AIRWAYS

Newsletter of the (NZNO) Respiratory Nurses Section

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Note from the Chairperson

"I would encourage each one of you to read this document, (Te Hā Ora: The Breath of Life, National Respiratory Strategy) and identify the action examples you could implement in your practice and help to improve respiratory health in New Zealand"

Welcome to the December edition of 'Airways', this being the last newsletter for 2015.

Looking back at 2015 this has been a busy, productive year for the committee. We have made good progress on the transition from section to college status and we will be presenting further documents such as the College Rules and the revised New Zealand Adult Respiratory Nursing Knowledge and Skills Framework (KSF) to you at the Annual General Meeting (AGM), along with a new logo to reflect our change to the College of Respiratory Nurses NZNO.

Recently I was fortunate to be able to attend the launch of Te Hā Ora: The Breath of Life, National Respiratory Strategy. This is the first national plan that aspires to unite all parties active in respiratory disease. The strategy outlines five high level goals to improve respiratory health in NZ, these include:

- The environment
- Individuals and families
- The health community
- The health system
- Research and evaluation

Each goal is supported by key objectives and suggested actions to achieve these objectives.

I would encourage each one of you to read this document, identify the action examples you could implement in your practice and help to improve respiratory health in New Zealand.

Link here: National Respiratory Strategy

Recently you have been invited to provide feedback on the review of the KSF. In 2015, representatives from the Respiratory Nurses Section NZNO and the Thoracic Society of Australia and New Zealand (TSANZ) Nurses' Special Interest group undertook to review the 2010 version to ensure that the KSF was up to date and relevant to all nurses. The review has consisted of adding patient outcomes, revising each Aspect of Care, adding new Aspects and updating all the reference guidelines. Again I would encourage you to read this document and comment.

Link here: Respiratory KSF Revised 2015

We have an exciting programme organised with a variety of speakers and topics on our theme "Bridging the gaps in COPD care". So get your registration forms in, organise your transport and take advantage of the Early Bird registration which closes on the 18th March 2016. There is a late registration fee after this date so get your forms in early to avoid the extra cost of late registration.

The final document will be presented at our next AGM in conjunction with our biannual Symposium which is being held in Hamilton on 15th April 2016. The registration form and Symposium Flyer can be found at:

http://www.nzno.org.nz/groups/colleges_sections/sections/respiratory_nurses/conferences_events

In this edition of 'Airways' we have an interesting article on "Are prognostic indicators underutilised in the acute management of COPD?" Thank you to Jen Gow, Clinical Nurse Educator at Dunedin Hospital for writing this article for our newsletter. There is also an alternative, fruit based, lighthearted look at COPD Classifications by Dr Ben Brockway, Respiratory Consultant at Dunedin Hospital and Sharon Hancock a Respiratory Clinical Nurse Specialist at MidCentral Health has very kindly provided a brief review of the Thoracic Society of Australia and New Zealand (TSANZ) 2015 guidelines for acute oxygen use in adults.

Additionally we have several conference reports covering the August TSANZ New Zealand branch meeting in Queenstown and the Influenza Symposium in Wellington in November. Thank you to Lynda Paris, Janet DeLooze, Elaine Murray and Annie Bradley-Ingle for writing these reports.

On behalf of the committee I would like to wish you all an enjoyable festive season and I look forward to catching up with you all at the Symposium and AGM in Hamilton.

Betty Poot
Chairperson
Respiratory Nurses Section NZNO

"Are Prognastic Indicators Underutilised in the Acute Management of COPD?"

Jennifer Gow (phone: 0275 666 779)
Clinical Nurse Educator, Cardio-Respiratory
Dunedin Hospital

This article was initially delivered as a presentation to a respiratory CME which was attended predominantly by respiratory consultants and their team members; nursing staff of all grades; and respiratory physiologists. Its aim is to update staff, generate lively discussions and ultimately ensure staff take something away with them.

For those involved in caring for people with COPD, the impact it has on quality of life and activities of daily living is apparent. It affects not only the individual but Whānau/family who often take an active role in contributing to their care. It carries a poor prognosis, with a poor socio-economic status that compounds the issue. Between 2008-2013 there were 61,516 admissions for COPD in New Zealand; (Milne & Beasley, 2015), making it the fourth leading cause of deaths in NZ in 2009 and responsible for 6% of deaths, establishing New Zealand to have one of the highest COPD admission rates in the developed world, (Boutou et al, 2013). Admission rates were higher for men than women and increased steeply with age and socio-economic deprivation, with mortality from COPD 70% higher for Māori than others, and consistent with higher admission rates.

In the outpatient setting or in primary care, pulmonary function tests are repeated, treatment prophylaxis optimised, antibiotics and steroids added as needed; but a point is reached when an exacerbation has a profound effect on health and an acute admission is unavoidable. This is where an inevitable degree of subjectivity in interpretation of symptoms occurs, and raises the issue of whether there is an objective assessment tool that may offer some clarification on the likely outcome.

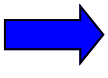
The Gold Standard Framework (GSF), (Royal College of General Practitioners. The GSF Prognostic Indicator Guidance, 2011), has yet to impact on the NZ health care system but since its introduction in the UK at the start of the Millennium it has become an established and valued tool in primary care. The goal is to improve the quality of care, reduce hospitalisation, and improve collaboration and teamwork for all patients nearing the end of life. If GSF criteria are met the patient triggers discussion points which can be helpful e.g. in Advance Care Planning (ACP). Although this factors in the patient nearing the end of life its use is predominantly in the chronic setting.

Gold Classification and its combined assessment staging system, (Global Initiative for chronic Obstructive Lung Disease (GOLD), 2014), is more readily used in NZ, and similarly the BODE index is an alternative, recognised, multi-dimensional scoring system to test patients who have been diagnosed with (COPD) and to predict long-term outcomes for them, (Boutou et al, 2013).

The BODE index uses the four factors of Body Mass Index, Airflow obstruction, Dyspnoea and Exercise to predict risk of death from the disease. A combined score generates a number between 0-10, and a percentage estimate 4 year survival is obtained, (Boutou et al, 2013).

What happens though when the patient becomes acutely unwell, is hospitalised and the aforementioned scoring systems no longer have a place? The CURB-65 is often used but many recognise that it has limited use or benefit in an acute exacerbation, reserved (as intended) for pneumonia.

The DECAF scoring system, (Steer et al, 2012), may have a role in this situation. The study, involving 920 consecutive patients admitted to a UK teaching hospital with AECOPD, concluded that it was able to accurately predict in-hospital mortality in this group of patients using routinely available indices. The strongest predictors of mortality were Dyspnoea, Eosinopenia, Consolidation (CXR), Acidaemia and (atrial) Fibrillation.



A further study, (Nafae et al, 2014), was discussed which demonstrated the application of DECAF in the clinical setting had 'excellent discriminatory value for in-hospital mortality'.

Pros and Cons for routine use of DECAF scoring was presented at the meeting, and the concluding slide asked the following questions:

- Would formalising the assessment be an option?
- Do we already consider this without applying the parameters together?
- Is it useful information for nursing handovers?
- Is it useful information for GP's?
- Would we, should we, do we, discuss this with patient's and keep them updated (and in a language that they understand)? (Roberts et al, 2008).

An interesting discussion ensued; the usefulness of CURB-65 was questioned by a junior doctor and reasons for its limited value in the AECOPD setting given by a respiratory consultant. Nursing staff felt an objective scoring system may help ACP and allow honest discussions with patients; it would also be useful to utilise MRC dyspnoea scoring rather than describing the patient as 'worse than usual', or 'not back to baseline'. As an aside, the practicality of DECAF scoring may present an obstacle for eosinophil count, as it wasn't measured with sufficient decimal point accuracy.

Overall an active discussion was generated with potential benefits in using DECAF identified that included appropriate treatment levels, information that may allow for ACP, identifying an improvement or decline, and it may reduce prognostic uncertainty. The downside to implementing it could be additional work and possible over reliance on 'results', difficult conversations and health literacy issues, and the issue of 'getting it wrong'.

Clearly a plan wasn't made either way, but a number of colleagues took the article reference and requests for copies of the Power Point were made so at least it generated discussion, and colleagues did hopefully go away with something of interest.

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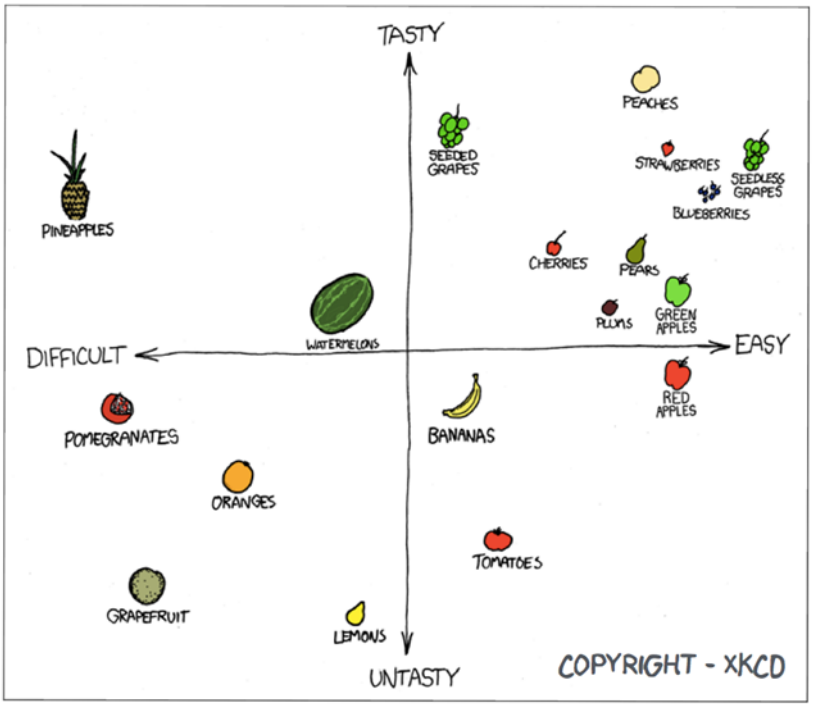
Fruit Based GOLD Classifications

Dr Ben Brockway
Consultant & Senior Lecturer in Respiratory Medicine
Dunedin Public Hospital

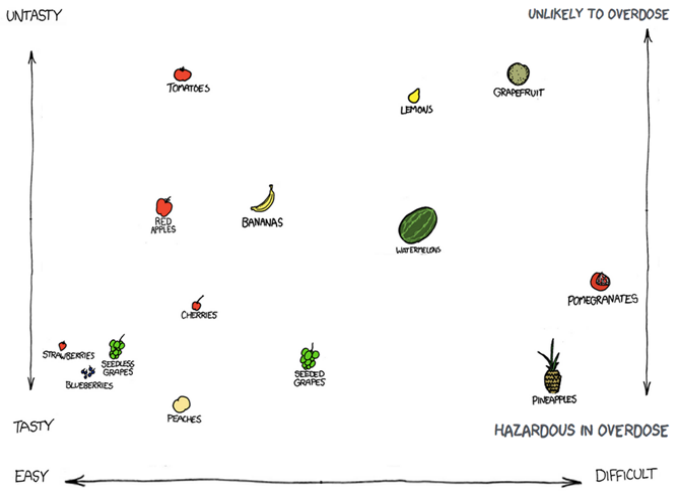
A few weeks ago I was looking at the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines again – and more specifically the combined assessment of COPD using the rubric assessment that focuses on symptoms, GOLD classification of airflow limitation, exacerbation history and its risk.

Although it is a very sensible framework for thinking about COPD patients, even the most ardent GOLD fan must struggle to say that the guidance is particularly easy to recall. Maybe I am missing some vital part of my brain, but apart from knowing that patients in group A are often less crook than group D, there must be some easier way of remembering the Bs and the Cs.

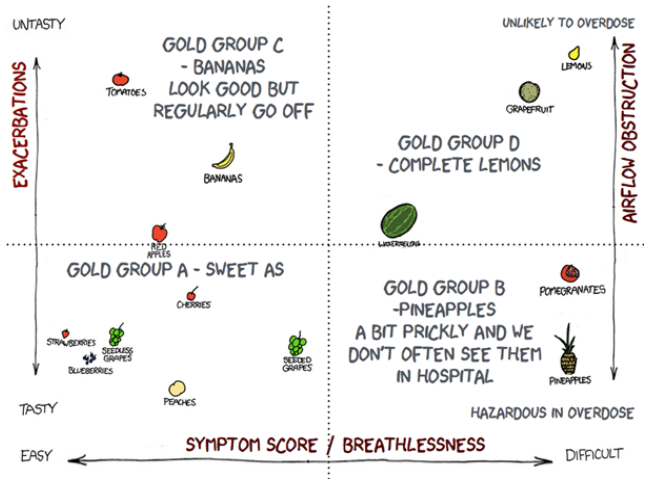
Looking at the table in the GOLD guide, I was struck by a resemblance to a cartoon I once saw by (the distinctly nerdy) XKCD. The point is that we can actually categorise lots of different things very well, either consciously or subconsciously. Maybe this admittedly somewhat flippant chart could help out with GOLD groupings. With some trickery I was able to turn this around a bit.



I wanted some allied but subtly different vertical axes (like RISK in GOLD, either as exacerbations or degree of airflow limitation) and settled on the laxative effects of overdosing on ripe peaches (although I shall not relate why I thought of that…). Some alterations are needed for my personal preferences.



I can then add the axes (exacerbations and airflow obstruction severity up the sides) and disability / symptom scores along the bottom…
And then add the quadrants:



At home I look at the bananas in the fruit bowl and they look fine; the next day they look fine, and then the day after they have gone black and squishy. The GOLD C's are similar: they look fine (low symptom scores) but then they just 'go off'. GOLD D's are complete lemons…. and the group B's are to my mind (as a hospital doctor) the pineapples - a bit prickly (lots of symptoms but without much in the way of objective reasons why) and we don't get to see them in hospital much. Group A, however - they are just sweet as, and the ones we all prefer to find in our rooms. So there you have it - fruit based GOLD classification. Other fruits are available!

A brief review of the Thoracic Society of Australia and New Zealand (TSANZ) 2015 guidelines for acute oxygen use in adults: "swimming between the flags"

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MidCentral Health

http://onlinelibrary.wiley.com/doi/10.1111/resp.12620/full

The Thoracic Society of Australia and New Zealand (TSANZ) guidelines 2015 for acute oxygen use in adults: "swimming between the flags," discusses the TSANZ acute oxygen guidelines and reviews basic concepts. The guidelines are based on the 2008 and draft 2015 British Thoracic Society (BTS) Guidelines for Emergency Oxygen Use in Adult Patients. The main points are summarised below:

- Oxygen should be considered a drug
- Oxygen is not given for breathlessness
- Hypoxaemia is a marker of risk of poor outcome and also an independent risk factor for poor outcome
- There are clinical risks associated with hypoxaemia and hyperoxaemia
- Specific target (swim between the flags)
- SpO2 (Saturation by pulse oximetry) monitors should be available. SpO2 recording is useful but of limited value and should not be used in isolation. (Practice point: there are variable machines which give variable results. A SpO2 of >92% means the ABG O2 will be > 60mmhg).
- An arterial blood gas (ABG) should be taken. Peripheral venous blood gas (VBG) is NOT accurate for measuring either CO2 level or O2 levels, but in an acutely unwell patient does provide rapid information. (Practice point: If a venous CO2 is less than 40mmHg, this will rule out hypercapnia).
- A specific prescription is needed with a target SpO2, a range of flow rates and instructions for clinical review.

Target range "Swimming between the flags":

- Hypoxaemia in acute medical conditions 92-96%
- COPD 88-92%. Practice point: In diagnostic uncertainty as to whether the patient is at risk of hypercapnia it may also be preferable to titrate oxygen therapy to 88-92% target range.

There are some key differences in this guideline from the BTS guidelines which the authors point out as below:

"Swimming between the flags": A target range of 92-96% in acute medical conditions is lower than that of the BTS of 94-98%. This lower threshold for acute medical conditions is considered a practical lower threshold to rule out hypoxaemia of <60mmHg.The authors felt that this would reduce the excessive use of high oxygen therapy and avoid the potential risks of hyperoxaemia, whilst explaining that evidence shows there is no known risk of hypoxic injury at 90%. They comment that for example older healthy people often have lower SpO2 < 90% and those with sleep disordered breathing often 80-90% for prolonged periods.

The algorithm of emergency oxygen use includes emphasis of titration of oxygen via nasal cannulae which also differs from the BTS guideline which does not emphasise this device.

Discussion

Oxygen therapy is commonly used in hospital and, as with all drugs; there are potential risks and benefits. In 2008, in response to conflicting advice and confusion surrounding oxygen therapy, the BTS published a guideline recommending provision of an oxygen prescription for defined indications including the specification of doses, method of delivery and target range (O`Driscoll et al 2008). Since the guidelines were released there have been small improvements in prescribing and administration but, despite having yearly national audits, many patients in the UK are still given oxygen without a prescription and clinical staff were not always responding appropriately to patients oxygen saturation levels (O`Driscoll, 2013). Audits in New Zealand have produced similar results (Boyle & Wong, 2006; Wijesinghe et al, 2010, Holbourn & Wong, 2014).

The TSANZ guideline article is useful in that it articulates some important practice points which are applicable to both medical staff and nurses. There is emphasis on clear prescribing, monitoring and documentation of SpO2, delivery system and flow rate. The authors argue that SpO2 is a “vital sign” to be considered with other signs including respiratory rate, which is a predictor of potentially serious events. This could have implications for the Early Warning Score (EWS) used in hospitals that do not include SpO2 on the EWS. The importance of clear prescribing means that national prescription charts may need to be updated to reflect the amount of room required to write a comprehensive and clear oxygen prescription. There also needs to be changes made to observation charts to reflect and encourage accurate monitoring. All other drugs are generally ordered by the Pharmacy department and are subject to strict controls. This does not seem to be the same for oxygen which does not promote a culture of accountability and responsibility around oxygen prescription and monitoring. There is also some emerging evidence from the home oxygen surveys and audits overseas that some patients do not consider oxygen to be a treatment in the same way as other drugs (O`Driscoll, 2013). This suggests that an awareness campaign may be needed for patients as well as staff around the issues and dangers of incorrect oxygen prescribing. The authors hope that the TSANZ guideline 2015 will clarify prescribing, monitoring and management of oxygen therapy leading to improved outcomes for our patients.

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Holbourn,A.,Wong,J.(2014). Oxygen prescribing at Waikato Hospital does not meet guideline recommendations. *Internal Medicine Journal,*1231-1234.

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O`Driscoll, B., Howard, L., Davison, A. (2008). British Thoracic Society guideline for emergency oxygen use in adult patients. *Thorax*, 63, supplement VI.

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International Primary Care Respiratory Group (IPCRG)

Carol Fitzgerald, Respiratory Clinical Nurse Specialist,
Southern District Health Board

The IPCRG are a primary care non-governmental organisation with a special interest in respiratory disease. Its mission is " to improve public health by carrying out, funding and organising research into care, treatment and prevention of respiratory illnesses, diseases and problems in a community setting, and to make available the results of such research for the benefit of the public and healthcare professionals" (IPGRG Annual Report, 2011, p. 3). With 18 full country members and 28 associate countries as members its activities reach more than 101,250 primary care professionals worldwide. It is the only international primary care respiratory organisation, and the only international primary care organisation with a respiratory research mission. The group consult and link widely with groups such as the World Health Organisation (WHO) and European Academy of allergy and Clinical immunology (EAACI) and European COPD Coalition where they can represent primary care in policy forums and have a voice on topics that effect primary care such as the production of real-life evidence that feeds to guidelines and guidance, universal access to good quality inhaled medicines for asthma and support for smoking cessation initiatives. They produce a journal, the *Primary Care Respiratory Journal (PCRJ)*, published in the UK and with online access. Their web platform aims to connect primary healthcare professionals with interests in lung diseases, education and research and enable individuals to find colleagues with similar interests to have live discussions. They run a biennial conference with the next meeting being held in Amsterdam on the 25th -28th May, 2016.

In 2012 I attended the IPCRG conference in Edinburgh and was very lucky to be invited to attend again in 2014 in Athens. One of the most exciting aspects of these meetings for me was the huge diversity of healthcare and approaches being delivered around the world. The challenges that third world countries have in access to trained professionals, medication and resources, yet the amazing work they manage to do despite this is fantastic. Although we often feel frustrated that respiratory healthcare in New Zealand is not ideal we are certainly better off than many.

Working within a DHB my particular interest is in improving the integration of health care services from hospital to community and vice versa for people with respiratory disease. It seems throughout the world the push to reduce hospital stays and admissions is universal and so improving access, quality and integration of primary services is a priority. I particularly enjoyed sessions on COPD discharge bundle from the Greek meeting where some work is being done in the NHS to improve discharge information and communication for people with this disease. I was a little disappointed in both conferences that there was minimal input from nursing and allied health. The IPCRG are trying hard to build a multidisciplinary approach to care and the theme for its next conference is 'Teamwork'. Prof Trisha Greenhalgh, a professor of Primary Health Care and practising GP will be providing the opening address for Amsterdam titled "The Value of Interdisciplinary Approaches for Patients Benefit".

If you fancy a trip to Amsterdam (and who wouldn't) and have a particular interest in respiratory primary healthcare I would highly recommend attending or consider submitting an abstract or poster on the great work you do. Either way I suggest checking out there website which has something for everyone www.theipcrg.org .

Reference:

IPCGR. (2011). *2011 annual report.* Scotland: Author.

CONFERENCE REPORTS

Thoracic Society of Australia and New Zealand (TSANZ) Nurses Meeting Hilton Hotel, Queenstown, Wednesday 5th August 2015

Lynda Paris
Respiratory Specialist Nurse
Southern District Health Board

The meeting started with an introduction by Deborah Box (CNS) from the organising committee. Most of those attending were nurses from a variety of working environments including DHB's, PHO's, and NGO's. There were also some physiotherapists attending.

The first presenter Susan Reid from Workbase, talked on Health Literacy and reminded us about the importance to work with clients/patients and ask what they know, then build on this information and then go back and check that the information they have understood is correct. She emphasised the importance of looking at the way we provide education/information as people learn differently and require a variety of techniques and mediums.

There is a new resource on "Health Literacy for Health Professionals" that Workbase has been involved in.

Judy Jones then spoke on Sleep Health. She highlighted the importance of including sleep assessment in our practice. With the increasing obesity in New Zealand sleep disorders are on the increase and identifying people early is important to reduce other health conditions.

Sue Ward (Respiratory CNS) walked us through her involvement in the Integrated Respiratory Project. The aim of the project was to work across all services to provide better care for respiratory patients. Sue worked closely with Asthma Hawkes Bay to upskill practice nurses in spirometry and education. They used Care Plus funding as additional financial support. The project was very successful and currently Sue is trying to get further funding for this to continue.

Prof Connie Katelaris (Professor Immunology and Allergy, University of Western Sydney) presented on the subject of Pulmonary Vasculitis. She discussed using the Chapel Hill classification for identifying types of vasculitis and discussed in length the different types of vasculitis and the associated vessel size affected. She highlighted the importance of thinking of these more uncommon conditions when assessing patients.

The last session for the day was by Prof Peter Gibson with an intriguing title of TOADS: Types of airways disease you don't want to miss. Prof Gibson's interesting talk covered a variety of other conditions such as the overlap of sleep disordered breathing, obesity and obstructive airways disease. He ended with a discussion on Vocal Cord Dysfunction which is often diagnosed as asthma. He highlighted symptoms, diagnostic tests and treatments for this.

It was a very interesting day and I want to thank the SDHB for their support to attend the conference.

The NZ Branch of TSANZ and New Zealand Society of Respiratory Science Annual Scientific Meeting 2015 Conference Report, Queenstown, 6-7 August 2015

Janet Delooze & Elaine Murray
Asthma Nurse Educators, Asthma Auckland

Janet Delooze & Elaine Murray
Asthma Nurse Educators, Asthma Auckland

(Editor's note: Janet and Elaine have also included in their report several sessions from the nurses meeting which have been published as they offer additional information to that of Lynda Paris.)

The 2015 conference was yet again, interesting and informative, and a great opportunity to network with others working in the respiratory field. A brief summary follows of some of the highlights.

Health Literacy - Susan Reid.
Consulting Manager, Workbase

Susan presented a very clear informative session and explained how health literacy, which originated in the US, was often viewed in terms of a 'patient deficit' rather than an inadequacy on the part of the health professional concerned. Health literacy is "the capacity to obtain, process and understand basic health information and services in order to make informed appropriate health decisions". It should be about achieving equity for all, by utilising available, relevant resources where they are needed most as opposed to equal distribution.

She advocated a 3-step model for health literacy:
Step 1 - Ask - find out what people know, ask them to tell you in their own words
Step 2 - Build - on what they know providing more information and explanations
Step 3 - Check - ask questions as a way of checking people have understood.

If you find that your communication was not clear, repeat Step 2 and fill in the gaps, then check again.

For further information the booklet "Three steps to better health literacy - a guide for health professionals" explains the three-step model, or check out the NZ Framework for health literacy

http://www.health.govt.nz/publication/framework-health-literacy

Sleep health - Judy Jones

Sleep - something we do every night but may not realise how important good sleep is. We should sleep for between 7-9 hours, less or more sleep increases the risk of diabetes, depression and hypertension.

Judy also spoke about Obstructive Sleep Apnoea (OSA) and the increase in risk of CVD, stroke, diabetes, depression and obesity. OSA is 5 times more prevalent in Maori and Pacific Island people

During assessment, look at total sleep time, how often the patient wakes during sleep and if they wake feeling refreshed.

Epworth Sleepiness Scale and the Berlin Score are used in assessment.

The Science of Happiness - Dr Tony Fernando

Psychiatrist/Sleep and Insomnia Specialist. Senior Lecturer. Psychological Medicine. University of Auckland.

This session about happiness was an interesting interlude between the respiratory sessions. His discussion on the different types of happiness was excellent, and described three main themes. Calm contentment, excitement and drive, (though an important part of life, are short lived) and the 'compassion connection circuit' which is the highest and the only sustainable form of happiness due to internally reignited oxytocin.

Multi-Dimensional Assessment & Treatment of Obstructive Airways Disease – Prof Peter Gibson

Respiratory Physician, John Hunter Hospital, NSW, Australia.
Co-Director. University of Newcastle's Priority Research Centre for Asthma and Respiratory Diseases

In a comparison of asthma and COPD, Prof Gibson discussed how, in asthma, the mortality rates are decreasing, it is often over-diagnosed and over-treated; in contrast to COPD where the mortality rates are increasing, and the condition is often under diagnosed and undertreated. The diagnosis and management of obstructive airways disease (OAD) in older people is complicated due to age-related changes, disease related changes, co-morbidities, and a paucity of evidence to guide treatment decisions for older people.

'A multidimensional assessment that addresses airway problems, comorbidities, risk factors, and management skills, will draw attention to key needs for intervention. Increased attention to the complications of asthma and obstructive airways disease in older people is needed, specifically to develop effective systems of care, appropriate clinical practice guidelines, and a research agenda that delivers improved health outcomes' (Gibson, P.G., McDonald, V.M., & Marks, G.B. (2010). Asthma in older adults. *Lancet,* Volume 376, Issue 9743, 803 – 813).

Vocal Cord Dysfunction – Prof Peter Gibson

Vocal cord dysfunction often co-exists with asthma or mimics asthma. The clue to the diagnosis lies in the history – tightness, pain, and voice symptoms. These patients are usually non-responsive to $beta_2$ agonists if there is no asthma component. A CT scan of the throat will confirm diagnosis. It is also associated with GORD.

Disordered breathing (BPD) - Tania Clifton- Smith

Breathing is the first and last thing we do in life – but many things can go wrong. The nose is the gate way to the lungs, and with each inhalation, we should breathe right down to the diaphragm, 10-14 times every minute. Babies breathe between 30-50 and a young child 25 per minute.

Inappropriate breathing, which is persistent, can cause symptoms with no apparent organic cause

Factors that may contribute to BPD include biomechanical factors such as posture, chronic mouth breathing, occupations such as diving and swimming; biochemical factors such as lung diseases, allergies, post nasal drip, drugs, hormonal, exercise; psychological factors such as anxiety, stress, panic, personality trait, suppressed emotions or anger.

Tania suggested observing the clients breathing pattern, their handshake (a clammy hand is an indicator of BPD), sitting or standing posture, postural or jaw tension, rounded shoulders, pokey chin. Explanation, education and retraining can improve hyperinflation and correct the breathing pattern. Remember that we can all improve our breathing pattern at any time - correct your posture and take note of your breathing.

When in doubt, breathe out!

The Middlemore Asthma Cohort – Dr Jeff Garrett

This was an audit that was carried out 5-6 years ago that looked at patients who presented at clinic with asthma over a 2 year period. Severe asthma was identified as poor symptom control, ≥ 2 courses of oral OCS, hospital admissions, and persistent airflow limitation. There seems to be a gap in the management of these patients with 82% being under-treated and poorly controlled: the guidelines are not being stepped up to Step 5.

Eosinophil measurement is the “ideal biomarker” in sputum and Fraction of Exhaled Nitric Oxide (FeNO). High eosinophilic levels warrant treatment with steroids: low eosinophils suggest that neutrophils are increased and therefore indicate treatment with antibiotics.

2nd New Zealand Influenza Symposium Report
University of Otago, Newtown, Wellington, 11th November 2015

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

This symposium was hosted by the Immunisation Advisory Centre, University of Auckland. Overall the symposium was extremely informative with vibrant, entertaining speakers that made at times complex, serious information very palatable and easy to comprehend. The day was sensibly divided into three very tightly managed sessions.

Session One

Marc-Alain Widdowson spoke of four issues. Firstly, about the rapidly growing body of evidence showing the increased rate of infection and subsequent death for patients suffering TB or HIV. Secondly he highlighted recent meta-analysis showing a 21% reduction in flu symptoms, 44% reduction in lower respiratory tract infections and 63% reduction in hospitalisation when rest home residents were provided with the use of Tamiflu. The same analysis indicated those elderly people who contracted flu like symptoms and were hospitalised and treated with Tamiflu were likely to have shorter hospital stays and return to their own homes as opposed to those not treated with Tamiflu who had longer hospital stays and were significantly more likely to require rest home placement post illness. Thirdly he outlined the predicted/actual results and attempted to explain some of the more bizarre results of data from Brazil's mass immunisation of the elderly programme and finally he provided interesting data around the very recently identified differences between avian flu in the US and Egypt.

Heath Kelly spoke about the effectiveness of flu vaccines this year and generally. Vaccines seemed to provide 60-80% effectiveness against H1N1 and the two major B strains however against H3N2 only 30% effectiveness was seen, likely due to the rapid evolution of the virus. Live attenuated Influenza (LAIV) was proving far less effective for children over recent years and the US has now changed its recommendation to require inactive influenza vaccines (IAIV) to be used on children. Of concern was further significant evidence indicating reduced effectiveness of vaccines when hosts are vaccinated year on year. He reminded the audience that quadravelant vaccines would soon be the only choice available and that internationally other determinants such as housing, smoking, environmental air condition, humidity and temperature also needed to be addressed.

Richard Webby was highly entertaining explaining why it is easier for humans to catch the flu from birds than from other humans! He also outlined that very clever scientists had developed a tool that helped identify which flu viruses were likely to be future nuisances so that vaccine work could be well underway if/when those particular viruses become an actual threat to the human population.

Finally Sue Huang spoke about New Zealand's experience with flu this year and outlined some of the very recently released data from their Auckland based SHIVERs Trial which has been running since 2012. 2015 was a "bad" year for flu after two relatively quiet years. Vaccines were late arriving and the season peaked later (in August) also. H3N2 was more prevalent early in the season and the Bs appeared late in the season. H1N1 was most commonly managed in the community and transmitted predominantly between younger children. Older school aged children were more likely to be infected with Bs. All three strains were represented in hospital admissions. The data was proving important as it strongly indicated pregnant women were more likely to develop more serious flu symptoms and this information was helping midwives to address this issue.

Session Two

Dianna Murfitt from the Ministry of Health (MoH) opened the session and discussed whether the 2015 programme had been successful. The main aims of increasing vaccination rates for those over 65 years and for those with chronic conditions had been achieved although she did not quantify the increase. The MoH distributed 1.2 million vaccines although again she did not detail how many of the vaccines had actually been given. The programme began earlier and finished later than initially planned.

There were geographical differences in the use of tri and quadravalent vaccines. The Auckland region had a higher prevalence of H3N2 whilst the Canterbury region saw a greater prominence of the B strains. District Health Boards (DHB's), reported an average of 66% staff vaccinations, apparently an increase from the last few years and Waikato and Northland were standout DHBs with over 80% vaccination achieved. The blue dust TV campaign was very successful and a similar campaign is planned for early in 2016 as well as including a floating start date for the season and a current and more accurate Pharmacist Vaccinator list and Vaccination register.

Michelle Kapinga also reflected on the 2015 programme reporting a general change in public perceptions of vaccinations. In particular she noted a marked increase in the number of pregnant women being vaccinated, further identification of motives for and barriers against getting vaccinated and how this is shaping future programmes. She finished noting that health professionals delivering easily understood, consistent messages about the safety and importance of being vaccinated was the key influencing factor in people choosing to be vaccinated.

Dr Richard Medlicott and Practice Nurse, Margo Martin delivered the third presentation on how their own Practice had managed the 2015 flu season and what they had planned for 2016. They stressed the importance of a multi-media approach to advertising the vaccines and having a robust and flexible system to provide and record the vaccines. They strongly encouraged keeping accurate data, having point of care viral testing and getting involved in studies where possible.

Of interest was they reported clients voicing concern and confusion about the types of vaccine available (Trivalent vs Quadravalent).

Dr Nigel Murray spoke next about Waikato DHBs staff immunisation policy including wearing of masks, managers knowing staff vaccination history and staff accountability. He focussed strongly on his responsibility to protect patients. He stated he was awaiting analysis of the impact of the policy and that early data seemed to indicate a reduction in staff sick leave. His fellow DHB member noted that Health and Safety Vaccinators were instructed not to vaccinate anyone who indicated they felt coerced. He mentioned dialogue with Unions was pending but that he was pleased the policy had generated robust and healthy community dialogue. He mentioned that "only three staff had resigned" due to the policy. The enforced wearing of masks for staff not vaccinated was discussed very briefly.

Dr Phil Schroeder followed with a lively presentation outlining the Canterbury Primary Health Strategy for managing the recent year's flu seasons and their future plans. Pre-planning saw increased numbers of vaccinators in place early in the year and extended multimedia drenching with facts and actions about flu. They used international intelligence to predict 2015 was likely to be a "bad" year realising they also needed to factor in the late arrival of vaccines, the removal of free vaccines for under 18yrs and the continuing restrictions of emergency department, (ED) services post-quake. Continued surveillance helped them to know the types of strain most likely to be prevalent and to recognise early the upturn in GP and ED presentations .The DHB supported the use of Tamiflu for over 65yrs and the Practices themselves use a range of call/recall methods plus they set aside separated waiting areas for the well wanting vaccination. The practice staff were managed to ensure they were all well and rested as the flu season approached. The practices extended their opening hours, advertised their vaccination programmes widely. They also enlisted the use of a range of other health professionals (from outside the practices) to provide vaccinations to the public.

Session Three

Bob Buckley provided a pharmacist view of how the 2015 flu season panned out for their services. He noted there were 580 pharmacist vaccinators and that the administration of various medicines was now included in the Pharmacists national framework.

As a group they were advocating for a national register, shared medical records especially because there was no consistent practice requirement that ensure patients GPs were informed if those patients were vaccinated by non-practice staff and they were awaiting confirmation that they would be able soon to vaccinate children as young as 13 years (currently restricted to over 18 yrs).

The final presentation was delivered by Clair Clissold, CNS. She was also a highly entertaining speaker. Her main message was pushing the message that fine droplets from coughing and sneezing holding viruses can remain airborne and active for several hours. Alcohol based hand gel kills over 95% of flu viruses. All masks work at reducing airborne viruses but the N95 is the best… regardless they will not work when worn incorrectly (on the chin, on the head!) Being community based and visiting rest homes frequently she advocated for early swabbing of suspected cases, use of isolation for five days from flu symptoms developing and much more aggressive use of Tamiflu in the elderly population.

Each session finished with a panel discussion and the last session had a longer period for discussion. This was an excellent symposium with current and relevant clinical information, great speakers and robust audience involvement encouraged. Well worth the time and effort to attend.

EVENTS FOR YOUR CALENDAR

Conferences/Seminars/Courses

SIREF 2016, 19th & 20th February

http://canbreathe.org.nz/page/333/health-professionals

http://canbreathe.org.nz/download/465/siref-2016-registration-form

Respiratory Nurses Section NZNO Symposium & AGM Friday 15th April 2016

"Bridging the Gaps in COPD Care"

Hamilton Airport Hotel & Conference Centre

201 Airport Road, Hamilton

8th IPCRG World Conference, Amsterdam

25-28 May 2016

Registration and Abstract Submission now open:

http://www.ipcrg2016.org

http://www.nzno.org.nz/groups/colleges_sections/sections/respiratory_nurses/conferences_events

National Asthma Council Australia

Provides a list of various respiratory focused conferences for health professionals

For more information: www.nationalasthma.org.au

2016 Valley District Health Board Respiratory Courses

For nurses working in acute, non-acute, secondary or primary health care settings The 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.

14th April – COPD course for nurses
23rd June – Asthma course for nurses

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 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

2016 Distance Learning: Asthma & COPD - Level 7 Nursing Courses
Asthma New Zealand/Unitec

Semester One: Asthma Course starts February 15th 2016
COPD Course starts April 26th 2016

Semester Two: Asthma Course starts July 18th 2016

For further information contact: Ann: 09 623 4777 annw@asthma-nz.org.nz
Swarna: 09 623 4771 swarnah@asthma-nz.org.nz

2016 Asthma New Zealand

1 Day – 6 hours 'Neat' Asthma Course for Registered Nurses
March 16th, June 15th, September 21st,

School NEAT - July 6th

COPD ½ day
April 20th, July 19th, October 19th

Further enquiries for any of these events phone (09) 630 2293

Spirometry Courses

Auckland District Health Board

Further information is available by contacting

resplab@adhb.govt.nz

Ph: 09 630 9918 Extn. 26234

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

PHARMAC Seminar Series

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

www.pharmac.health.nz/seminars

2016 COPD and Asthma 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 on your nearest course email the national education services manager, Teresa Demetriou, teresa@asthmafoundation.org.nz or call (04) 499 4592

Peer Group Meetings

Asthma & Respiratory Management, BOP Inc

REPS (Respiratory Educators Peer Support) 2016

20th April, 13th July, 28th September, 7th 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 Regional Respiratory Nurses Forum

Venue: Te Awakairanga, 4th Floor, Levin House, 330 High Street, Lower Hutt

For 2016 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 2015/2016

Role	Name	Email
Chairperson	Betty Poot	betty.poot@huttvalleydhb.org.nz
Secretary	Chris Rothman	chris.rothman@wdhb.org.nz
Treasurer	Zoe Briggs	zoe.briggs@bopdhb.govt.nz
Newsletter Editor Vice Chair	Cathy Modrich	modrich@xtra.co.nz
Newsletter Co-editor Website	Sharon Hancock	sharon.hancock@midcentraldhb.govt.nz
Symposium Co-ordinator	Michelle Hopley	mish-mash@clear.net.nz
Symposium Treasurer	Peter Cole	peter.cole@bopdhb.govt.nz
Membership Secretary Submissions	Louise Weatherall	Louise.Weatherall@pegasus.org.nz
NZNO Professional Nursing Advisor	Annie Bradley-Ingle	annetteb@nzno.org.nz

Happy Holidays from the Respiratory Nurses Section (NZNO)

(Left to right)

Michelle Hopley, Louise Weatherell, Annie Bradley-Ingle, Cathy Modrich

Zoe Briggs, Peter Cole, Sharon Hancock, Chris Rothman, Betty Poot