AIRWAYS

20th Anniversary Edition!

Newsletter of the (NZNO) Respiratory Nurses Section
September 2016

Inside this Issue:

Note from the Chairperson

Kia ora koutou and welcome to a celebration of the "then and now" in respiratory nursing in this 20th anniversary edition of Airways. There have been some major respiratory initiatives since the Section was formed and all are worth celebrating. Some recent respiratory achievements include the updated 2016 Adult Respiratory Knowledge and Skills Framework (KSF) and the launch of the National Respiratory Strategy by the Asthma and Respiratory Foundation NZ. The positive changes and advances in respiratory nursing in the past 20 years are clear to see with some excellent reports in this newsletter written by past and current members of the Respiratory Section.

Julie Livesey who was the original Chair of the Respiratory Nurses Section looks back on the birth of the Section and what was happening in Respiratory nursing at the time. It shows how far respiratory nursing has progressed in the last 20 years! John Hewitt has given a 21st Century look at respiratory nursing with the introduction of electronic monitoring and there is much more for your enjoyment in this edition.

As the new Chair of the Respiratory Section I would like to acknowledge the outstanding work the committee has achieved under the guidance of outgoing Chair, Betty Poot. Betty has provided sound leadership skills which has enabled me as the new Chair to continue with the important work of the Section. Other committee members who were farewelled at the AGM in Hamilton were Zoe Briggs, Cathy Modrich and Peter Cole. Thank you for your commitment and hard work. Welcome to new committee members Laura Campbell, Carol George, Erin Morris and Mary Gluyas and thanks to Chris Rothman, Michelle Hopley and Sharon Hancock for their continued stabling influence on the committee moving forward. The new committee met in June and has a vast amount of experience and varied backgrounds to serve the best interests of the membership.

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Our focus for 2016 remains the transition to College status. This is well underway and the committee is hopeful this will be achieved before the end of the year. The committee will also remain committed to increasing membership and updating the website during 2016. Planning is also underway for the Respiratory Nurses Section NZNO Symposium in 2018.

The committee welcome articles, innovations and practice improvements from nurses working in all areas of respiratory nursing. Your contribution is a great way to acknowledge achievements in your practice and to share with a wider respiratory audience..

On behalf of the committee I would like to thank all members for their on-going support and promotion of excellence in respiratory nursing.

Louise Weatherall

Chairperson

Respiratory Nurses Section NZNO

Looking Back 20 Years

Julie Livesey, RN, AND, Canterbury District Health Board

When asked by the Editor to put something together for the NZNO Respiratory Nurses Section 20 Year anniversary my initial reaction was 'where has 20 years gone?!'

This request has given me the opportunity to reflect on the Respiratory Nurses of New Zealand (NZ) (as the Section was then known) and I realize this group didn't happen by chance! The initial thinking three years prior to its inauguration was to have a group with a common theme, namely asthma, and to be independent. This meant no affiliation with NZNO. We came to the realization, once attempting to put a philosophy and a constitution together, that there was a need to look more widely at other Respiratory conditions and not just asthma and that to be affiliated alongside NZNO was vital.

At that time asthma had reached an all-time high in New Zealand with multiple deaths occurring annually. With the introduction of spacer and inhaler treatments that we know so well today, there were also all sorts of nebulizer compressor pumps available from Asthma Societies and hospitals. No annual auditing procedures were undertaken to ensure the pump compression levels were correct to nebulize the contents at the correct particle size for maximum patient inhalation.

Registered Nurses (RN') were attached to main center Asthma Societies only. As RNs with respiratory interest we felt there was a clear need to have the professional input of respiratory RNs, not only to assist with educational requirements, but also to promote a professional nursing aspect to managing asthma conditions.

So to that end the Respiratory Nurses of NZ was born. The first meeting was held in Auckland, September 1996 with 19 attendees along with Mary Gibbs, NZNO's coordinator of professional structures. Our goals were to develop Respiratory Nursing Standards that could be used as guidelines within our nursing practice, to provide forums for the exchange of information and research and to promote research within the area of practice. One of the first tasks of Respiratory Nurses of NZ was to design a logo that portrayed our ideals. The late Glenys Martin is acknowledged for her wonderful work as secretary and facilitating the completion of the logo which the NZNO Respiratory Nurses Section has continued to use until today where it is soon to change to herald in the College of Respiratory Nurses. Believe it or not a lot of energy went into finalizing the original logo's colour scheme with the selected colours representing an aspect of the lung and respiratory system. As our mode of communication was via landline telephone, fax and telephone conferencing, decisions like these took much longer to conclude 20 years ago!

Initially meetings were attached to Asthma Conferences usually held in Auckland or Wellington, due to the population base in these cities. On one occasion we held our meeting at the conclusion of the South Island Asthma Educators study days. Within these meetings we incorporated a main speaker or presenter. E.g. once we had a presentation on 'power point presentation' in an attempt to demystify the complexity of this form of presentation!

On a very special occasion Irahapete Ramsden attended and reflected with us on why she had become involved with cultural safety and the Treaty of Waitangi as we know it within the health sector today. Her personal experiences of being a RN and as a Maori patient in hospital, overhearing staff and patients referring to her as 'the Maori person' while in a screened cubicle; all contributed towards better education for health providers in this arena.

I believe that an excellent decision was made when we became the respiratory group aligned with NZNO, as it gave us the opportunity to have a voice in nursing matters that was of concern to us as RNs. As a group aligned with NZNO we contributed to the discussion papers on the development of the PDRP programme as we know it today i.e. competent, proficient and expert levels of nursing practice with corresponding levels for Nurse Educator and Clinical Nurse Specialist. Another example where our influence was felt was with the advent of Pharmac and ensuring we contributed our voice with decisions around the streamlining of respiratory medications that we considered essential for patients wellbeing.

I am impressed with the work of the NZNO Respiratory Nurses Section and have noted in a newsletter discussion around a new inhaler medication and the role the Section played in influencing such matters. This is what the inaugural committee members of the Respiratory Nurses of NZ had hoped would eventually happen. It is also noted the cultural diversity of patients you are involved with in ensuring all targeted populations have access to optimal care under the guidelines of the respiratory nursing competencies.

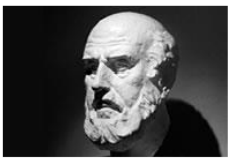
Congratulations on getting to 20 years and I wish you well into the future.

Short of Breath?

Asthma has been known for centuries, and some of our modern remedies have been used for surprisingly long times…

In Ancient China, Ma huang (Ephedra sinica) was used for bronchial complaints including asthma & similar products have been taken ever since – legally or not…

Dried herbs in Ancient Egypt: "Thou shalt fetch 7 stones and heat them by the fire, thou shalt take one thereof and place (a little) of these remedies on it and cover it with a new vessel whose bottom is perforated and place a stalk of a reed in this hole; thou shalt put thy mouth to this stalk, so that thou inhalest the smoke of it"



The Greeks - Homer talks about asthma in the Iliad and Hippocrates, Aretaeus of Cappadocia and Galen all describe it. Not so sure about their remedies though – owl's blood in wine, anyone?

Moses Maimonides was a physician who practiced medicine in the court of Sultan Saladin of Egypt and Syria. He recommended the dry atmosphere of Egypt, but also suggested avoidance of strong medication, plenty of sleep, fluids, moderation of sexual activity, and chicken soup.

No partying in Egypt then, and who knew Chicken soup was an ancient remedy???

1500's & 1600's

…. a disease of the bronchial pipes of the lungs
…. linked to organic dust
…. Can be brought on by exercise….

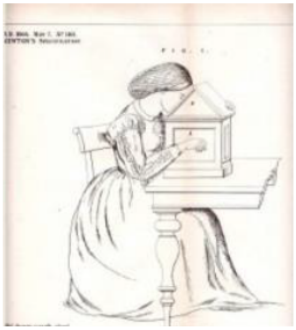
1700's

In 1778, Dr John Mudge modified a beer tankard and called it an "inhaler"

1800's

In the early 1800's smoking stramonium was introduced into Europe from India, leading to increased interest in inhalational treatments for asthma

DR NELSON'S INHALER
A ceramic, double-valved inhaler which was invented by Dr Nelson between 1861 and 1865 ……and still commonly used today!

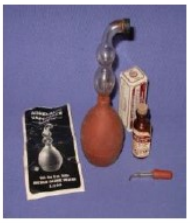


1864 – Alfred Newton's Dry Powder Inhaler

Physiological basis of asthma….. Stedman's Twentieth Century Practice, published in 1896 recommended removal of the offending allergens from the environment: "This may be the avoidance of certain foods, the avoidance of exposure to dust or pollen or flowers . . . or other specific irritants. It may be the correction of a gastric . . disorder . . . or it may be the removal of nasal polyps

And the 1900's ……

1905 – Anticholinergics delivered by smoking extracts of stramonium, atropine, belladonna, or thorn apple were sold as "asthma cigarettes"
…. Similar asthma powders were burned and the smoke inhaled…
…..Asthma cigarettes were still available until the 1980's…..



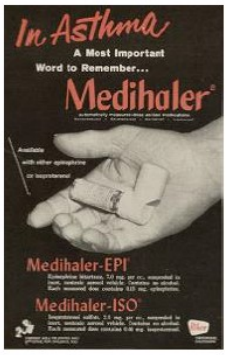
1910 – Adrenaline injections

1930's - solutions for inhalation developed

1914 – coffee… Yes!!

1940's – coffee's relations – theophylline & aminophylline

1949 – Cortisone … Corticosteroids… 1957 - Prednisone …



1957 –
Metered Dose Inhaler
adrenaline or isoprenaline

1960 –
beclomethasone inhaler

1960's –
β-2 Selectivity

1967 – Salbutamol inhaler

…and then we got…

Spinhalers  … Diskhalers  …. Rotahalers  … Aerolizers 

Nebulisers  … Spacers  … Turbuhalers  … Accuhalers  …

Handihalers  … Respimats  … Elliptas  and … Breezhalers  …

Containing … SABAs and SAMAs and LAMAs and LABAs, and ICS's and now LA ICS's …

not forgetting mast cell stabilisers, antileukotrienes, phosphodiesterase type-4 inhibitors …

and then there's allergy tests, desensitisation and hygiene theories, IgE antagonists and airway remodelling and calcium-sensing receptors and eosinophils and gene tests ….

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Respiratory Nursing at Christchurch Hospital – Then and Now

Robyn Baird, Adult Cystic Fibrosis Clinical Nurse Specialist, Canterbury DHB

In 1997, I moved from Australia back to New Zealand and was employed as a staff nurse on the respiratory ward at Christchurch Hospital. It doesn't seem that long ago – but on reflection a lot has changed for acute respiratory nursing in the (nearly) 20 years that have passed since then. The number of beds and configuration on the ward has stayed largely the same but the complexity of the inpatient group has certainly changed.

One of the most significant changes to respiratory nursing care at Christchurch Hospital started back in 2002. Discussions began between nursing and medical staff, the Intensive Care Unit (ICU) and management about providing ward based acute non-invasive ventilation (NIV) for Chronic Obstructive Pulmonary Disease patients in type 2 respiratory failure. A new Respiratory Clinical Nurse Specialist position was appointed to drive this nurse led project forward. Three years later in June 2005, the Christchurch Hospital ward based NIV service began admitting patients for acute bipap. Previously those requiring acute bipap were admitted to the ICU. This was a major shift for the respiratory nurses on the ward. As well as completing the NIV training package and attending a one- day workshop, all of the nurses (SN2 and above) were trained to take arterial blood gases; the key parameter to measure whether NIV is successfully reversing hypercapnia. These days if you ask any of the chronic respiratory patients admitted to the respiratory ward, they would tell you they'd rather have one of the nurses take a blood gas when needed than one of the medical staff! The NIV unit has been fantastically successful in reducing ICU admissions ($$) and in decreasing the risks to the patient associated with mechanical ventilation. In 2008 the acute NIV service won the "Excellence in Quality Improvement" award at the national Health Innovation Awards. After 11 years of operation, acute NIV has become business as usual for the respiratory nurses of ward 25.

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Another area of "core business" for acute respiratory nursing is chest drain insertion and management. In the 1990s chest drain insertions were a much more brutal (and sometimes very messy!) procedure. Wide bore tubes (up to 32Fr) were inserted by blunt dissection, rather than the small bore tubes (12-14Fr) inserted using plastic dilators that are the routine choice today. Many of us would remember medical staff getting the white gumboots on to avoid a shoe full of pleural fluid!

At Christchurch hospital, the instillation of intra-pleural medications such as talc, or alteplase became a nursing rather than a medical responsibility in 2010. This made sense given that nursing staff are the health professionals most familiar with the management and care of chest drains.

The development of a hospital-wide home intravenous (IV) service and the excellent nurse-led peripheral central catheter service at Christchurch Hospital has resulted in another change to the demographic of inpatients in respiratory care. Patients with bronchiectasis are able to receive the majority (if not all) of their routine IV antibiotic therapy at home, supported by the district nursing service and the home IV infusion centre. Previously these patients would have been admitted to the respiratory ward for two weeks of treatment. This has obviously been a fantastic initiative for patients who are always happier to be treated at home, and indeed are often able to continue with work and family commitments while receiving treatment.

One of the most recent changes has been the introduction this year of both electronic medication charting and E-observations. From July 2016, nurses will have i-pads to carry to the bed side to electronically sign off medication delivery. Electronic recording of patient observations will mean that clinical staff in any location throughout the hospital will be able to access real-time information about their patients. This use of technology in health care is ever increasing - as well as being competent in complex clinical skills related to respiratory nursing, technological literacy is now also a must.

What will the next 20 years bring? Well for me, retirement I hope! For respiratory nursing – to the galaxy and beyond!

Courtesy of ESA/Hubble

In my Humble Opinion, Nursing and Technology

John Hewitt, RN, IT Project clinical lead Canterbury DHB

“Why me?” I often ask myself. Well I am a nurse, I have over 20 years of experience, and I have worked through varied settings in a few different countries. I have been a manager, an educator and a specialist. But does any of this give me the experience to advise on the design and implementation of technology to be used by my peers in their everyday working days?

As a child from the 70s, I have grown up in a world in which computers have gone from being the size of a house to something that fits in your pocket. That thing that fits in your pocket today has more computing power than NASA had in the Apollo missions (Saran, 2015). The Apollo Guidance Computer used a real time operating system, which enabled astronauts to enter simple commands by typing in pairs of nouns and verbs, to control the spacecraft. It was more basic than the electronics in modern toasters that have computer controlled stop/start/defrost buttons (Saran, 2015). Computers in some form are now in every facet of our lives. Our Generation Z grows up having a Touch screen as a toy. These technologies now have a firm place in our lives and therefore our health.

Following technology trends everywhere, health technology has been mainly concentrated within private industry and research institutes. There is no doubt that this technology has improved the health of humanity. Smart drugs can now target specific cells, smart devices tell you when and how much of your medication you need. Genetic research may find cures for very debilitating diseases following on from the health technology that allowed Banting and Best (Simoni, Hill, & Vaughan, 2002) to find injectable insulin, Salk’s (Juskewitch, Tapia, & Winderbank, 2010) to culture the polio vaccine and Sheehan (Sheehan & Henery-Logan, 1959) to synthesise penicillin. But what does technology mean to the nurse in their everyday life?

In October 2015 at the Health Informatics New Zealand conference, Jonathan Coleman, the New Zealand (NZ) Minister of Health, announced the need for a single electronic health record for every NZ’er. The majority of our DHBs are paper based with documentation. Some of our General Practitioners (GPs) are computer-based and some have patient portals. Mr Coleman’s aspiration of using NZ’s unique identifier the National Health Index number as a base is in my opinion achievable. It makes sense that all of our health providers should label and identify their patient information in the same way. After all this information does not belong to the health provider, it belongs to the person whose health it describes. So the health record should be patient centric not provider centric. Twenty years ago when I started nursing, I worked on a Nightingale ward, we had a computer to manage the admission transfer and discharges system. The X-rays were films in large envelopes, the lab results were posted to the ward twice a day in an envelope and attached to the relevant patient notes.

The ward round was a conversation between doctors, nurses and the patient. It was recorded by the Junior Doctor r in completely paper-based system. The ward round would have been completely recognisable to Florence Nightingale. We did not have or use technology in a way that we look at today.

Despite 20 years of change, technology has not changed that much for the ward nurse in our everyday work— we still rely on the pen and paper. For the last year I have been leading a project that is bringing technology to the inpatient wards. Initially this is giving RNs a tablet on which they can enter and view vital signs and other patient assessments but the future is much bigger. I am representing the user in this process ensuring that the technology will benefit the clinician. This is a completely new environment for me, a role that is challenging and worthwhile. The change for the nursing workforce is huge and has knock on effects on every other clinical process. Many people believe that this is change for change sake, or technology for technologies sake but I don't. I believe that to survive into the third millennia nursing has to look into itself and refocus on that nursing core. The only way that we can free ourselves to do this is by the use of technology.

A critical part of our everyday work is using information. We are required to gain information through many sources and then flow this information on in every action that we take. This is the nursing process. Our work is not isolated, to maintain a continuity of care each action is built upon and intertwines with other work streams. Nursing bears a great burden of documenting the care process. Alongside this we are providing care whilst progressing towards goals. So information work is a considerable and essential part of nursing. (Documentation and the Nurse Care Planning Process, 2008).

Within my previous role as a Clinical Nurse Specialist the main problem on the wards was the growing burden of this documentation. The mantra of "if it's not charted then it is not done" echoing down from those above. My colleagues would forgo breaks and go home late from shift to get this work done. Despite their hatred of the forms and the box ticking exercises, they understand the importance of ensuring safe care. This importance is acknowledged by the other professions that we work with on a day to day basis, professions allied to nursing. However, this information is written in a disparate fashion and often duplicated. Hardey and colleagues (Hardey M, 2000), describe this information as "scraps". Often containing information that is not explicit in the patient record but instead in handovers, end of bed charts, risk forms. This documentation could be infinite so there has to be a better way.

Well there is a better way. Some of us use this better way in our everyday lives already. Platforms like Facebook can contain your Spotify, Instagram and Twitter accounts. All you have to do is put one thing in once for it to be in many places at the same time. This should be the vision for our documentation. Document once and it can be seen in multiple places. Medication lists will self-populate from pharmacy records. Intelligent algorithms will simplify the documentation of assessments and automatically create appropriate care plans.

Health literacy sites will provide information. There may even be small diagnosis booths in supermarkets that will be able to tell you whether to see your GP or not and when you get there your GP will already have all the information that they require to talk to you. This technology is either already here or just around the corner.

Obviously there are risks from technology. Technology can support our practice but it is not a panacea for all ills. Hellen Ansell and her colleagues highlight this concern with the simple use of electronic equipment when taking vital sign observations (Ansell, 2015). Reliance on the machine will often take the place of actual assessment, taking away or threatening critical thinking. The boundary between machines that supply clinical support to decision making should not become blurred with the actual critical process of decision making.

The data, information, knowledge, wisdom framework (Matney, Brewster, Sward, Cloyes, & Staggers, 2011) often described within nursing informatics is poorly understood and not taught to nursing. The machine gathers the data and presents it as information, the nurse then looks at this information, discusses it with the person puts it into perspective and adds critical thinking. This information then becomes knowledge. The application of this knowledge in the therapeutic perspective is wisdom. That is nursing practice. That is the art or essence of what we do. Technology should support us in what we do, not try to do what people think we do.

So in conclusion, the future is coming very quickly. The future has the ability to change our environments and allow us to give up the burden of information handling and streamline this process allowing us to concentrate on the moment of care. But we have to understand this as the people designing the algorithms are often not nurses and they do not understand what we do. The addition of wisdom and knowledge of our actual practice is essential in the next steps that NZ takes along the road to the Single Electronic health record. So when you hear of a new project near you get involved, feedback, and be critical. If the nursing voice is not part of the debate it will definitely not be heard.

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30 years of Sleep Medicine in NZ

By Sally Powell – Clinical Nurse Specialist –Sleep Health -CDHB

As I was reflecting on the best way to address this subject, I realized how far we have come. The enormity of the challenge to nail this succinctly is difficult. What I can say is that we have come a long way in our understanding of the what, why and how of sleep.

Thirty years ago, sleep medicine was an emerging field. Strong overseas influences were entering the New Zealand health system, albeit slowly. DHB's throughout NZ adopted services for sleep disorders in various ways. The practice of positive airway pressure therapy increased from the mid 1990's and now a variety of modes are used acutely and in the home setting to treat an array of sleep breathing disorders. The most common being obstructive sleep apnoea (OSA) and Continuous Positive Airway Pressure (CPAP) treatment. Further advances in technology have seen more neuromuscular conditions being treated with Bi-level PAP treatments, improving quality of life and life expectancy in many cases.

Traditionally, sleep services were run with a mix of physician and physiologist; however, with the advent of the nursing role this century, a greater interdisciplinary service has emerged. New initiatives, aimed at reducing equity challenges have allowed for advances of health service, with integration between specialist service and community providers in association with the growing burden of undiagnosed OSA. Several sleep services within NZ have designed programmes to improve access for service.

Philippa Gander (2010) and her team have provided pivotal research in understanding the impact and cost burden of sleep disorders and deprivation, enabling the funding, diagnosis and understanding to become established within the health system. They provide compelling arguments as to why conditions such as OSA are cheap to treat, with far reaching benefits to health and society as a whole.

In Canterbury, the integrated respiratory services have supported the role for community assessors to assess suspected OSA cases and with the support from the specialist service, have made an improved pathway from assessment to treatment, achieving the goals of sooner, more accessible care. There are 22 approved practices able to perform sleep assessments for OSA in Canterbury, with a similar scheme in partnership with the WCDHB and SCDHB. The interest from the community providers has benefited the local population, with the added benefit of an improved understanding of sleep health in the community.

From my own experience of working in the sleep field, I have transitioned from looking at sleep disorders, to working on sleep health. A change of focus that I could akin to the ambulance moving to the top of the hill, rather than waiting at the bottom. If we can improve the sleep health of our communities, we will go a long way in improving the overall health. A pivotal article for my own knowledge was from Lee et al (2004), who highlighted the need to understand sleep chronobiology – I would recommend this for building an understanding of the complexities of sleep.

The last 30 years have certainly taken us on a journey of understanding. We live in communities that operate 24 hours per day and shift work is a common factor for many. Understanding circadian rhythm and managing the need for good sleep health is a challenge that affects many. Our ageing population and burdening long-term health conditions will frequently demonstrate poor sleep health impacting on the overall health status. I would like to extend the challenge of considering the sleep health of the individuals you see on a daily basis. I wonder what improvements can be achieved.

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NZNO Respiratory Nurses Section Symposium, 15th April 2016

Esme Moloney, RN, Te Korowai Hauora o Hauraki Waikato, MHprac.

The NZNO Respiratory Nurses Section one day Symposium was held at the Hamilton Airport Hotel & Conference Centre on Friday 15th April 2016. Kirikiriroa, infamous for its fog, sure lived up to its name on this winter's morning! The conference was opened by a beautiful Mihi fronted by Hemi Curtis from Te Puna Oranga, Waikato District Health Board (WDHB).

Chronic and serious respiratory illnesses continue to make a substantial contribution to New Zealand's (NZ) health burden. Not surprisingly patients with respiratory complaints are frequently presenting to both primary and secondary services, accounting for 1 in 8 of all overnight hospitalisations in NZ. The 2016 symposium was testament to the NZNO Respiratory Nurses Section creative innovation and passion for promotion of respiratory nursing knowledge, research and care delivery. It provided nurses from a wide variety of clinical settings the opportunity to accelerate best practice knowledge for clinical management and interventions, highlighting the potential influence advancing nursing practice can have as catalysts for positive health gains.

Dr. Cat Chang MBChB FRACP, MD, Respiratory and Sleep Physician, WDHB, delivered an interactive community pharmacy update with exceptional clarity and ease of understanding. The multitude of new respiratory products were systematically compared and analysed for efficacy based on current available research.

Linley Edmeades NZRP, Dip. Pelvic Health Physio delivered a both informative and entertaining presentation on managing continence in respiratory conditions. Linley used role play to demonstrate the importance of asking questions in different ways and how observing behaviours can tell us a lot, even if a patient is reluctant or embarrassed to discuss their continence issues. She had the whole symposium on their feet actively participating in exercises demonstrating effective positions for voiding, good bowel and bladder habits and simple exercises to train the pelvic floor.

Dr. Jaideep Sood, Respiratory Physician, Waitemata DHB presented an interesting talk on travel advice for people with Chronic Obstructive Pulmonary Disease (COPD). He provided insight into a topic not often discussed, and it is always valuable to expand understanding on a broad range of topics.

Several short presentations were heard from nurses showcasing their outstanding initiatives in the community. This included Marg Matchett's (RGON PGDip, Practice Nurse, Pukekohe) presentation on a short term psychological support pilot for patients on a wellness program.

Gayle Williams' (Respiratory Nurse, Capital and Coast DHB) heart-warming presentation "Sing Your Lungs Out", demonstrated the importance of community involvement for enhancing quality of life. And Carol George (CNS Respiratory, Capital and Coast DHB) discussed targeting COPD patients at high risk of Bronchiectasis.

Other highlights included Sue Ward Respiratory CNS, Hawkes Bay DHB and Julie Shaw from Breathe Hawkes Bay presenting the Hawkes Bay DHB Respiratory Service redesign. The steering group identified contextual factors which resulted in longer and more frequent hospital admissions and addressed these by creating robust protocols and consistent systems for effective follow up. The improved service has had a significant impact on the burden of disease in the region. This has been measured through increases in access to service, decreased length of hospital stays, and dramatically increased referral to pulmonary rehabilitation; an intervention which has consistently been proven to improve outcomes in respiratory patients in the medical literature.

Afternoon breakout sessions included a spirometry workshop taken by Victoria Perry, Nurse Practitioner Respiratory, Mid-Central DHB and oxygen therapy for COPD, lead by Sharon Hancock Respiratory CNS, Mid-Central DHB. The day was concluded by Respiratory Nurse Practitioner Betty Poot (Hutt Valley DHB) in a presentation about the all-important topic of sexual wellbeing in COPD. Betty emphasized the importance of asking the question and talking about the topic to overcome fears and anxieties in an effort to allay preconceptions of being too old or sick to be intimate.

The NZNO Respiratory Nurses Section again demonstrates professional leadership, expertise and dedication to improving health outcomes through a thoroughly enjoyable symposium. A special thank you to all involved in organising the conference.

EVENTS FOR YOUR CALENDAR

Conferences/Seminars/Courses

National Asthma Council Australia

Provides a list of various respiratory focused conferences for health professionals.

For further information: www.nationalasthma.org.au

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

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 Asthma New Zealand

1 Day – 6 hours 'Neat' Asthma Course for Registered Nurses

September 21st

Spirometry Courses

Auckland District Health Board

Further information is available by contacting:

Ph: 09 630 9918 Extn. 26234

resplab@adhb.govt.nz

Bay of Plenty

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

Peer Group Meetings

Bay of Plenty

Asthma & Respiratory Management, BOP Inc.

REPS (Respiratory Educators Peer Support) 2016

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

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 2016

Role	Name	Email
Chairperson	Louise Weatherall	louise.weatherall@ccn.health.nz
Secretary	Chris Rothman	chris.rothman@wdhb.org.nz
Treasurer	Sharon Hancock	sharon.hancock@midcentraldhb.govt.nz
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