AIRWAYS

Newsletter of the (NZNO) Respiratory Nurses Section
August 2014 edition

Inside this Issue:

Note from the Chairperson

Welcome to our August edition 'Airways' for 2014.

'Welcome to our August edition of 'Airways'. You will be receiving this newsletter at the tail end of the winter months, generally the busy time of year for respiratory nurses. I hope that you will be able to take some time out from your busy work schedule to read 'Airways'.

In this issue we have highlighted an integrated care in practice with some cutting edge initiatives from our members. Many of you joined us in Whanganui for our biannual symposium and annual general meeting (AGM). I trust you enjoyed the day and have been able to use some of the information in your clinical practice. For those of you who were unable to attend, read on, as there is a review of the symposium in this issue of 'Airways'. We also have our regular feature of 'events' that you may be interested in attending.

"Each article in this issue of 'Airways' demonstrates innovative thinking and illustrates new solutions to issues we each face in our daily practice".

At the AGM several new committee members, Michele Hopley, Zoe Briggs and Cathy Modrich, were voted onto our committee. They join Chris Rothman, Sara Mason, Betty Poot and the NZNO Professional Nurse Advisor Lorraine Ritchie. As we had one vacancy for a committee member Ann Wheat has kindly agreed to be seconded onto the committee for one year. Our committee roles and contact details are also in this edition of 'Airways'. I would like thank the outgoing committee members, Nicola Corna, Liz Fellerhof, Judith Quinlan-Logan and Steph Parker, for all the hard work over the past years.

If you have any suggestions for our newsletter, or wish to contribute by writing an article or conference report please contact us (chris.rothman@huttvalleydhb.org.nz). Our newsletter editors Sara and Cathy would welcome your articles. For our next issue they have planned to celebrate respiratory nurses wherever you may be as the holiday season falls upon us. So tell us about what you are doing in your clinical setting.

Betty Poot
Chair
Respiratory Nurses Section (NZNO)

International Acclaim for Integrated Community Health Service

Julia Paterson-Fourie Senior Communications Advisor for Healthcare of New Zealand Holdings Limited.

Acknowledgement: The TWO team

The *Te Whiringa Ora/Care Connections* (*TWO*) service in the Eastern Bay of Plenty has been internationally recognised as an innovative integrated community health solution that engages clients and connects providers (Goodwin, Dixon, Anderson, Wodchis, 2014).

TWO was recently selected by the Commonwealth Fund as one of seven international case studies on integrated care in the community. In the first of a series of papers to be released on these case studies, the authors found compelling evidence that integrated care for older people with complex needs can be successfully delivered through incremental improvements to existing services provided in the community (Goodwin, Dixon, Anderson, Wodchis, 2014).

As the lone example from New Zealand, *TWO* was the only case study using telehealth remote monitoring and it placed the most emphasis on engaging clients and family/whānau to improve self-management of chronic conditions. The paper also confirmed that *TWO* is a service that incorporates the right principles in order to achieve success - for both clients and the health system (Goodwin, Dixon, Anderson, Wodchis, 2014).

About *TWO*

Te Whiringa Ora/Care Connections (*TWO*) works with other health and social services to provide a web of support around clients (and their family/whānau) with chronic conditions like heart disease, diabetes and Chronic Obstructive Pulmonary Disease (COPD) (HHL Group, 2013). The service targets these clients and those who are high users of hospital services so that they can remain active in their community.

TWO is a partnership between the Bay of Plenty DHB, the Eastern Bay Primary Health Alliance and Healthcare of New Zealand and was implemented in February 2011 in the Eastern Bay of Plenty,

TWO's model is established on a philosophy of improving the client's self-management of their condition - it is client-centred and client-focused. A client and their whānau work in partnership with a kaitautoko (navigator) over an intervention period of three to six months to navigate and co-ordinate the required services. The kaitautoko is supported by a registered nurse within a robust clinical governance framework. *Telehealth* technology allows remote monitoring of the client's wellbeing so that they can remain at home while reinforcing confidence in self-management (HHL Group, 2013).

The initial *TWO* pilot evaluation involved 250 clients, with an age range from 26-98 years (average age 69years). Approximately half the client group were Māori.

Previous analysis by Synergia of *TWO* found the following:

1. All clients (Māori, non-Māori, male, female and all age groups) experienced a clinically significant increase in their SF-12 scores (a quality of life assessment tool).

2. Improved primary care management of chronic and long-term conditions:
    - 10% reduction in bed days for clients
    - 47% increase in bed days for the control group
    - COPD clients: 22% increase in admission free days
    - Diabetes clients: 89% increase in admission free days
    - ED presentations: 88% increase in days between events (COPD clients)
    - Heart disease clients: stabilisation in admissions to hospital.

(Appleton-Dyer, Hanham, Field, 2013)

Value for money

In addition to international acclaim, an independent value for money study of *TWO* has found that the service is capable of delivering substantial savings to the health sector. However it is important to acknowledge that the "savings" are not necessarily realisable, but rather delay future investment in additional capital expenditure.

The economic analysis by consultancy Synergia suggests *TWO* represents excellent value for money, including:

- Projected local health system net savings of $6.8 million over five years for a community of 50,000 people
- Potential to break-even within the first 12 months
- Annual savings of $3,416 per client and $7,966 for clients with a primary diagnosis of COPD

(King, Appleton-Dyer, Field, Hanham, 2014)

"This is a successful locally grown and tested innovation that provides an answer to other countries struggling with increased healthcare costs and unmet demand," says Peter Hausmann, Chief Executive Officer of Healthcare of New Zealand Holdings Limited. "I'm also particularly excited that in an earlier Synergia study there were examples of general practice saying that *TWO* cut their workload in half and freed up the primary sector team to do clinical work"

"It is our vision that this versatile model is implemented in communities throughout the country to improve quality of life and health outcomes," says Peter. "*TWO* is easily replicable for all demographics within every community and provides an excellent opportunity to further the integration of primary care and community support within the New Zealand health system."

(Personal interview with author, 2014)

Copies of the Commonwealth Fund's paper can be accessed at www.tewhiringaora.co.nz.

Appleton-Dyer, S.; Hanham, G.; Field, A.,. (May 2013). *An Evaluation of Te Whiringa Ora – Report Health-care NZ.* Auckland : Synergia Ltd. .

Goodwin, Dixon, Anderson, Wodchis, . (2014). *Providing integrated care for older people with complex needs: Lessons from seven international case studies.* London: The King's Fund. Retrieved from www.kingsfund.org.uk

HHL Group. (2013). *Te Whiringa Ora/Care Connections:Enabling people to actively manage their long-term health condition*. Retrieved July 2014, from Health Care New Zealand : http:// www.healthcarenz.co.nz/clients-families/long-term-conditions/te-whiringa-ora

King, J; Appleton-Dyer, S; Field, A. Hanham, G. (January 2014). *Te Whiringa Ora: Value for Money study Report for Healthcare NZ.* Auckland : Synergia Ltd.

A Chronic Obstructive Pulmonary Disease Management Guideline

Incorporated into Integrated Patient Care at a Primary Care Health Centre

Cathy Modrich, Specialty Respiratory Nurse/Practice Nurse, Mornington Health Centre, Dunedin, cmodrich@mhc.co.nz

Background

In 2009 a review of chronic disease management at the Mornington Health Centre (MHC) in Dunedin highlighted a lack of planned care for patients with Chronic Obstructive Pulmonary Disease, (COPD). This review found that care for COPD patients was based on consultations with the GP for regular prescriptions and reactive prescriptions for exacerbations. It was felt that a proactive planned care approach was needed and a COPD Management Guideline was developed based on the methodology of an Integrated Care Pathway, (ICP).

Campbell, Hotchkiss, Bradshaw and Porteous (1998) define an ICP as a multidisciplinary outline of anticipated care for patients with the same diagnosis that is evidence based and incorporates national guidelines. The care provided is set against an appropriate timeframe, and in the case of COPD, this would be about matching the right intervention to disease severity. It is patient focused and aims to provide coordinated and consistent care yet allow clinical freedom to adapt to each patient's needs and improve patient outcomes and increase patient satisfaction.

The COPD Management Guideline

According to the severity of the COPD, the guideline comprises of aims of care followed by detailed steps of clinical practice for the assessment and management of COPD. It also includes when it is appropriate to refer to the GP and specialist.

The guideline was formatted using the headings of **C**onfirm Diagnosis and Assess Severity, **O**ptimise Function, **P**revent Deterioration, **D**evelop Support Network and Self-Management Plan and Manage e**X**acerbations (COPD-X). MHC included the additional heading of Palliative/End of Life Care. These headings were derived from The COPD-X Plan: Australian and New Zealand Guidelines for the Management of Chronic Obstructive Pulmonary Disease (2012).

The first step in implementing the guideline was to identify those patients with COPD through a MedTech 32 Query Build Search. These patients were then invited to register for Care Plus, which is a primary health care initiative that is able to provide services to people with high health needs at a reduced cost (Ministry of Health, 2004).

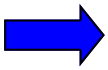
Utilising the delivery of the Care Plus programme, along with the COPD Management Guideline, a reduced cost service was instigated that provided alternating three-monthly reviews with the Specialty Respiratory Nurse (SRN) for 45-minutes and the GP for 15-minutes.

COPD Management Guideline incorporated into a SRN Assessment Review

Confirm Diagnosis and Assess Severity

At the appointment a physical health assessment is completed. This includes, height, weight, body mass index, blood pressure, Sp02, spirometry and assessment of sputum and cough. From the spirometry, a classification of severity of airflow limitation according to Global Initiative for Chronic Obstructive Lung Disease (GOLD, 2013) is made. Other data obtained is smoking status, assessment of Alpha 1 Antitrypsin Deficiency, COPD Assessment Test (CAT) Score, and frequency and severity of exacerbations. Recently, the inclusion of the Combined Assessment of COPD (GOLD, 2013) that uses the CAT Score, or Modified Medical Research Council Dyspnoea Score, GOLD classification of airway limitation and exacerbations per year to categorise the patients into A, B, C or D has been documented to especially identify the at-risk Group B and thus assess future risk.

All information obtained is recorded in a MHC MedTech Advanced Form.



Optimise Function

This is achieved within each severity category of COPD by implementing medication changes, and offering Pulmonary Rehabilitation to checking for complications, comorbidities and involving the multidisciplinary team. Additionally a Socio-Environmental assessment is completed which considers the impact of COPD on their daily life so that appropriate interventions are undertaken. It is highlighted if they live alone, hold a Mobility Parking Permit, retain a "back-pocket prescription" for antibiotics and prednisone and possess a Medical Alarm.

Prevent Deterioration

This is centered on support for smoking cessation, flu and pneumococcal vaccinations and monitoring clinical signs and symptoms that may require increased support.

Develop Support Network and Self-Management Plan

An example of some additional support network services include Community Exercise Classes, Pulmonary Rehabilitation, Dietician, Meals on Wheels and Home Help and/or Personal Care Services.

An important link with secondary care has been the development of integrated care relationships with the Respiratory Clinical Nurse Specialists at the Dunedin Public Hospital who say that the r*elationship between respiratory nurses within these two settings ensures support between colleagues and reduces feelings of isolation.*

> *"Ensuring that we are communicating plans of care and working together has been vital to providing a smooth transition between the secondary and primary services and improving patient outcomes"*
>
> *"Patients particularly as their disease progresses will be vulnerable to acute exacerbations and possible hospital admission. Interventions include meeting together with the patient and family to begin advanced care planning discussions or reviewing and adapting plans of care to meet the requirements of patients with advanced disease and co-morbidity"*
>
> *(Personal interview with Clinical Nurse Specialists, 2014)*

An individualised self-management and breathlessness management plan is developed and may require more in depth education and training in self-management skills such as, breathing control, sputum clearance techniques, how to conserve energy, use of medications, nutrition and when to seek medical help.

Manage Exacerbations

This may include a COPD Management Plan as an extension of the self-management plan, to assist early detection and prompt treatment with antibiotics and prednisone, which may mean the availability of a “back pocket” prescription.

Palliative/End of Life Care

This stage can be difficult to identify and Rocker, Sinuff, Horton, and Hernandez (2007) suggest health professionals ask themselves the question “Would I be surprised if this patient died within the next 12 months?” If the answer were “no” you would not be surprised, then planning for palliative care needs to be considered.

Care at this stage of COPD may be around anxiety, depression, nutrition, hypoxia and inability to cope at home, which may lead to hospice involvement.

Conclusion

The guideline provides MHC COPD patients with a comprehensive assessment and review, with optimal treatment and timely referrals to the support network, secondary care and hospice. Patient feedback has indicated that they feel secure and reassured that their needs are being met with an opportunity to discuss any problems and be heard. In addition, MHC staff has gained an increased awareness of the varied supports and interventions available.

Campbell, H., Hotchkiss, R., Bradshaw, N., Porteous, M. (1998). Integrated Care Pathways. *British Medical Journal*, 316: 133-137.

Glaxo Smith Kline Services Unlimited. (2009) COPD Assessment Test *www.catestonline.org* Updated 10 June 2013. Retrieved 23/07/14.

Global Initiative for Chronic Obstructive Lung Disease, Inc. (2013) Global Strategy for the Diagnosis, Management, and Prevention of COPD. Downloaded from http://www.goldcopd.org/uploads/users/files/GOLD_Report_2013_Feb20.pdf. On 2/8/14.

McKenzie, D.K., Abramson, M., Crockett, A.J., Dabscheck, E., Glasgow, N., Jenkins, S., McDonald, C., Wood-Baker, R., Yang, I., Frith, P.A. (2012) The COPD-X Plan: Australian and New Zealand Guidelines for the management of Chronic Obstructive Pulmonary Disease. *The Australian Lung Foundation* V2.32-06

Ministry of Health. (2004). *Care Plus: an Overview*. Retrieved from *www.moh.govt.nz*

Rocker, GM., Sinuff, T., Horton, R., Hernandez, P. (2007). Advanced Chronic Obstructive Disease: Innovative Approaches to Palliation. *Journal of Palliative Medicine*, 10:3: 738-797.

Obtaining health equity by utilising our community connections

Sara Mason, Speciality Clinical Nurse, Hawkes Bay, usnursennz@hotmail.com

An abstract on this pilot programme has been accepted for the Inaugural NZ Population Health Congress

In New Zealand one in 15 adults over the age of 45 years has Chronic Obstructive Pulmonary Disease (COPD) (National Health Committee, 2013). New Zealand has the second highest rate of hospitalisations for these patients in the Organisation for Economic Co-operation and Development OECD (OECD, 2011).

Typically this cohort of patients presents at diagnosis symptomatic and with limited functional ability. They can experience a slow decline in function along with acute exacerbations of their condition, never fully re-gaining their functional ability.

Pulmonary Rehabilitation (PR) is a non-pharmacological management option for those with respiratory disease and is recommended for all patients with COPD (GOLD, 2014). It is proven to decrease hospitalisations, readmissions, emergency department presentations and nursing home utilisation (Kacmarek, Stoller, & Heuer, 2013).

Historically the connection between health care services has been reactive with referrals to services, including PR, being made during an acute exacerbation as services react to the crisis that is at hand. Furthermore, if patients do not fit into the mainstream healthcare 'box' they are often lost in the system and unable to attend PR leaving patients unsupported in their health care.

Programmes can work with whānau, beyond the borders of the interdisciplinary health team to provide alternative treatment options and a continuum of care into the communities where the patients live.

Once such programme is the Trajectory of Long Term Care Model (TLC). This provides services that are customised for the individual's health status using already established relationships to support patients throughout their lives moving between health services proactively.

Inter-professional shared decision making is the heart of TLC. This shared decision making supports general practice as patients experience the progression of their condition. Support services including specialist services provide proactive management for high risk patients, and use the patient's own networks and existing and future support to assist in patient care and self management. The intention is to work across all sectors and community settings to encourage self management and proactive planning of expected changes in health status. Settings for the programmes can vary, depending on circumstances and ability to participate and travel.

In February this year a pilot was introduced into the Hawkes Bay Pulmonary Rehabilitation programme which was underpinned by the TLC model. The aim of the pilot was to explore if the TLC model could be introduced into non traditional and traditional settings and explore patient's experiences and health outcomes in both rural and urban settings.

The outcome of the pilot showed that TLC supported patients and whānau in local gyms, schools, churches and at home. It also provided professional support and education to public and private health providers to assist them in better management of respiratory patients within the community.

Obtaining health equity by utilising our community connections (Cont).

Customised programmes, crisis plans and care plans were developed in partnership with the patient, their whānau and services involved in their care. Involvement was dependent on where the patient was in their trajectory of health. The goal of TLC is to support the patient, the general practitioner (GP) and other services across the sectors encouraging communication, and sharing of knowledge, with the aim of improving the patient's journey.

This pilot has demonstrated that the TLC model would successfully provide a framework for the integration of services. It has proved successful in all areas explored with better communication between services, with proactive care and crisis planning. Anecdotally it also resulted in decreasing avoidable hospital admissions for those patients on our home PR programme, patients living in rest homes and some high risk patients.

Global Initiative for Chronic Obstructive Lung Disease. (2014). *Global Strategy for Diagnosis, Management, and Prevention of COPD.* Global Strategy for Diagnosis, Management and Prevention of COPD, Inc. Retrieved March 5, 2014, from http://www.goldcopd.org/uploads/users/files/GOLD_Report2014_Feb07.pdf

Kacmarek, R., Stoller, J., & Heuer, A. (2013). *Egan's fundamentals of respiratory care* (10th ed.). St. Louis, Missouri: Elsevier.

National Health Committee. (2013). *National Health Committee: Strategic overview of respiratory disease in New Zealand (Working Draft).* Wellington, New Zealand: National Health Committee.

OECD. (2011). *Health at a glance 2011: OECD indicators.* OECD Publishing. Retrieved from http://dx.doi.org/10.1787/health_glance-2011-en

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

******Attention everyone! NZNO Respiratory Section will soon be moving into College status and we are going to be looking for a new logo. Contest information will be in the next issue of Airways...Keep watch for the next issue...**

Report on the Respiratory Nurses Section (NZNO) symposium – 11th April 2014, Whanganui

Alice Paul, RN, Asthma educator, Asthma Society, Wellington

This year's theme was 'Reaching Out –Hospital to Community'. The theme focussed on the connection between hospital and community workers and the importance of always ensuring that our care is patient and whānau focused. The symposium began with a powhiri and a welcoming speech by the local Maori elder.

We were very lucky to have had six experts in the respiratory area presenting on various topics related to the respiratory nursing.

Josephine Davis-Wheaton, a Nurse Practitioner from Midlands Health Network, gave us an insight into her work in a rural community. She talked about her role and how it has developed over time, and shared with us the model of care at the Tokoroa Medical Centre.

Dr Aldoph Nanguzgambo, Respiratory Physician, Mid Central District Health Board (DHB),gave an interactive and informative presentation on respiratory assessment. He emphasised the importance of going back to basics when a patient presents with breathlessness, and taking a holistic approach to the patient. He advised starting the assessment from the head and ending at the feet before introducing the stethoscope! Dr Nanguzgambo used the scenario of approaching the assessment like a 'crime scene' collecting the evidence, determining who is the culprit and surveying the surrounding.

Dr. William Levack, Senior Lecturer in Rehabilitation and associate Dean of Research of Postgraduate Studies at Otago University Wellington, presented a session on Pulmonary Rehabilitation. He emphasised that a Pulmonary Rehabilitation programme of 8-12 weeks duration will significantly improve symptom management in COPD, improve quality of life and reduce hospitalisation rates.

Victoria Perry Nurse Practitioner, Respiratory from Mid Central DHB gave us the very latest information on registered nurse (RN) prescribing. In Victoria's opinion RN prescribing is a reality. Additionally she advised us that from the 1st July 2014 Nurse Practitioners will become authorised prescribers and be able to prescribe medicines relevant to their scope of practice and no longer be limited to a schedule of medicines.

Sharon Hancock Respiratory Clinical Nurse Specialist from Mid Central DHB provided an interesting session on oxygen therapy and the COPD patient. She discussed the rationale for prescribing oxygen to the COPD patient as well as the side effects of oxygen therapy.

Nicola Corna Respiratory Clinical Nurse Specialist gave us an insight into her outpatient bi-level service at Counties Manakau DHB. This DHB has a population of over 500,000 people, with a high percentage of Maori, Pacific and Asian peoples. It also appears to have a higher rate of health related conditions related to overcrowding and poor quality housing. Nicola discussed the obesity hypoventilation syndrome and how it effects those with a body mass index >30. This syndrome overlaps with obstructive sleep apnoea. Nicola's presentation also covered the use of Continuous Positive Airway Pressure in the community.

A great meeting which was enjoyed by all those attending.

Events for your Calendar

CONFERENCES/COURSES/SEMINARS

2014 The New Zealand Respiratory Conference – Asthma Foundation

A Breath of Hope - Conference will focus on practical measures to bring a breath of hope to those who struggle to breathe freely.

9 – 10 October 2014

Venue: InterContinental, Wellington, New Zealand

Keynote speaker – Dr Christopher Worsnop, Respiratory and Sleep Physician, Austin Hospital, Melbourne - will be speaking on 'Obesity and Breathing' and 'Preventing Exacerbations in COPD.

Day 1 : Focus on Asthma and Respiratory Health

Day 2 : Focus on COPD

Registrations close 1 September 2014

Further information and registration is available at: www.asthmafoundation.org.nz

Auckland District Health Board, Spirometry Workshops

18-19 September and 20-21 November 2014

Further information and registration is available by contacting by email resplab@adhb.govt.nz

Phone (09) 630 9918 Extn. 26234

Fax (09) 623 4638

Asthma Waikato Spirometry Training Course

23-24 September 2014

9.00am-4.00pm

Contact to register:

P O Box 7013, Hamilton East, HAMILTON 3247

Ph: 07 838 0851 Fax: 07 838 0852

E: info@asthmawaikato.co.nz

Venue: Norris Ward McKinnon Building, 711 Victoria Street, Hamilton CBD

Events for your Calendar Cont.

CONFERENCES/COURSES/SEMINARS

Christchurch Spirometry Course

31 October – 1 November 2014

Friday & Saturday 8:15am - 2:45pm

Venue: The George Hotel, 50 Park Terrace, Christchurch

Further information and registration is available by contacting Emily Ingram at Emily.Ingram@cdhb.health.nz

Pharmac Seminar Series

Practical management of childhood eczema

17 November 2014

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

Speakers:

Dr Karen Hoare will be facilitating this seminar and Dr Diana Purvis will be presenting this seminar. Diana is trained both as a paediatrician and a dermatologist. She works at Starship Children's Hospital and in private practice in Auckland. Debbie Rickard, Nurse Practitioner at Capital and Coast DHB, specialising in the management of eczema and skin infections in primary and secondary care. Pauline Brown, Nurse Specialist at Northland DHB, specialising in eczema and allergy.

This seminar will focus on practical aspects of the management of eczema in childhood in both the primary and secondary care setting. Areas to be covered will include use of topical therapy, improving adherence, skin infections, food and eczema and when to refer to secondary/tertiary services. There will be a workshop on topical therapy and an opportunity to discuss case-based management.

Audience: Anyone involved in child health in both primary and secondary settings.

Further information and registration is available at:

www.pharmac.health.nz/seminars

Events for your Calendar Cont.

2015

South Island Respiratory Educators Forum (SIREF)

Annual conference for health professionals in the respiratory field run by the Canterbury Asthma Society

Further details to follow

19 — 20 February 2015
Contact: office@canbreathe.org.nz

Thoracic Society of Australia & New Zealand (TSANZ) Annual Scientific Meeting - Gold Coast

27 March — April 2015

Venue: Gold Coast Convention Centre, Queensland, Australia

TSANZ ASM – The Air We Breathe – Environmental and Occupational Impacts on Lung Health

ANZSRS ASM – Lung Function Testing, More than just the numbers

Asthma New Zealand/Unitec: Distance learning Asthma & COPD Nursing Courses

Asthma Nursing Course

February 2015, closing date – 30 January 2015

COPD Nursing Course

April 2015, Closing date -10 April 2015

For further information contact:

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

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

Events for your Calendar Cont.

REGIONAL EVENTS

Bay of Plenty

Asthma & Respiratory Management, BOP Inc

REPS (Respiratory Educators Peer Support)

24 September and 3 December 2014

10 am, Cup of Tea at 9.30am

Venue: 254 Chadwick Road, Greerton, Tauranga

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

Wellington

Wellington Regional Respiratory Nurses Forum

4 September 2014

1.00pm-4.00pm

Venue: Kohiri Marae, 7-9 Barnes Street, Seaview, Lower Hutt

Contact: betty.poot@huttvalleydhb.org.nz

Your Committee 2014

Role	Name	Email
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