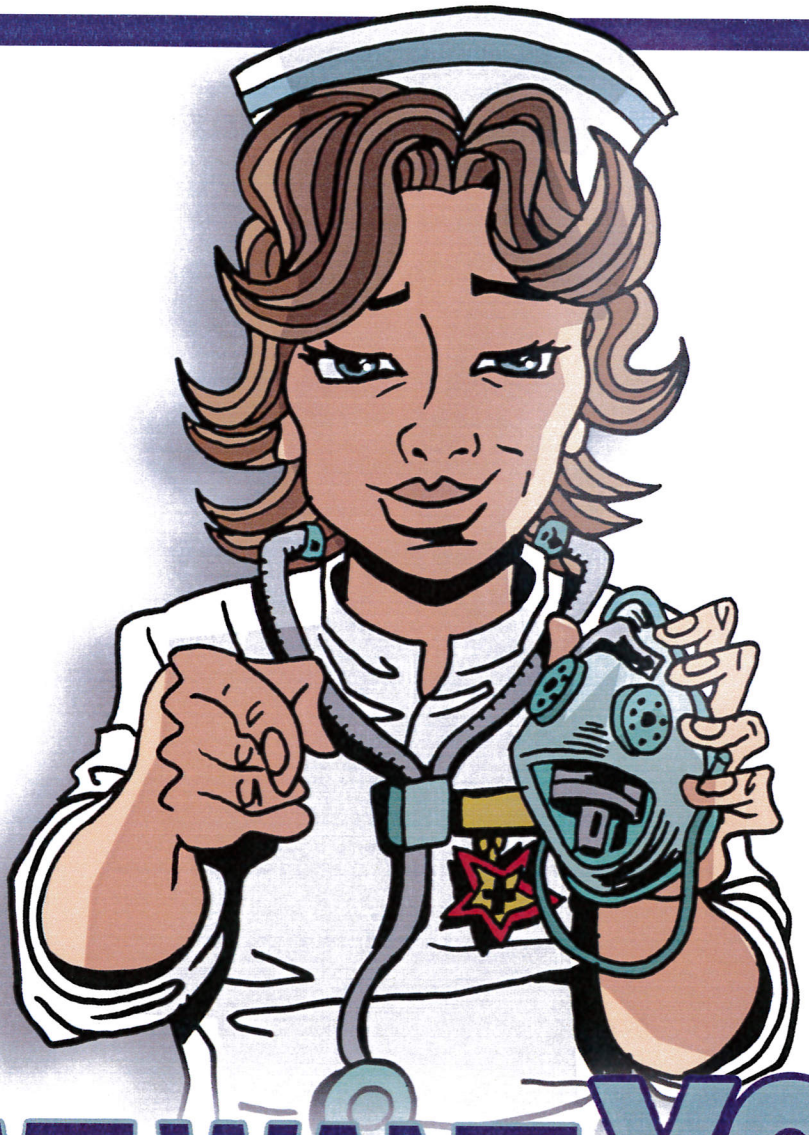
In this issue of 'Airways' we have two articles and two conference reports as well as an update on the transition from Section to College and our usual 'events calendar'. Our first article is on the 'Management of Dyspnoea in Advanced Disease' and the second is on 'Dysfunctional Breathing'. Thanks to Helen and Sarah for sharing their knowledge and providing tips relevant to clinical practice. The conference reports are from the Thoracic Society of Australia and New Zealand annual conference held in April 2015 and the Australasian Asthma Conference held in Brisbane in May 2015. It is great to be able to inform you as members of relevant recent events, thank you Vic and Teresa for writing the reports. There is also an update on the Respiratory Nurses Section NZNO position on Self Management Plans.

The focus for us in 2015, as your committee is the transition from Section to College status. Our new Professional Nurse Advisor Annie Bradley-Ingle has written an update on our progress in this edition of 'Airways'.

Do email the committee (**secretaryrn.nzno@gmail.com**) if you have any suggestions for our newsletter, or wish to contribute by writing an article or conference report. Our newsletter editor Cathy and co-editor Sharon would welcome your articles.

Happy reading

Betty Poot
Chairperson
Respiratory Nurses Section, NZNO



WE WANT YOU

NZNO RESPIRATORY NURSES SECTION

... to join us at:

Symposium 2016

Bridging the Gaps in COPD care

Venue: Hamilton

Date: 15 April 2016

Contact: peter.cole@bopdhb.org.nz

RESPIRATORY NURSES SECTION (NZNO)

NURSES

Management of Dyspnoea in Advanced Disease

Helen Sawyer
Clinical Nurse Specialist, Palliative Care
Dunedin Hospital

Background

The goal of a palliative care approach is 'relief of suffering'. Understanding the suffering described by the person and their family/whanau is paramount. Simply looking and making an assumption from the health provider's perspective, (of what suffering looks like), is not respecting the experience of the person. There are models of care on which palliative care is based incorporating the wishes and values of the person.

Dame Cicely Saunders, the founder of the hospice movement, coined the phrase 'total pain', (also known as 'total suffering'), describing it as 'the division of a whole experience into physical, emotional, social and spiritual components'.

World Health Organisation (2002): Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Te Whare Tapa Whā model emphasises a holistic approach. It describes four dimensions that contribute to wellbeing: te taha wairua (spiritual), te taha hinengaro (mental and emotional), te taha whanau (family and community), and te taha tinana (physical).

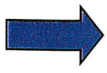
In addition the nursing approach focuses on the individual's personal needs, wants, desires and goals so that they become central to the care and nursing process.

Dyspnoea: a review from a palliative care perspective

Dyspnoea is a common, disturbing symptom. It is reported in 10–70% of cancer patients; 60–95% of patients with cardiorespiratory diseases, and idiopathic pulmonary disease; and most patients with motor neurone disease.(1)

Assessment of dyspnoea in patients with advanced disease

As well as routine history taking and clinical assessment an assessment of the patient in the palliative care setting should include physical and psychological symptoms; decision-making capacity, social circumstances; spiritual and practical needs, and anticipatory planning for death. In the assessment of symptoms ask about the intensity; quality; onset; frequency; precipitating; aggravating and alleviating factors of the symptom. Asking about accompanying symptoms and the resulting emotional stress on the patient and family is also important. In patients with dyspnoea, feelings of fear, loneliness, tension, and sadness play a major role and often make dyspnoea worse (2).



Dyspnoea is a subjective sensation; objective findings are only moderately correlated with patients' subjective feelings of dyspnoea. The subjective severity and intensity of dyspnoea can be recorded to evaluate the degree of suffering and the effect of treatment. A numerical rating scale may be helpful.

Part of the assessment of dyspnoea is ensuring that there are no reversible causes of dyspnoea and that all treatments for the patients underlying disease have been trialled. Remember that advance care planning conversations are integral in the assessment process.

The non-pharmacological treatment options for dyspnoea (4)

One of the most helpful strategies that a clinician can offer is to listen to the experience of the patient (and their carers) during a dyspnoeic episode and write a 'breathlessness plan' with them, incorporating pharmacological and non-pharmacological strategies.

Advice to the patient includes:

Stay physically active and get adequate exercise to counteract progressive deconditioning and fatigue

Fans can be helpful. Facial cooling in the areas sub served by the second and third branches of the trigeminal nerve will reduce the sensation of breathlessness. It is ideal for use in a 'breathlessness/crisis plan'. (5)

Useful exercises, positions, and breathing control techniques can be taught to be performed at home, this enables the patient to take an active role in symptom control.

Relaxation exercises are an effective component of treatment, especially in acute emergencies, and can improve the quality of life for patients and their families.

Neuromuscular electric stimulation of the leg muscles may be helpful This was found to relieve shortness of breath significantly in three different randomized controlled trials on COPD patients. (7).

CPAP given for 2-3 hours was found to give relief from breathlessness (4)

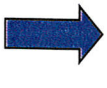
The pharmacological treatment options for dyspnoea (8)

Opioids

Opioids are the drug of choice for intractable dyspnoea. Respiratory depression has not been observed in any clinical trial. The dose needed to treat dyspnoea is much lower than that needed to treat pain. (9-12)

Benzodiazepines

There is no research evidence showing efficacy, but there is a trend in the direction of symptom relief. Many patients spontaneously report that dyspnoea and anxiety tend to reinforce each other. It may be useful to break the vicious circle by treating shortness of breath with opioids and anxiety with benzodiazepines at the same time (13).



Steroids

These are not recommended as there is no research evidence of steroids for dyspnoea in cancer patients. (14)

Antidepressants

There is limited evidence to support the routine use of antidepressants in shortness of breath. However the dyspnoeic patients should always be evaluated for anxiety and depression. (15)

The role of oxygen in the treatment of dyspnoea

Oxygen is indicated in those with hypoxemia, but not for those who do not have hypoxemia. A large multicentre international trial has shown that non-hypoxic patients with refractory shortness of breath do not gain any additional benefit from supplemental oxygen in comparison to room air (16).

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Dysfunctional Breathing

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MidCentral Health

Dysfunctional Breathing (DB) or Breathing Pattern Disorders are common with around 10% of the population being diagnosed with Hyperventilation Syndrome. It is likely there are far more people that may have a more subtle, but still clinically relevant breathing pattern disorder.

Dysfunctional Breathing is defined as chronic or recurrent changes in the breathing pattern that cannot be attributed to a specific medical diagnosis causing respiratory and non-respiratory complaints. DB can also occur in those with respiratory, cardiac disease and those with chronic pain.

Some common signs of DB may include forward head posture, overuse of the muscles around the neck and upper chest and elevation of the shoulders. The person may mouth breathe, breathe too fast and the rhythm and size of their breaths appear irregular. The hands may be clammy, they may be fidgety, talk quickly, appear anxious, and they might sigh or yawn frequently, sniff or repeatedly clear their throat.

Symptoms presented with DB may be, chest pain/tightness, nausea, muscle aches around the neck/ shoulders/arms, dry mouth, feelings of anxiety, poor balance, tingling in the fingers, palpitations, dizziness or light-headedness, poor concentration, chronic fatigue/weakness, abdominal cramps/bloating, backaches and headaches.

People with asthma can have poor breathing habits which can make their asthma worse. Those with asthma can develop DB due to changes in their breathing pattern as it is harder to breathe in and out due to the effects of airway swelling, bronchospasm and increased mucus. DB can be further compounded if there are frequent acute episodes when the asthma is difficult or poorly controlled. Contributing factors include anxiety, panic attacks or stressful events such as death of a loved one, divorce, loss of a job, hospital or ICU admission. Asthma patients are particularly prone to Chronic Hyperventilation Syndrome.

DB should be considered in those with asthma particularly when there is an increase in their breathlessness that is not attributable to a change in lung function and treatment has been optimised. These patients will present with a feeling of breathlessness that can occur at rest or with exercise causing an increase in use of their reliever medication, which may or may not relieve their breathlessness.

So how can we help?

It is important to firstly establish that there is no other cause for their increased breathlessness. Once this has been ruled out advice can be given to better manage their breathlessness.

At the time of an acute episode of asthma encourage the person to take up a relaxed position to reduce shoulder tension to allow the diaphragm to work with least effort. The leaning forward position allows more room for the diaphragm to move optimally and fixing but dropping the shoulders reduces the energy used.

When the person is stable then address the breathing pattern. Encourage them to achieve a rhythmic nose/ diaphragm breathing pattern at rest. Nose breathing is really important as the nose warms filters and humidifies the air entering the lungs. When you breathe in through the mouth the air is cool, dry and unfiltered which causes irritation and can trigger asthma symptoms. If there are problems with blocked nose/sinuses these must be treated appropriately.

Technique

The person needs to acknowledge and understand how they are currently breathing in order to correct and change their breathing pattern.

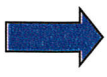
- If the shoulders are elevated ask them to drop their shoulders and relax – gently rolling the shoulders can release this tension.
- Get the person to place their dominant hand over their tummy button and the other hand over the upper chest and ask them to identify which hand is moving either the most or first.
- With the dominant hand still over their tummy, direct them to breathe in gently through their nose into their hand/tummy and then 'let go'. These are just normal size breaths, NOT big breaths.
- The aim is to achieve an even rhythm and allow the air to 'fall out'. When relaxed, the breath out is longer than the breath in.

It is important for the person to know it can take several weeks to change a breathing pattern and so the idea is to practice 5-10 minutes twice a day to allow the brain to re-establish the pathways. Some people prefer to practice in shorter 2-3 minute spells. The other key to change is for the person to acknowledge what happens to their breathing pattern when they are short of breath and anxious. Do they breathe through their mouth or nose? Do they breathe in their upper chest or tummy? Is their breathing faster? Are their shoulders raised?

Once they understand their own breathing pattern they can work on relaxing any muscle tension and then correct their breathing pattern by practicing 10-20 relaxed breaths before they carry on with what they were doing.

When a person has difficulty slowing down their breathing, they need to understand all that has happened is that the breath out has become shorter. They can correct this by slowing the breathing down by stopping to rest, breathing out slowly and gently through the mouth until the breathing rate is back to normal when they can resume a normal nose abdominal pattern. This is of particular relevance to the person with Chronic Obstructive Airways Disease (COPD) where pursed-lip breathing (like breathing through a straw) can be very effective to control the breath out.

Those with COPD commonly present with DB, this may be related to their breathlessness and anxiety. Good management of their breathlessness is very important. Practicing the relaxed nose abdominal breathing described above is an important part of gaining breathing control.



Breathing control when breathless:

- Drop the shoulders and breathe **normal** size breaths in through the mouth and out through pursed lips
- Progress to breathe in through the nose and out through pursed lips
- As breathing slows breathe in and out through the nose
- Once breathing has returned to normal continue activity

We can all help in the treatment and management of DB by encouraging those with DB to acknowledge this is an aspect of their disease they can manage themselves and which does not involve medication. It can be performed anywhere at any time and can really improve quality of life.

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These books are also excellent resources for patients.

Patient Self Management Plans

Betty Poot
Nurse
Practitioner
Chair Respiratory Nurses Section (NZNO)

In our December issue of 'Airways' we outlined the Respiratory Nurses Section (NZNO) position that transcribing medications onto self management plans is not recommended. This position is underpinned by the recommendations from the New Zealand Nurses Organisation (NZNO, 2014). The rationale for this is provided by the 2014 NZNO document on Guidelines for Nurses on the Administration of Medicines, and the HealthCERT bulletin (2010) published by the Ministry of Health. There is evidence to suggest that 50% of medication errors are transcribing errors (http://www.qnu.org.au/your-work/professional/professional-news/archived-professional-news/archived-releases/best-practice-in-transcribing-medication-orders).

The Respiratory Nurses Section (NZNO) position statement has resulted in some queries and discussion from nurses who provide self management plans for their patients. Some nurses feel that they can no longer provide these plans for their patients as they are not able to complete the medication side.

There is strong evidence that education in self management and regular review, as well as written self management plans in asthma are effective and improve health outcomes (Gibson et al, 2002). Therefore it is important that we as respiratory nurses continue to provide education, regular reviews and written plans to enable respiratory patients to be confident in self managing their condition.

Most generic self management plans have three sections; these are symptoms, actions and medication. It is strongly advised that every patient is given patient centred education on each one of these sections as it is essential that the patient understands their health condition, recognises their symptoms and is aware of the appropriate actions to take.

Certain actions involve medications. As transcribing is not recommended for non prescribers here are some practical solutions to enable you to continue to provide self management plans and work within your Nursing Council of New Zealand scope of practice.

Practical tips for non prescribers who want to complete the medication section could include;

- Have a discussion with your health care team, informing them why you will be requesting a prescriber to complete the medication side of the plan.
- Focus on the symptom and action section of the plan. The prescriber you work with can complete the plan by writing in the medication names, doses and give clear instructions for medication changes when unwell.
- Review inhaler (and spacer) technique and provide education on when, why and how to take inhalers. Clarify prescription instructions (for example what does prn mean?).
- Ensure that the patient has a regular review with their GP, and encourage the patient to ask the GP to review their self management plan.
- If you are a non prescribing nurse and are completing the plan ask a prescriber who is involved in the patients care to write in the medication names and doses with clear instructions for medication changes when unwell. This could be either the General Practitioner, prescribing nurse practitioner, registered nurse with prescribing rights, prescribing and non-prescribing pharmacist.
- Write in the medications section for their usual medications 'use your medications as prescribed' or use the words 'preventer' 'reliever' or write in the colour of the inhaler.
- Ask the patient to take the plan along to the GP at their next appointment, so that the GP can complete the medication side of the plan with clear instructions for medication changes when unwell.
- Send a copy of the plan to the patient's GP, and ask the GP to write in the medications with clear instructions for medication changes when unwell, and then send onto the patient.

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The Thoracic Society of Australia and New Zealand (TSANZ) Annual Scientific Meeting (ASM) Conference Report 28 March—1 April 2015

Victoria Perry
Nurse Practitioner Respiratory
MidCentral Health

I attended the TSANZ ASM held at the Gold Coast, Queensland, Australia. I would like to thank and acknowledge the financial support to attend this from the MidCentral Health NEED Committee.

The following report is on the one-day TSANZ Nurses Special Interest Group (SIG) meeting which was well attended and included excellent content. The highlight for me was the two presentations by Dr Maureen George a Nurse Practitioner with an extensive respiratory clinical academic and research background. I then attended as much as possible of the formal TSANZ ASM meeting over the following four days as well as three breakfast sessions and evening symposium.

Presentations from TSANZ ASM can be viewed by going to http://www.thoracic.org.au/meetings-and-conferences/annual-scientific-meetings/tsanz-asm-gold-coast-2015

For a full report on the TSANZ ASM conference by Victoria Perry go http://www.nzno.org.nz/groups/sections/respiratory_nurses/conferences_events

The first session was to review our values/goals and to discuss credentialing and accreditation for the TSANZ Respiratory Nurses SIG. This included a panel on which I was asked to sit and involved some robust dialogue. The outcome was that the Nurses SIG has updated the mission and values statement and has agreed to move forward in smaller working groups to look at options for accreditation.

Presentations:

Topic: Primary care provider communication preferences for asthma self-management in a vulnerable adult population, a five-year study.

Presenter: Professor Maureen George, Pennsylvania School of Nursing/Seattle Children's Hospital, USA.

A 17 item instrument was designed to describe and define what the patient group used for asthma therapy instead of inhaled preventer therapy to determine what personal health beliefs influence clinical outcomes.

Study findings: (The majority of the group studied were poor and of African American descent).

- 93% used home remedies
- 65% has negative health beliefs about inhaled preventer therapy
- More than 70% had uncontrolled asthma
- Included multiple instances of 'folk care' including the use of herbs; chest rubs; teas; onion tonic; home chest percussion
- Personal health belief influenced 52% of the home remedies used in the first instance before using prescribed bronchodilators, also a belief that the inhalers worked better if used with home remedies.
- Most patients did not know about or have an action plan.
- If patients did have an action plan they didn't use it.
- Many patients withheld their short acting bronchodilators to 'save them' for when things got bad.

Two of the questions specifically predicted negative health outcomes

1. Negative beliefs about inhaled steroid

If the patient included both conventional AND complementary and alternative medicine (CAM) – this actually increased the risk of uncontrolled asthma by 43%

Themes:

1. Wanting to 'take something natural'
2. What I had used from the doctor hadn't worked
3. A belief that asthma could be 'cured not controlled'

A follow up study was undertaken to see if the health professional knew if the patient was using CAM and if so then this information was included in the consultation discussion.

Findings:

The consultation did not take any longer and had a positive effect on outcomes including patient satisfaction.

An aspect of this study that was sobering given that the goals for 'Obama Care' in the US are to close the inequalities in the treatment group, enhance recognition with clinicians and engage the patient appropriately;

Level of health literacy results:

- 12% were at a proficient level to understand and manage their health
- 53% couldn't read the treatment recommendations
- 63% were not performing at a level to be able to manage their health

Topic: Asthma Self-management – Urban myths and consequences

Presenter: Professor Maureen George, Pennsylvania School of Nursing/Seattle Children's Hospital, USA.

Overview

1. To discuss level of mobility in an urban population with asthma.
2. To describe the programme of research undertaken.

The burden of asthma is not shared equally across the population, with higher mortality in adults and incident rates two times higher amongst the poor. Similar results to other published studied supported the literature regarding patients perceived good control of asthma (71%), compared to guideline recommendations.

Findings:

Addressing disparities need to focus on low income and minority groups to support Primary Health Care at the federally qualified health centre for the "poor of the poorest". Dr George undertook a study looking at the two groups.

Comment:

A sobering study with aspects directly applicable to New Zealand among the poor and sick population in our region. Effective care can only occur if the clinician understands and appreciates the patient context.

Australasian Asthma Conference – 4th & 5th May 2015

Theme – Connecting Asthma Care

Teresa Chalecki
Nurse Manager CanBreathe
Canterbury Asthma Society

I was fortunate to have the opportunity to attend the Australasian Asthma Conference in May. I found it a valuable opportunity to focus on this disease which is often underestimated by health professionals and the public, however, as is evident from the presentations and discussion, continues to have a significant impact on individuals and health services. Asthma and respiratory disease is seen as a priority by the Australian Government and they therefore have been able to invest in identifying issues relating to asthma and developing programmes. In this Australian based international conference it was good to see New Zealand well represented in the speakers and delegates.

I have given an overview of the sessions I attended, however all of the presentations are available on the Asthma Australia youtube page https://www.youtube.com/user/asthmansw

Dr Mark Levy: Why Asthma Still Kills? - National Review of Asthma Deaths in United Kingdom

Mark was the lead author for the above report, published in May 2014. It looked at deaths from asthma between 1 February 2012 and 31 January 2013. It found widespread issues with the quality of asthma care amongst those who died. He presented on the review process, the findings of the report and the recommendations. While the review was on asthma deaths in the UK the avoidable issues identified are likely to be present in New Zealand and Australia and it is an important reminder that these issues need to be identified and addressed.

Asthma throughout Australia and the Asia Pacific Region – Dr Lutz Beckert

Dr Beckert presented on the methodology and findings from this multinational survey conducted in 2011 of patients from 8 Asia Pacific countries and Hong Kong. The report was published in the Respirology Journal in 2013. The conclusion was that the four key areas of focus to improve asthma management were: smoking cessation, use of spirometry, decrease in use of Salbutamol and investment in the community (to provide asthma education and support).

Panel Discussion – If I had $50m to invest in a National Asthma Programme, my top four initiatives would be?

The expert panel presented consistent messages with their initiatives and this was followed by the opportunity for the delegates to vote, with the top initiative being a national awareness campaign. Key issues identified were the need to increase understanding of asthma, the importance of good management and the risks associated with overuse of Salbutamol.

The conference then split in to concurrent sessions with three separate themes – Asthma and Allergy, Asthma and Technology and Paediatric Asthma including young people. I attended the Asthma and Allergy sessions:

Dr Janet Davies on the Australian Pollen Allergen Project

Dr Davies provided an overview of the project which was initiated following the "thunderstorm asthma" issue where it was noted that there was an influx of asthma presentations at Emergency Departments following thunderstorms in Victoria, particularly around high pollen seasons. The project involved the analysis of the different types of pollen allergens present around Australia and the pollen counts of each of these at different times of year and the potential impact on those with pollen allergic asthma.

Dr Mika Mikela on The Hygiene Hypothesis

Dr Mikela is a Paediatrician and Allergy Specialist from Finland and he provided an interesting summary on the issue of the increase in allergies in the modern population, particularly in Finland which has a relatively high standard of living. The study compared the level of allergies in children from an area in Finland and those from a nearby, but lower socio-economic area across the border in Russia. The children in the Russian sample had a much higher exposure to farm animals and bacteria than those in the Finnish sample and had a lower incidence of allergies.

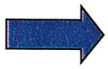
Prof. Peter Wark - Tackling cold-induced asthma – a study of reduced asthma exacerbations triggered by the common cold

This presentation discussed viral infections as a trigger for asthma. This session identified that not all asthmatics had an impaired viral response and unsurprising that the poorly/uncontrolled asthma patient was more at risk. The findings concluded that the following were indicators of risk of acute asthma: poor asthma control; more severe asthma; smoking and high BMI. Suggestions to help reduce risk of exacerbations were use of: inhaled corticosteroids; Leucotriene receptor agonists, Symbicort SMART and Omalizumab.

The next group of concurrent sessions had the following three themes – Collaborative Asthma Care Models, Health Professional Training & Professional Development for General Practice and Behaviour Management and Change including Smoking Cessation. I attended the sessions in the last of these themes. Session summaries are as below:

Ms Holly Foot – Exploring how beliefs affect medication adherence in individuals with asthma.

This was an interesting presentation and identified while there were a number of factors that affect adherence including: condition related factors; health system; socio-economic and therapy related (side effects). The most salient and prevalent reason was the patient's beliefs in that many patients did not 'fail to comply' they chose to take another action based on their personal beliefs in the necessity and concerns regarding their medication.



The next group of concurrent sessions had the following three themes – Collaborative Asthma Care Models, Health Professional Training & Professional Development for General Practice and Behaviour Management and Change including Smoking Cessation. I attended the sessions in the last of these themes. Session summaries are as below:

Ms Holly Foot – Exploring how beliefs affect medication adherence in individuals with asthma.

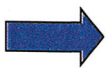
This was an interesting presentation and identified while there were a number of factors that affect adherence including: condition related factors; health system; socio-economic and therapy related (side effects). The most salient and prevalent reason was the patient's beliefs in that many patients did not 'fail to comply' they chose to take another action based on their personal beliefs in the necessity and concerns regarding their medication.

Dr Michelle Blanchard – The National Young People with Asthma Survey – asthma and impact on the mental health of young people

This presentation was on the findings of the above survey which clearly illustrated the impact poorly controlled asthma can have on the mental health of young people. Recommendations included: education of practitioners and young people regarding the benefits of using preventers; embed asthma related support into mental health service models; train professionals to understand and support the mental health of young people with asthma; create online ecosystem of care addressing prevention, health promotion and peer education.

The last session for the day had the title of "Laughter as an asthma trigger" by Dr Scott Thompson, who referred to himself as a laughter specialist, although I believe stand up comic may be a more apt description. In this regard he did keep the room engaged and laughing. While this was a humorous session it delivered the serious message about the importance of laughter and how we should ensure we take time to laugh multiple times every day. All present were inspired to laugh throughout the 30 minute presentation interspersed with pictures and short clips to help stress the point of how easy it is to laugh if we take the time. An excellent way to end the day and the message was well received and left the delegates relaxed and smiling. Unfortunately this session is not available to view on the youtube link due to copyright.

Day 2 commenced with Professor Innes Asher, Chair of the Global Asthma Network Presentation on recognising World Asthma Day and discussing the work of the Global Asthma Network.



Professor Mika Makela – The Finnish National Asthma and Allergy Programs

Professor Makela provided an overview of the successful fight against asthma in Finland. Asthma was identified as the 14th most important disability. There is a high rate of allergy in Finland, for a number of reasons, as discussed in his presentation in day 1, and early exposure to allergens was identified as a means of reducing this. Respiratory Specialists in Finland are also Allergists. In Finland it was identified that asthma diagnosis was often delayed so they undertake Oscillometry for asthma diagnosis for children aged three to seven years and Spirometry for over seven years. Interventions included: early intervention with Inhaled Corticosteroids to stop exacerbations; treated early and hard with anti-inflammatory; follow up patients; workforce – asthma GPs, Nurses and Pharmacists. Keys to success were: motivate and organise; innovation and new knowledge; attitude and motivation. Their programs have resulted in an increase in asthma treated, decrease in need for hospitalisation and emergency care and an enviable zero rate of mortality from asthma.

"Space to Breathe, preschool asthma education program" – Dr Natalie Walker, University of Auckland, and Janet Mackay from PHARMAC

This presentation was on a pilot program undertaken in Auckland around the effectiveness of education on asthma to Preschools and Parents and comparing two separate education options. The outcome measurement of reducing hospitalisations in this cohort was not well demonstrated; however there was improvement in understanding of asthma and management by parents and preschool staff.

The next session was another Panel Discussion asking "What do we recommend to the Ministers of Health?" The theme from this was the need for a National Asthma or National Lung Health Strategy and a co-ordinated approach to lung/airways health – sounds familiar!

The remaining afternoon sessions took on several themes including Asthma in Aboriginal and Torres Strait Islander People, Asthma in Pregnancy and Asthma in General Practice.

In summary I found this a very informative conference and I returned with a renewed perspective that there is much that can be done to improve asthma outcomes here in New Zealand however it requires recognition that there are issues needing to be addressed and a commitment from funders, health professionals and the community to achieve it.

Section to College Transition Update

Annie Bradley-Ingle
Professional Nurse Advisor, NZNO

The Respiratory Nurses Section NZNO committee with approval from the wider respiratory section membership are on track to achieve College status by 2016.

The proposed College of Respiratory Nurses NZNO will have benefits of pooling present resources, an expansion of expertise and skills and a 'louder' political voice for nursing issues. The section to college transitioning is a lengthy process and the Section has a small and very dedicated team that is making good progress with completing the many steps in the process. Just to give you a taste of the work the team is undertaking I will outline the steps they are aiming to complete before the April 2016 Annual General Meeting (AGM).

The Section Rules, which provide the fundamental information about how the College would operate, are near completion. The Rules set out the Colleges objectives and the expected management of membership, finances, national committee, conferences and AGM.

All position descriptions that describe the proposed Colleges committee members roles such as Chairperson, Treasurer, Secretary have been updated and approved by the membership, as has the Annual (and long term) Business and Operational plan. This plan remains current until 2018.

Financial records are kept and audited annually. Current and previous records are ready to be incorporated into the College application document.

A substantial piece of work is updating the New Zealand Adult Respiratory Nursing Knowledge and Skills Framework (KSF). It is hoped the KSF will be ready to be tabled for approval at the AGM in April 2016.

Evidence of the education the Section has provided must also be included in the College application. This includes records of the Sections symposiums and the Airways Newsletter, which informs members of relevant conferences and educational courses. The Section must demonstrate National and International research and involvement through these media.

The Committee is aiming to have the College application documents ready to table for approval at the April 2016 AGM. Once approved by Members the document is scrutinised by the Professional Manager (NZNO) and on his/her recommendation presented to the NZNO Board of Directors for final approval.

To me as a new Professional Advisor this sounds like a mammoth undertaking but it is obvious the Committee is making excellent headway with great decorum.

Members should feel in very safe hands and hopefully we will all be celebrating the new College status by mid 2016.

Introducing Annie Bradley- Ingle, Professional Nurse Advisor (PNA)

Hello everyone,

I am a RGON trained in Whanganui Hospital and once registered spent some time working as a District Nurse. After moving to Hamilton my nursing focus shifted to Cardiology spending more than twenty years with the Waikato District Health Board (DHB) working in CCU and the Cath Lab, with short stints in Nursing Agency and Orthopaedics.

I spent a year establishing the role of Nursing Director in a new private hospital in Hamilton and several years in the United Kingdom working as a Nurse Advisor in Cardiology for Primary Care. On returning to New Zealand I joined the Community Services Team at Waikato DHB and worked as their Rural Liaison for six years with a year out on secondment undertaking the role of Clinical Nurse Director; Rural and Community Service, Older Persons Services and Population Health.

Over the last thirty plus years I have nursed, had children and supported a husband to become a nurse. I have seen the world through my profession and continued to learn and grow through postgraduate study. Nursing has provided me with amazing opportunities and experiences throughout my working life. Two months ago I made a conscious choice to try and give something back to the profession that has been my life since I was a teenager. I chose to try and serve nurses by working for NZNO as the PNA for the Waikato and Bay of Plenty region and look forward to extending the PNA role to the Respiratory Nurses Section.

Your committee would like to welcome Annie to her role of PNA for the Respiratory Nurses Section

EVENTS FOR YOUR CALENDAR

Conferences/Seminars/Courses

Respiratory Conference New Zealand

5 & 6 November 2015

Venue: InterContinental, Wellington

Theme: National Respiratory Strategy

Further details on website www.asthmafoundation.org.nz/

National Asthma Council Australia

Provides a list of various respiratory focused conferences for health professionals

For more information visit website: www.nationalasthma.org.au

2016 Hutt Valley DHB Respiratory Courses

For nurses working in acute, non-acute, secondary or primary health care settings. These courses will enable nurses to have a better understanding of asthma and COPD including diagnosis, treatment and management. It also helps nurses provide better education and support and care for their patients.

For further details and to register your interest contact

Melinda McGinty Melinda.mcginty@huttvalleydhb.org.nz

Kirsten Lassey Kirsten.lassey@huttvalleydhb.org.nz

Dunedin Respiratory Study Day

Applicable to nurses and allied health working in the acute and non-acute settings. Content will include a variety of respiratory conditions and treatments.

To register expressions of interest please contact

Carol Fitzgerald, Respiratory Clinical Nurse Specialist, Dunedin Hospital

Ph: 0274 989218

carol.fitzgerald@southerndhb.govt.nz

EVENTS FOR YOUR CALENDAR

PHARMAC Seminar Series

Venue: PHARMAC, Level 9 Simple House, 40 Mercer Street, Central Wellington

Check website for any relevant seminars and registration

www.pharmac.health.nz/seminars

2016 Distance Learning: Asthma & COPD - Level 7 Nursing Courses

Asthma New Zealand/Unitec

For further information contact:

Ann: 09 623 4777 annw@asthma-nz.org.nz

Swarna: 09 623 4771 swarnah@asthma-nz.org.nz

Asthma New Zealand
1 Day 'Neat' Asthma Course for Registered Nurses

16 September 2015 at Auckland

2 Day COPD Course for Registered Nurses

21 October 2015 at Auckland
Further enquiries for any of these events phone (09) 630 2293

EVENTS FOR YOUR CALENDAR

Spirometry Courses

Auckland District Health Board
17 - 18 September 2015
Further information is available by contacting

resplab@adhb.govt.nz

Ph: 09 630 9918 Extn. 26234

Bay of Plenty

1 – 2 October 2015

Contact: Lyn Tissingh, Nurse Manager
Ph: 07 577 6738
lyn@asthmabop.org.nz

Asthma Waikato

Further information is available by contacting

Ruth Taylor

Ph: 07 838 0851

info@asthmawaikato.co.nz

Canterbury District Health Board

Further information is available by contacting

Emily Ingram

emily.ingram@cdhb.health.nz

Southern District Health Board

Further information is available by contacting

Sue Filsell

Ph: 03 470 9831 or 470 9742

sue.filsell@southerndhb.govt.nz

2015 Asthma and COPD Fundamentals Training Courses for Health Professionals

Run by a Regional Trainer the course covers all the asthma and COPD basics including management and practice. All participants receive a comprehensive resource manual with material on asthma and COPD. A typical course, held over two days, involves around 10 participants in an interactive learning environment.

For further information and to express your interest contact a Regional Trainer

Asthma Waikato

Vanda Watson: vanda.watson@asthmawaikato.co.nz

Bay of Plenty

Wendy McBride: wendy@asthmabop.org.nz

Asthma Hawke's Bay

Jo Smiley: jo.asthma@xtra.co.nz

Canbreathe, Canterbury Asthma Society

Teresa Chalecki: office@canbreathe.org.nz

South Canterbury District Health Board, Timaru

7 and 14 September 2015

Deborah Box: dbox@scdhb.health.nz

Southern District Health Board

Carol Fitzgerald: carol.fitzgerald@southerndhb.govt.nz

Peer Group Meetings

Bay of Plenty

Asthma & Respiratory Management, BOP Inc

REPS (Respiratory Educators Peer Support) 2015

23 September, 2 December

10.00am meeting (0930-1000 cup of tea)

Venue: 254 Chadwick Road, Greerton, Tauranga

Contact: Lyn Tissingh, Nurse Manager
Ph: 07 577 6738
lyn@asthmabop.org.nz

Wellington

Wellington Regional Respiratory Nurses Forum

For 2015 dates, contact Betty Poot

Contact: Betty Poot

betty.poot@huttvalleydhb.org.nz

Editors Note – If you have regular meetings for Respiratory Nurses in your area, email: **secretaryrn.nzno@gmail.com** with the group's name, place of meeting, date and contact person and I can put the information in the next newsletter.

Respiratory Nurses Section (NZNO) Committee Members 2015

To contact the committee email: secretaryrn.nzno@gmail.com

Role	Name
Chairperson	Betty Poot
Secretary	Chris Rothman
Treasurer	Zoe Briggs
Newsletter Editor Vice Chair	Cathy Modrich
Newsletter Co-editor Website	Sharon Hancock
Symposium Co-ordinator	Michelle Hopley
Symposium Treasurer	Peter Cole
Membership Secretary Submissions	Louise Weatherall
NZNO Professional Nursing Advisor	Annie Bradley-Ingle