

The Role of the Nurse in Family Education for the Child with Asthma

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Family education and partnership are identified as essential components in nationally recognized guidelines for asthma management developed over the past decade. Although levels of responsibility for family education and partnership belong to every health care provider, often the nurse has responsibility within a practice for this essential asthma management component.

Asthma is a chronic condition requiring daily care to monitor symptoms, diligence to avoid trigger exposure, and consistent usage of appropriate medications. These skills are typically not fully achieved until the family is an active partner with the health care providers and is educated in asthma care. To use a practical analogy, the child and family are the “players”, the ones making the daily observations, decisions, and actions to manage asthma; the health care providers are the “coaches” providing education and building partnership to help the family “win” in managing their child’s asthma. Health care providers will build partnership by sharing power in decision-making with the family as they recognize and respect the family’s critical contribution to asthma management.

Often health care providers are frustrated with the families’ inconsistent use of daily-inhaled corticosteroids (ICS), the bedrock for asthma stability in a child with persistent asthma. Families report approximately 80% adherence with use of inhaled ICS, but when studied, actual ICS adherence dropped to 15-50%. Multiple factors contribute to difficulty with adherence. By nature, asthma symptoms are typically episodic. Yet families are asked to administer a daily, expensive medication (ICS) even on days when the child appears symptom-free. A cheaper medication (albuterol) offers quick, effective relief for symptoms not requiring the daily commitment to use. At other times, the family may be attempting to use the ICS regularly, but delivery techniques for inhaled products are difficult or confusing and the child is actually receiving little or no medication. Above all, the families’ health beliefs and characteristics have the greatest impact on health behaviors of the family. Time and skill are needed to provide the education and to build trust with families allowing honest disclosure with the nurse or health care providers about health beliefs and behaviors.

Key components for family partnership and education include:

- ❑ Include both the child and the family in simple, clear asthma education over time. Adjust teaching to incorporate the child’s growing developmental skills. Teach the families to then become the teachers for others responsibility for their child in various settings such as coaches, daycare workers, step-parents, camp counselors, etc. This process is continuous.
- ❑ Recognize early as well as late signs of asthma instability. Quick-relief medications should be started at the first signs of asthma symptoms (coughing, allergic flares, runny nose) and not waiting until the child is in clear distress.
- ❑ Demonstrate and review proper inhaled medication techniques at each office visit. Even good technique erodes over time and should be reviewed often. Poor technique often

causes the family to lose confidence in the effectiveness of the product or the medication plan.

- ❑ Implement specific trigger avoidance such as good hand washing to reduce viral illness, annual flu vaccine, smoking cessation, and allergy avoidance. Families often can identify their child's asthma triggers.
- ❑ Identify what works and does not work in terms of asthma management for their child and their situation. Connect asthma stability to medication use and trigger exposure.
- ❑ Provide a written asthma plan for home and school or day care. The booklet "What You and Your Family Can Do about Asthma" is available in both English and Spanish at www.ginasthma.com.
- ❑ Expect participation in sports and uninterrupted sleep when there is good asthma control. Families often control symptoms by keeping the child inactive and think a daily or nighttime cough is "normal" for the child with asthma. Provide school forms to allow albuterol use at school as needed and before sports participation or other physical activities.
- ❑ Stress the importance of regular office visits to monitor this chronic condition. Asthma, just like diabetes, should not be managed from an emergency department, but in partnership with a regular health provider.

Often nurses and health care providers desire additional expertise or recognition in providing asthma education. An Asthma Educator Certification Exam is now available through the National Asthma Educator Certification Board (NAECB). Successfully passing the exam earns the official designation AE-C (Asthma Educator-Certified). An AE-C is an expert counselor who advises individuals with asthma and their families regarding the management of their asthma to minimize its impact on quality of life. The exam has both pediatric and adult content and has a current pass rate of 75%. The exam costs \$275.00 and is computer administered at H & R Block Offices nationwide. Application and scheduling are available on online. Certification is renewed every five years. For additional information on the Asthma Educator Certification Exam visit the NAECB website at www.naecb.org. The Association of Asthma Educators offers review courses to prepare individuals for the exam as well as an annual education conference and quarterly newsletters to support and educate asthma educators. Information for the Association of Asthma Educators is available at www.asthmaeducators.org or 1-888-988-7447.

The University of Alabama at Birmingham Pediatric Pulmonary Center (PPC), funded by the Maternal Child Health Bureau, is an additional regional resource for practices that would like assistance in family education. The PPC is an interdisciplinary graduate level training program that provides care as well as continuing education in asthma management. For further information please contact Janet Johnston at jjohnston@peds.uab.edu.