The Changing Landscape for Rehabilitation Nursing: Transitions, Transformation, Future Visions
<table>
<thead>
<tr>
<th>1</th>
<th>Welcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Information</td>
</tr>
<tr>
<td>3</td>
<td>Dinner details</td>
</tr>
<tr>
<td>4</td>
<td>Program</td>
</tr>
<tr>
<td>7</td>
<td>Speakers</td>
</tr>
<tr>
<td>9</td>
<td>Abstracts</td>
</tr>
<tr>
<td>29</td>
<td>Sponsors</td>
</tr>
<tr>
<td>30</td>
<td>Award Presentations</td>
</tr>
<tr>
<td>31</td>
<td>Membership</td>
</tr>
</tbody>
</table>
Welcome

from the National President

Welcome to Adelaide for the 27th Australasian Rehabilitation Nurses’ Association (ARNA) National Conference, held in the National Wine Centre. We have an interesting and exciting program. Thanks to the high calibre of papers and presenters and the work of the conference and abstract committees. We are also privileged to have Professor Kathryn McPherson as our Keynote speaker.

This year the theme is topical and relevant to the changing nature of our health service structures and consequent expectations for rehabilitation nursing. It is hoped the conference theme THE CHANGING LANDSCAPE FOR REHABILITATION NURSING: “TRANSITIONS, TRANSFORMATION, FUTURE VISIONS”, and content will be of interest, challenge your thinking and provide inspiration.

Please make the most of opportunities to network, share knowledge and support with your fellow rehabilitation nurse colleagues. We welcome feedback and need this to continue providing high quality conference content and experiences, so please complete the evaluation online.

Happy conferencing,

Deidre Widdall
National President

Welcome

from the Conference Committee

The Conference Committee warmly welcomes you to Adelaide and looks forward to offering you the opportunity to network with peers and gain new knowledge in the rapidly growing speciality of Rehabilitation in Nursing. We wish to thank our 2017 Scientific Committee for their commitment and diligence in the selecting and supporting the abstracts presented. Most obviously we would like to thank the presenters for their willingness to share new research and practices in Rehabilitation. We trust you will enjoy all aspects of the National ARNA 2017 Conference in Adelaide and invite you to provide feedback by completing the Feedback form at the completion of the conference. This will ensure ARNA continues to grow and develop this great educational and networking opportunity in Rehabilitation Nursing.

CONFERENCE COMMITTEE
Terry Wells (Conference Convener)
Sandra Lever
Murray Fisher
Denys Spencer
Natalie Thackray
Justin Prendergast
With assistance from Lyn McBain

ABSTRACT COMMITTEE
Deidre Widdall (Committee Convener)
Murray Fisher
Erika Schlemmer
Brendan Bakes
Conference Aim

The Changing Landscape for Rehabilitation Nursing: Transitions, Transformation, Future Visions

The conference is a chance to enlighten and inform Rehabilitation Nurses of the opportunities for all professionals who come in contact with clients to engage in the Rehabilitation process. It is not just an end process but a comprehensive methodology for a holistic recovery plan depending on each individual’s requirements. Experiences, attitudes and guidance can be shared with colleagues so they can become aware of their position in the rehabilitation process which will improve the wellbeing of all; including the community. By participating we will continue to develop and advance the practice of Rehabilitation Nursing.

Venue Information

Registration

National Wine Centre
Thursday 12th October
8:00am – 5:00pm
Friday 13th October
8:00am – 5:00pm

Name Badges and Dinner tickets will be distributed upon registration. We ask that you wear your name badge at all times as it is your entry ticket to all sessions. Dinner tickets are conditional of prior booking and payment.

All enquiries can be attended to at the Registration Desk or a member of the conference committee identified by Pink Lanyards.

Wi-fi

Wi-fi is available at the Venue. Details can be found at the registration desk.

Car Parking

Parking is available after the first parking bay off Hackney Road and on Plane tree Drive in Botanic Park. Parking is Adelaide City Council Pay and Display metered parking with up to 4 or 8 hours.

Second Bay – Hackney Road, Botanic Park
Pay and Display
Maximum of 4 hours between 8am – 6pm,
Monday- Saturday
$2.20 per hour
Free after 6pm, all day Sunday and Public Holidays

Plane Tree Drive – Botanic Park
Pay and Display
Maximum of 4 hours between 8am – 6pm,
Monday- Saturday
$2.20 per hour
Free after 6pm, all day Sunday and Public Holidays

Multi story car parks are located Frome Road, Rundle Street and North Terrace followed by a 5 – 10 minute walk along Botanic Road to The National Wine Centre.
Conference Dinner
Hindmarsh Room at Crowne Plaza Adelaide

The dinner is on the Thursday night and is in the Hindmarsh room 3 & 4 at the Crowne Plaza Adelaide commencing at 7:00pm.

A perfect opportunity to network, to make some new friends, and enjoy contemporary South Australian cuisine with some of your fellow conference attendees. Seasonal dishes, created using the finest locally sourced ingredients, with a focus on fresh South Australian produce.

Complement your meal with a selection of renowned local wines and beers from the extensive beverage list.

Enjoy a fantastic evening in the Hindmarsh Room at the Crowne Plaza Adelaide.
# Conference Program

## PROGRAM DAY 1 • THURSDAY 12TH OCTOBER

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800 - 0830</td>
<td>Registration: Complimentary Tea and Coffee</td>
</tr>
<tr>
<td>0830 - 0845</td>
<td><strong>SESSION ONE</strong> Chairperson Terry Wells</td>
</tr>
<tr>
<td>0830 - 0845</td>
<td>Welcome to ARNA 27th National Conference Introduction - National President</td>
</tr>
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<td>0830 - 0845</td>
<td>Welcome to Country: Frank Wangutya Wanganeen</td>
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<tr>
<td>0845 - 0850</td>
<td>Introduction to Opening Address</td>
</tr>
<tr>
<td>0850 - 0910</td>
<td><strong>Opening Address:</strong> Ms Julie Brown</td>
</tr>
<tr>
<td>0850 - 0910</td>
<td>SA Senior Nursing and Midwifery Policy Advisor</td>
</tr>
<tr>
<td>0910 - 0915</td>
<td>Introduction Keynote Speaker</td>
</tr>
<tr>
<td>0915 - 1015</td>
<td><strong>Keynote Speaker:</strong> Kathryn McPherson Chief Executive of the Health</td>
</tr>
<tr>
<td>0915 - 1015</td>
<td>Research Council of New Zealand</td>
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<tr>
<td>0915 - 1015</td>
<td>The Changing Landscape for Rehabilitation Nursing</td>
</tr>
<tr>
<td>1015 - 1045</td>
<td>Morning Tea</td>
</tr>
<tr>
<td>1045 - 1045</td>
<td><strong>SESSION TWO</strong> Chairperson Deidre Widdall</td>
</tr>
<tr>
<td>1045 - 1050</td>
<td>Introductions Session 2 speakers</td>
</tr>
<tr>
<td>1050 - 1120</td>
<td>Duncan McKechnie, Murray Fisher, Julie Pryor, Tara Alexander</td>
</tr>
<tr>
<td>1050 - 1120</td>
<td>The changing face of rehabilitation in Australia: An exploration of the</td>
</tr>
<tr>
<td>1050 - 1120</td>
<td>change in patient dependency and complexity from 2007 to 2016</td>
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<tr>
<td>1120 - 1150</td>
<td>Alison New</td>
</tr>
<tr>
<td>1120 - 1150</td>
<td>Preparing for the future by thinking critically about rehabilitation</td>
</tr>
<tr>
<td>1120 - 1150</td>
<td>nursing practice</td>
</tr>
<tr>
<td>1150 - 1220</td>
<td>Nelson Logan</td>
</tr>
<tr>
<td>1150 - 1220</td>
<td>PAH BIRU - Transitioning and adapting to the digital age</td>
</tr>
<tr>
<td>1220 - 1305</td>
<td>Lunch</td>
</tr>
<tr>
<td>1305 - 1405</td>
<td><strong>ARNA Annual General Meeting</strong></td>
</tr>
<tr>
<td>1405 - 1410</td>
<td>Introducing ARNA 2017/2018 National Committee</td>
</tr>
<tr>
<td>1410 - 1415</td>
<td><strong>SESSION THREE</strong> Chairperson Sandra Lever</td>
</tr>
<tr>
<td>1410 - 1415</td>
<td>Introductions Session 3 speakers</td>
</tr>
<tr>
<td>1415 - 1445</td>
<td>Deidre Widdall, Ruth Finn, John Death, Alanna Barr</td>
</tr>
<tr>
<td>1415 - 1445</td>
<td>Implementing cognitive &amp; delirium care in the Top End</td>
</tr>
<tr>
<td>1445 - 1500</td>
<td>Kylie Wicks</td>
</tr>
<tr>
<td>1445 - 1500</td>
<td>Supporting tools for participants entering the NDIS</td>
</tr>
<tr>
<td>1500 - 1520</td>
<td>Afternoon Tea</td>
</tr>
</tbody>
</table>

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*Conference Program*
### PROGRAM DAY 1 • CONTINUED

<table>
<thead>
<tr>
<th>SESSION FOUR</th>
<th>CONCURRENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 4A (Hickinbotham Hall)</strong></td>
<td><strong>Session 4B (The Vines Room)</strong></td>
</tr>
<tr>
<td>Chairperson Natalie Thackray</td>
<td>Chairperson Brendan Bakes</td>
</tr>
<tr>
<td><strong>1525 - 1530</strong></td>
<td>Introductions Session 4A speakers</td>
</tr>
<tr>
<td><strong>1530 - 1545</strong></td>
<td>Melanie Wityk, Col Kilmier, Fan Loo</td>
</tr>
<tr>
<td>400 days and counting, our story on pressure injury prevention</td>
<td>Them and Us- How we are breaking down the barriers between the allied health staff and nurses</td>
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<tr>
<td><strong>1545 - 1600</strong></td>
<td>Marilou Dellow, Anija Mathew, Denys Spencer</td>
</tr>
<tr>
<td>Traffic light system is still the No.1 tool in falls prevention in 4A RDH</td>
<td>Rehabilitation clinical learning circlae</td>
</tr>
<tr>
<td><strong>1600 - 1615</strong></td>
<td>Jillian Sibly, Lee Byars, Sheelagh Donohoe, Simone Niejalke, Lisa Olafsen, Dee Wilson</td>
</tr>
<tr>
<td>Contemplating complexity: a preliminary exploration in the context of a community based specialist spinal cord injury service</td>
<td>Changing the way nurses think about clinical handover using the digital system</td>
</tr>
<tr>
<td><strong>1615 - 1630</strong></td>
<td>Coralie Graham</td>
</tr>
<tr>
<td>Perispinal Etanercept Treatment- A new paradigm for treatment for brain injury and stroke</td>
<td>Transitioning from nursing in rehabilitation to rehabilitation nursing in a rural setting</td>
</tr>
<tr>
<td><strong>1630</strong></td>
<td><strong>CLOSE DAY 1</strong></td>
</tr>
<tr>
<td><strong>1900 - late</strong></td>
<td>CONFERENCE DINNER</td>
</tr>
</tbody>
</table>
# PROGRAM DAY 2 • FRIDAY 13TH OCTOBER

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
</table>
| 0700 – 0800 | Breakfast Session ‘A conversation with Julie Pryor’  
Crowne Plaza Adelaide - Executive Board Room |
| 0800 – 0825 | Registration: Complimentary Tea and Coffee |
| 0825 – 0830 | Welcome: National President |
|        | **SESSION FIVE** Chairperson Terry Wells |
| 0830 - 0835 | Introductions Session 5 speakers |
| 0835 - 0905 | Invited Presentation: Julie Pryor, Sandra Lever  
Using program logic to understand rehabilitation service delivery |
| 0905 - 0935 | Deidre Widdall  
Transforming acute care culture: Introducing as standard care preventative / rehabilitative care principles |
| 0935 - 1005 | Duncan McKechnie, Murray Fisher, Julie Pryor, Melissa Bonser, Jhoven De Jesus  
Development of the Sydney falls risk screening tool: a two phase project |
| 1005 - 1035 | Morning Tea |
|        | **SESSION SIX** Chairperson Denys Spencer |
| 1035 - 1040 | Introductions Session 6 speakers |
| 1040 - 1110 | Kate O’Reilly, Kath Peters, Nathan Wilson, Cannas Kwok  
I AM WOMAN - Transition and Transformation following Traumatic Brain Injury |
| 1115 - 1145 | Valerie Pick, Alison New  
Roles and Goals: Planning for life after severe ABI |
| 1145 - 1215 | Murray Fisher, Julie Pryor  
Bowel care practices in Australian and New Zealand spinal injury units: a cross-sectional survey |
| 1215 - 1245 | Julie Pryor, Murray Fisher, Denise Haylen  
Problems accessing help with bowel care practices following spinal cord injury: a qualitative study |
| 1245 - 1330 | Lunch |
|        | **SESSION SEVEN** Panel Discussion ‘There are significant pressures on health service delivery globally, including rehabilitation services. Such pressures are shaping and transforming contemporary rehabilitation and rehabilitation nursing practice.**  
Moderator Murray Fisher |
| 1330 - 1335 | Introducing Panel Members |
| 1335 - 1500 | Panel Session: Kathryn McPherson, Sandra Lever, Kristen Hunter, Justin Prendergast, Jane Gray |
| 1500 - 1520 | Afternoon Tea |
| 1520 - 1540 | AWARDS PRESENTATIONS |
| 1540 - 1610 | Announcement of 28th National Conference 2018 and closing remarks |
Invited Speakers

Keynote Speaker - Professor Kathryn McPherson

Chief Executive, Health Research Council of New Zealand

Professor Kathryn McPherson became the Chief Executive at the HRC in 2015 (www.hrc.govt.nz) but for most of her professional life has been a nurse and rehabilitation researcher. Kath established a Centre for Person Centred Research at Auckland University of Technology which grew from just her in 2004 to a team of more than 20 academics and researchers many of whom remained part time in clinical work in 2014 when she took her new role. The centre continues to be considered a leading rehabilitation research hub in NZ with an international reputation.

Kath’s own research over 20 years since her PhD (yikes) focused on identifying new approaches to improving outcome and quality of healthcare for people with long term disabling health conditions. Kath is author or co-author of more than 180 peer-reviewed journal articles and holds a PhD from the University of Edinburgh.

Kath maintains an active involvement in research and publication although at a reduced level in view of her current appointment. She is now leading the HRC as it works to implement a new Health Research Strategy for New Zealand which aims to maintain the quality and excellence NZ is known for, and more strongly connect research to impact in health outcomes and policy.

Julie Brown

Julie Brown is the Senior Nursing and Midwifery Policy Advisor in the Office of the South Australian Chief Nurse and Midwifery Officer, SA Health. In this role Julie is responsible for leading state-wide projects and policy development, the provision of advice on national reform and policy and representing South Australia on matters related to nursing and midwifery practice in the national arena. Julie has completed a Master of Nursing (Leadership and Management) and currently leads the Professional Practice Innovation Team which has responsibility for the portfolio for nursing and midwifery practice. Julie brings over 35 years of experience in the profession to this role and some of her career achievements include:

- The implementation of the nursing and midwifery career structure in 2007 - 2008,
- The development and introduction of the SA Health Governance Framework for Advanced and Extended Scope of Practice Roles 2013, which incorporated a non-medical health prescribing pathway
- Leading the development of the Nursing and Midwifery Strategic Commitment 2016-2018
- Leading the development and implementation of the SA Health Caring with Kindness – Nursing and Midwifery Professional Practice Framework.

Sandra Lever

Sandra is a Life Member of ARNA and has previously served as the National President. Sandra is the Co-Chair of the NSW Agency for Clinical Innovation Rehabilitation Network and the Stroke Rehabilitation and Stroke Recovery working party. Sandra has been part of the team that has developed the new NSW Rehabilitation Model of Care. Sandra is a member of the Sydney Sexuality Group which has been awarded research grants to address sexuality and stroke. Sandra’s full-time position is as the Clinical Nurse Consultant in Rehabilitation at Ryde Hospital, NSW and she holds a Clinical Lecturer appointment at the University of Sydney.
Invited Speakers

Julie Pryor
Julie is a life member of ARNA, best known for her research and publications about rehabilitation and nursing. As a supervisor of research higher degree students, she mentors the next generation of rehabilitation nurse researchers. As the editor of JARNA, she encourages and supports nurses to record rehabilitation nursing’s body of knowledge. Her substantive position is Nursing Research & Development Leader at Royal Rehab in Sydney and she has an academic appointment with the University of Sydney.

Jane Gray
Jane Gray completed her bachelors of nursing in 1997 and since that time has worked in numerous rehabilitation settings and roles. Janes current role is a Nurse Unit Manager within the Northern Adelaide Rehabilitation Service based at Modbury Hospital which has recently expanded to include 52 inpatient beds, Rehabilitation In The Home and day rehabilitation services. Within this role Jane has supported the transition of inpatients and nursing staff from the Central Adelaide Local Health Network allowing patients to receive rehabilitation services within their own local area as well as developing an engaged, enthusiastic team committed to achieving high quality outcomes for patients.

Kristin Hunter
Kristin has worked in a variety of Rehabilitation roles over the past 21 years in clinical and management positions. Starting her nursing career at The Queen Elizabeth Hospital with an acute Orthopaedic surgical background she naturally transitioned into rehabilitation nursing to support patients in their recovery and return to function continuum. Her rehabilitation roles have been based at St Margaret’s Rehabilitation Hospital and since 2013 at Hampstead Rehabilitation Centre. Recent focus has been on operational leadership, rehab reform projects and assisting to develop Ambulatory models of care, advocating for rehabilitation nursing to be a key part in all initiatives. Spent four months in the Statewide Telerehabilitation Team as the Nursing Clinical Lead earlier this year, being involved in the new technologies, service delivery and systems that are going to be supporting clients in better access and intensity of Rehabilitation in their own homes. Exciting and innovative times ahead for rehabilitation and the part we all play to support our patients and service.

Justin Prendergast
Justin is the Nursing Director in Rehabilitation & Aged Care in the Southern Adelaide Local Health Network. Justin has lead work in rehabilitation nursing projects and practice development since 2004 – and more recently has been the SALHN lead for the Transforming Health Rehabilitation Model of Care initiative across the state. Justin is a long standing member of ARNA and holds a double masters degree in Nursing and Clinical Rehabilitation.
The Changing Landscape for Rehabilitation Nursing: Transitions, Transformation, Future Visions

Abstracts


Duncan McKechnie | RN, BN(Hons), DipPublicSafety, GradCertRehabNurse

Acting Clinical Nurse Consultant

Additional Authors:
Murray J Fisher RN, BHSc (Nursing), MHPEd, PhD
Julie Pryor RN, BA, GradCertRemoteHlthPrac, MN, PhD, FACN
Tara Alexander BA(Stat), MAppStat

Speaker Profile

Duncan has over 15 years experience in traumatic brain injury rehabilitation nursing. Duncan is currently the acting Clinical Nurse Consultant on the Brain Injury Unit, Royal Rehab. He is also a PhD candidate at the Sydney Nursing School, University of Sydney. Duncan’s current field of research involves developing a falls risk patient profile and screening tool for the brain injury rehabilitation population.

Background:

With the Australian population average age increasing, the number of comorbidities rehabilitation patients have may be on the rise. Consequently, the complexity of patients being admitted to rehabilitation may be increasing.

Aim:

To identify if there has been a change in the dependency and complexity of patients’ admitted to rehabilitation in Australia between 2007 and 2016.

Methods:

This study analyzed Functional Independence Measure (FIM) item scores to develop an understanding of change in patient dependency in Australian rehabilitation services over a ten year period. Comorbidity and inpatient complications data were used to examine for change in patient complexity. Differences in individual patient impairment groups were also explored. Ten years of aggregated de-identified inpatient data held in the Australasian Rehabilitation Outcomes Centre (AROC) Registry Database were accessed in April 2017.

Results:

Over the ten year study period there was no change in patient age and sex across the whole study sample; there was a decrease in rehabilitation length of stay. Whilst there was no change in admission total FIM score for the whole study sample, there was a decrease in admission total FIM for some impairment groups (such as, stroke, brain injury and spinal cord injury) indicating an increase in dependence. There was an increase in some comorbidities (cardiac disease, respiratory disease, diabetes and dementia) identified to have interrupted rehabilitation. There was, however, a reduction in some complications (urinary tract infection, pressure injury and wound infection); there was no change in the proportion of patient falls.

Discussion:

This study shows that over the last ten years there has been a change in patient characteristics admitted to rehabilitation. This reflects a change in the Australian population generally and increased demands for Australian healthcare.

Conclusion:

Patients admitted to rehabilitation are more dependent and complex than ten years ago, but not necessarily sicker.
PREPARING FOR THE FUTURE BY THINKING CRITICALLY ABOUT REHABILITATION NURSING PRACTICE

Alison New | Master of Clinical Rehabilitation; Masters of Health Science (Clinical Education)
Nurse Educator Brain Injury Rehabilitation Service (Qld)

Background:
Rehabilitation nurses operate in increasingly complex healthcare settings, and in this environment, high-level critical (or professional) thinking skills are required. (Bannigan & Moore, 2009) Clinical simulation that supports reflective practice and evidenced based practice can shape the way rehabilitation nurses think and practice.

Aim / Purpose:
To create a contextualized clinical simulation experience for rehabilitation nurses to teach and strengthen critical thinking skills and optimize patient safety outcomes, through integration of reflective practice and evidence based practice.

Methods / Activities:
Initially part of a Rehabilitation Graduate Nurse Programme, regular "professional thinking" sessions are attended by all rehabilitation nurses. Clinical scenarios are informed by participant suggestions, and current evidence identified and circulated to the group prior. Post session debriefings allow participants to share their professional experience and learning, review current evidence and critically reflect on possible implications for their future rehabilitation nursing practice.

Results / Findings:
Feedback has been overwhelmingly positive with participants citing improved confidence, and increased clinical knowledge, critical thinking skills and professional practice safety. Most importantly, participants also relate that professional thinking sessions help them deliver safer, individualized "rehabilitation" that helps make a difference "in people lives".

Discussion:
Guided simulation experiences in conjunction with "professional thinking" can teach and strengthen staff essential critical thinking skills by integrating reflective practice and evidence based practice skills. Bannigan & Moore's Model of Professional Thinking provides a contemporary practical framework to guide and strengthen rehabilitation nursing practice.

Conclusion:
It is not possible to separate out rehabilitation nurses professional thinking from the context of the individual health care settings in which they work. Therefore, it is essential to create opportunities to embed reflective practice and evidence-based practice skills that contribute to clinical reasoning, within our rehabilitation units. A "model of professional thinking" can support rehabilitation nurses to integrate these two skills into their professional thinking to inform and guide their clinical practice.

Notes:
PAH BIRU – TRANSITIONING AND ADAPTING TO THE DIGITAL AGE

Nelson Graeme Logan | Bachelor of Nursing

Acting Clinical Facilitator

Speaker Profile:

Nelson completed his Bachelor Degree in 2013 and started his career at TriCare Mount Gravatt. While working at TriCare, he worked as a Palliative Care Program Coordinator in a project team focused on improving palliation in aged care. Nelson started working at Queensland Health in the Brain Injury Rehabilitation Unit and is currently Acting as a Clinical Facilitator. Nelson is passionate about innovation and Rehabilitation Nursing.

Background:

The use of Information and communication technology is one of the key elements transforming healthcare (Duplaga, 2016). In November 2015, the Princess Alexandra Hospital (PAH) became Australia’s first large-scale digital hospital implementing both the integrated electronic Medical Record (IeMR) and Medication Anesthetics and Research support consecutively (eHealth Queensland, 2017).

Aim / Purpose:

IeMR and MARS deliver a wide range of benefits including increased patient safety, early detection and monitoring of possible adverse clinical events, healthcare quality, reductions in admissions and improved patient flow. Successful implementation of a large scale system requires careful coordination, planning and training. IeMR and MARS implementation could not occur without nurses’ participation and leadership (Duplaga, 2016).

Methods / Activities:

A training support team was formed including nursing staff from all wards. Instructor lead training taught system functionality in conjunction with online modules. “Super Users” and “Change Champions” were selected to receive extra training and to support other staff within their ward. Nurse educator and working groups were created to discuss system functionality, workflows and adherence to policies and procedures.

Results / Findings:

The IeMR and MARS releases had differing approaches with training methodologies. IeMR was the first release allowing for feedback, critical reflection and change approaching MARS.

Differing levels of resistance to change was observed over time. Intergenerational workforce challenges were encountered and responded to.

Discussion:

MARS included a longer lead time allowing for competency goals to be met. Training was formulated and contextualised to the learner to include local workflows, simulations and individualised training.

It was evident that there were generational factors at play during implementation, including some nurses who were confronted by the change.

Conclusion:

We continue to find challenges and embrace change within the system. It is important that health professionals realise e-health platforms are inevitable and rather than constrain us they can inform, support and advance our rehabilitation nursing practice into the future.

Notes:

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IMPLEMENTING COGNITIVE & DELIRIUM CARE IN THE TOP END

Deidre Widdall | RN, GradCertStomalTherapyNurs, MClinRehab
Cognitive Care Project Officer

Background:
The Top End Health Service (TEHS) Cognitive and Delirium Care in Hospital Project (CDCP) commenced implementation of an ‘Integrated Cognitive Care Pathway’, for in-patients 16 years and over with cognitive and delirium risks in November 2016.

Aim / Purpose:
The CDCP is an all-of-hospital approach aiming to improve safety and quality of care and develop needed culturally relevant protocols for a diverse and unique patient cohort.

Methods / Activities:
A mixed methods study design to evaluate implementation with staged timing across 3 hospital sites is being used. Preliminary evaluation and ‘proof of concept’ commenced at Royal Darwin Hospital (RDH) with roll-out to 2 regional sites in 2017. Project activities include development of cognition and delirium screening protocols to guide clinical practice, a new TEHS Cognition Screen and use of the Nu-DESC to screen for delirium, provision of information and education, establishing a cross-disciplinary Champion Network, collection of data of admitted patients with delirium risk criteria and evaluation of implementation performance. An innovative program for essential prevention care is integral to the project.

Results / Findings:
Analysis of the TEHS Cognition Screen confirms abnormal cognition screen results however, further evaluation is needed. Data from 932 admissions at RDH is being analysed, with collection underway at the other sites. Preliminary results show that 56% of the study population were Indigenous and the overall mean age 63 years, however there is a wide disparity in age patterns between the two groups.

71% of admissions studied were screened for delirium risk. Of those who had cognition screening (62%), an abnormal cognition screen was found in 25%. A positive Delirium Screen result was found in 1-2 patients per day.

Discussion:
This comprehensive multi-component project is part way through effecting a culture change in the acute hospital setting.

Conclusion:
Developing new knowledge to improve delivery of culturally relevant cognitive and delirium care is the ultimate outcome.

Speaker Profile:
Deidre has had a varied clinical background in the NT and SA mainly in rehabilitation and community nursing. With post graduate qualifications in stoma, wound, and continence and Masters by research in Clinical Rehabilitation. Deidre is currently working as the Project Officer for the Top End Health Service Cognitive and Delirium Care in Hospital Project.

Notes:

Additional Authors:
Ruth Finn RN
John Death FRACP
Alanna Barr BHSc Occupational Therapist
SUPPORTING TOOLS FOR PARTICIPANTS ENTERING THE NDIS

Kylie Wicks | MN(Res) BHlth DipAppSc(nursing)
General Manager - Clinical Services

Background:

The NDIS represents significant change to how people with disabilities can access supports and ongoing care. Many are unaware of the supports they currently receive through state funding that will now be provided under NDIS and many don’t know they have to request these supports.

Aim / Purpose:

The aim of this paper is to discuss the projects that led to tools developed to assist people with Spinal Cord Injury (SCI) to empower them to have detailed planning discussions to support their individual needs.

Methods / Activities:

Project 1 - a literature review and brainstorming of senior experienced clinicians to develop a preplanning tool that aided participants in NDIS planning discussions.

Project 2 - specifically on continence management with the aim of developing a fact sheet for participants when considering their continence needs for the development of an NDIS plan. It was divided into 3 phases.

Phase 1: ParaQuad NSW members (approximately 1500) were surveyed regarding their understanding of their neurogenic bladder and bowel continence needs and their readiness for the NDIS.

Phase 2: Review and analysis of existing literature and guidelines regarding neurogenic continence management.

Phase 3: Analyses and evaluation of data collected to develop a fact sheet to aid participants plan for their continence needs.

Results / Findings:

Project 1: The development of a preplanning tool.
Project 2: Data collection regarding participant understanding of continence complications and the subsequent development of continence fact sheet.

Discussion:

The disability sector is in a state of change with the introduction of the NDIS, resulting in people with disabilities purchasing their supports individually, replacing traditional block funding. This requires the participant to understand and consider their day-to-day needs when planning how to meet their individual goals.

Conclusion:

Acquired SCI has both a physiological and psychological impact resulting in the need for coordinated complex care to enhance quality of life due to significant impairment in various aspects of their life. These projects provide information to participants with SCI and those responsible for decision making in relation to care needs.

Speaker Profile:

Kylie Wicks is a Clinical Nurse Consultant in spinal cord injury and general continence and currently the Clinical Services General Manager for ParaQuad NSW BrightSky Australia. Kylie has a Master of Nursing Research; her area of interest is disability continence prescription. Winner of the 2013 NSW Disability industry Innovation Awards, Emerging Leader category, for development of 3 product selection tools to assist health professionals prescribe the most suitable continence products. Since that time Kylie has developed further product selection tools and provides a number of neurogenic continence assessments under a variety of funding packages.

Notes:
400 DAYS AND COUNTING, OUR STORY ON PRESSURE INJURY PREVENTION

Melanie Wityk | Registered Nurse
Nurse Unit Manager

Additional Authors:
Col Kilmier (Wound Clinical Nurse Consultant)
Fan Loo (Associate Nurse Unit Manager)

Speaker Profile:
Melanie is a Registered Nurse who commenced at Western Health in 2002 on the Ground floor Subacute ward (GFSA) at Williamstown Hospital. Melanie has been working in her current role as the Nurse Unit Manager since 2011. In 2015, she was awarded the recognition of WH Nurse of the year by her peers for her leadership, drive and passion in providing the person-centered care in line with Western Health’s clinical governance framework. Her strategic focus is minimizing harm from adverse outcomes of care in the older population. Her passion includes pressure injury prevention however her expertise encompasses all aspects of care of the rehabilitation patient.

Background:
Hospital acquired pressure injuries (HAPI’s) is one of the top five causes of harm to patients, and considered to be an adverse outcome of care provided (Robinson, 2005). HAPI’s can occur within 24 hours and most occur in patients aged 65 and over who have medical co-morbidities and risk factors such as: altered conscious state, immobility, impaired circulation, diabetes and malnutrition. HAPI’s are known to impact on patient’s quality of life, increase length of stay and result in systemic infection leading to amputation and even death.

Aim / Purpose:
GFSA identified a problem with the amount of HAPI’s developed on the ward; the aim of our project was to implement a pressure injury prevention strategy that incorporated all facets of the patient’s care including skin integrity, mobility, incontinence, nutrition and equipment.

Results / Findings:
Our project was rolled out in November of 2013, since the rollout we have had progressive improvement in the number of pressure injuries acquired on the ward.

<table>
<thead>
<tr>
<th>Period</th>
<th>Pressure Injuries</th>
</tr>
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<tbody>
<tr>
<td>July 2013 – June 2014</td>
<td>11</td>
</tr>
<tr>
<td>July 2014 - June 2015</td>
<td>6</td>
</tr>
<tr>
<td>July 2015 – June 2016</td>
<td>4</td>
</tr>
<tr>
<td>June 2016 – Present</td>
<td>0 Pressure Injuries (currently 422 pressure injury free)</td>
</tr>
</tbody>
</table>

Discussion:
The prevention of pressure injuries acquired whilst in care has had significant impact on the way staff care for rehabilitation patients. Staff have seen the achievements of this project and implemented similar methodology on reducing falls and other harm acquired whilst in care. Staff have taken ownership of the project and in doing so, have embedded the learnings and processes in the day to day management of the ward.

Conclusion:
Achieving and maintaining zero hospital acquired pressure injuries among highly vulnerable inpatients is possible, with a collaborative leadership style, a commitment to consistent care, staff enthusiasm and engagement, encouragement and flexibility in overcoming challenges as they arise, and adopting a multidisciplinary approach to providing evidenced based preventative care.

Notes:
The Changing Landscape for Rehabilitation Nursing: Transitions, Transformation, Future Visions

TRAFFIC LIGHT SYSTEM IS STILL THE NO.1 TOOL IN FALLS PREVENTION IN 4A RDH

Ma Lourdes Dellow | RN, Bsc Nursing, Grad Cert Clinical Rehab
Acting Clinical Nurse Consultant

Additional Authors:
Anija Mathew RN
Denys Spencer RN RPN B Nur Cert Geriatric N Cert Gov Grad Cert Rehab N Clinical Nurse Manager

Background:
Falls are one of the largest causes of harm in health care and are a national safety and quality priority. Falls are associated with increased health care use, including increased length of stay and higher rates of discharge from hospital into long term care facilities (Miake-Lye, Hempel, Ganz, Shekelle, 2013). In collaboration with 4A Rehabilitation Restorative and GEM (Geriatric Evaluation and Management) Ward’s multi-disciplinary team, the mobility chart using the traffic light system was identified as a strategy in falls prevention. It was first established in July 2010 for patients and staff’s safety and communication.

Aim / Purpose:
This presentation aims to improve patient care, facilitates better communication between health professionals. Moreover, this also aims to influence the use of mobility charts as future strategy in falls prevention.

Methods / Activities:
The presentation, through the use of qualitative and quantitative methods sought to gain insights on the number of falls in 4A as well as falls situation in the ward. Through literature reviews, canvassing of falls records, conducting surveys and interviews, it provided a clear picture of mobility chart’s effectiveness.

Results / Findings:
The use of mobility charts has improved the communication between patients, families and staff. It facilitated consistency of multidisciplinary team approach to patient care and decreases the number of falls for the past 3 years.

Discussion:
The creation of mobility chart in 4A Rehabilitation and GEM Ward of RDH engaged every in-patient to improve functional outcome as it communicates to staff and patients the limits of the patient’s mobility status using the visual communication.

Conclusion:
Mobility charts using the traffic light system are still the tool of choice in preventing falls and harm from falls in both patients and staff, supporting Standard 10 of Australian Commission on Safety and Quality in Health Care (ACSQHC). This tool could lead the way of ‘culture change’ in falls prevention across the Top End Health Service.

Speaker Profile:
Ma Lourdes also known as Marilou, has been a registered nurse for 20 years specializing in Rehabilitation Nursing for the last 6 years. She completed her Bachelor of Nursing in the Philippines and has nursed in Australia for the past 11 years, working in roles in Community and Acute Care Nursing in both Alice Springs and Darwin. She completed her Graduate Certificate in Clinical Rehabilitation in 2014 and is currently working in the Clinical Nurse Consultant role for the rehabilitation ward at the RDH. Her current passions are continence management, falls prevention and geriatric rehabilitation.

Notes:
CONTEMPLATING COMPLEXITY: A PRELIMINARY EXPLORATION IN THE CONTEXT OF A COMMUNITY BASED SPECIALIST SPINAL CORD INJURY SERVICE

Jillian Sibly | Registered Nurse B.N.
Clinical Practice Consultant

Background:

The South Australian Spinal Outreach Rehabilitation Team (SORT) provides interdisciplinary home and centre-based rehabilitation programs to support people with a new spinal cord injury (SCI) transition from the inpatient setting to the community. SORT clinicians talk of complex and non-complex client episodes within their service, irrespective of the client’s level and completeness of injury, and ascribe greater resources and risk of poorer outcomes to complex clients. Clinicians sought to qualify how these clients are complex, aside from the inherent complexities of SCI. Complexity is not easy to define and there is no widely accepted measurement tool. The literature acknowledges that complexity descriptions extend beyond medical co-morbidities to include health service utilization, socioeconomic, cultural, environmental and patient behavioural considerations.

Aim / Purpose:

SORT aimed to build a profile of complexity within the context of an interdisciplinary, community-based SCI service.

Methods / Activities:

Using a consensus approach, SORT clinicians were asked to identify which multidisciplinary client episodes from the previous seven months they considered complex. For the two-thirds of clients considered complex, clinicians were asked to indicate the factors they considered contributed to this complexity. Service use, demographic and outcome data was compared between clients considered complex and non-complex. The clinician perspective and the descriptive data were mapped against a complexity conceptual framework.

Results / Findings:

The data supported the clinicians’ initial perception that the most complex client episodes were not necessarily those with the highest level of SCI. Equal representation of paraplegia and tetraplegia was evident within the complex client episode. The majority of these clients presented with multi-faceted issues of a psycho-social nature and these dimensions of complexity were the greatest determinant of the amount of time, occasions of service and overall length of SORT episode.

Discussion:

SORT will build on and use their complexity profile to articulate their client group needs, inform service models of care and improve the management of these clients e.g.

• Earlier set up of psycho-social management on discharge from in-patient rehabilitation, allowing early linkages to complimentary community services.

• Adherence to goals which are manageable by SORT, exploring and tapping into other service pathways to support clients’ psychosocial needs.

Conclusion:

This preliminary exploration provides an initial framework for defining complexity in SORT. It has highlighted elements that warrant further exploration to improve the effectiveness of services to this client group.

Speaker Profile:

Registered Nurse for more than 40 years, working in spinal cord injuries rehabilitation for last 16 years at Hampstead Rehabilitation Centre, South Australia. Currently across inpatient rehabilitation and outreach spinal cord injuries, state wide services.

Additional Authors:

Lee Byars, B.App.Sc (OT),
Sheelagh Donohoe, DipPhysio,Grad.Dip.Health Science,
Simone Niejalke, B.Bus.,B.App.Sc(OT)(Hons),
Lisa Olafsen, B.A,B.Soc.Admin.,
Dee Wilson, B.App.Sc.(Physio)
PERISPINAL ETANERCEPT TREATMENT- A NEW PARADIGM FOR TREATMENT FOR BRAIN INJURY AND STROKE

Dr Coralie Graham | RN, BSc(Hons) Psych, PGTT, PhD

Senior Lecturer

Speaker Profile:

Coralie is dually registered as a Registered Nurse and Psychologist, having also completed a PhD and Post-Graduate Certificate in Tertiary Teaching and has worked in a number of roles in both professional capacities. She works as a Senior Lecturer in the School of Nursing & Midwifery at the University of Southern Queensland where she teaches courses related to rehabilitation and disability. Coralie is also the founder and Managing Director of the Australian Health Promotion Charity, Stroke Recovery Trail Fund which provides information and education about stroke and brain-injury and supports funding of clinical trials using Perispinal Etanercept.

Background:

Scientists looking at inflammatory processes within the brain following injury, identify that neuro-inflammation not only increases symptoms of brain tissue injury but is responsible for a whole range of symptoms, separate to the initial injury.

Aim / Purpose:

In additional to my professional roles as a Registered Nurse, Psychologist and Academic, I have been personally affected by brain injury when my son suffered a catastrophic brain injury at the age of 3 years. In 2014 after researching the scientific literature in the area of neuro-inflammation, I took my son to the USA to be treated with Perispinal Etanercept (PSE), 23 years after his initial injury. PSE which reduces neuro-inflammation has been shown to have unprecedented improvements in patients with brain injury and stroke, even many years after the initial injury.

Methods / Activities:

My son has made significant improvements in mobility, swallowing, memory, concentration, continence and speech and has reduced seizures, aggression, and upper respiratory infections.

In response to the dramatic improvements in his quality of life, the Stroke Recovery Trial Fund (SRTF) charity was set-up and has raised enough money to fund a world-first medical clinical trial at Griffith University's School of Medical Science which will commence in June 2017, with clinical trials for other populations planned.

Results / Findings:

The groundswell of international scientific literature in the area of neuro-inflammation and subsequent disability, and potential for regaining function is immense.

Discussion:

In addition to the reductions in neuropathic pain, and muscle spasticity and global clinically significant improvements in the functioning of those affected by brain injury, stroke as well as other conditions where neuro-inflammation has been identified, the improvements in the quality of life of those affected and their carers is enormous.

Conclusion:

PSE as a treatment for all conditions where neuro-inflammation is present should be viewed as a medical breakthrough and made a research priority for government funding.
Background:
In an effort to improve the relationship between the nursing and allied health team a number of initiatives have been put in place to remove the discourse which can be present.

The importance of a multi-disciplinary approach to run an effective team and that each discipline is aware of their role and how it fits into the team. (Waters & Luker 1996; Pryor 2007; Manser 2009; Epstein 2014) Recognition in and beyond the immediate condition of care depends greatly on the ability of clinical leaders to be coherent about the distinct nursing contribution within the multidisciplinary team and to promote their respective disciplinary contribution within the wider MDT.

Aim / Purpose:
To improve the relationship between the nurses and allied health which will then improve the outcomes of patients on the rehab ward.

Methods / Activities:
A weekly education series for all staff both nursing and allied health attend, the series commenced with each member of the team explaining their role.

We also have introduced an allied health component to the 2pm handover session to report any changes from their perspectives.

We have had a number of shared lunches and social events for all staff.

Results / Findings:
So far the results have been very good increasing face to face time between nursing and allied health staff Evaluation will be available in August 2017- In January 2017 teamwork between the allied health team and the nurses was rated at 5.3 out of 10 in a recent survey it is now 8 out of 10.

Discussion:
The education sessions have improved the knowledge and understanding of each person’s role and has developed better relationships between the team approach is acknowledged by McNamara (2011) who states recognition in and beyond the immediate context of care depends greatly on the ability of clinical leaders to articulate the distinct nursing contribution in multidisciplinary care setting and to promote their respective disciplinary contribution in wider MDT.

Conclusion:
Still early days in but communication has improved between the team members and more discussion about patients is occurring. All the staff when asked do feel that the ward has improved and the atmosphere is much better.

We have had some very positive comments from patients about how smoothly the ward is running and how happy everyone appears to be.

Looking for other people’s ideas on how they have tried to improve the communication between team.

Notes:
REHABILITATION CLINICAL LEARNING CIRCLE

Tracey Tattam | Registered Nurse

Acting Nurse Educator

Additional Authors:
Alison New: RN; (Master in Clinical Rehabilitation; Masters of Health Science Nursing (Clinical Education)
Jenny Kolhardt: RN; (Master in Clinical Rehabilitation)

Speaker Profile:
Tracey commenced as a RN in 1990 in Spinal Injuries Unit (SIU), Princess Alexandra Hospital (PAH) for 2 years. In 1992 she worked overseas as a carer for six months then travelled extensively for 18 months. Returning back to SIU, she also completed a Diploma in Tourism. She has worked as a claims assessor, Early Intervention Officer dealing with injury claims and for the MS Society, returning back to SIU in 2002. Tracey is currently completing a Graduate Certificate in Clinical Rehabilitation and Gerontology at the University of Wollongong.

Background:
The Rehabilitation Nurse Educator Group Queensland (RNEG) discusses current rehab nursing practice developments, and reviews and refines training programmes. Time to discuss new ideas, practice changes or research however was limited, so an alternative was sought. A Rehabilitation Clinical Learning Circle for sharing new information, and enabling reflective practice was proposed.

Aim / Purpose:
Our aim was to create an opportunity for rehabilitation nurses from across Qld to meet to explore the what, why, how and when of contemporary rehabilitation nursing practice, critically reflect on this and new best practice evidence and learning, and to explore possible impacts of all of this in an open and honest environment.

Methods / Activities:
- Discussed possibility of developing a Clinical Learning Circle at the RNEG meetings.
- Feedback sought re appropriate times for meetings, scope who would be interested.
- Survey monkey utilised for RNEG members to distribute survey to own staff to identify possible topics, suitable time frames, availability of equipment to link in etc, and to formalise all feedback.

Results / Findings:
Feedback indicated:
The Rehabilitation Clinical Learning Circle process was agreed, and communicated by RNEG members to colleagues in all rehabilitation units in Qld. Topics were varied, interesting and clinically relevant. It is well attended with participants reporting "great learning from colleagues" and better understanding of "what it means to be a rehab nurse".

Discussion:
Learning circles are widely used to teach and support open and collaborative discussion. Walker et al (2013) reported that Clinical Learning Circles should be safe environments where topics or ideas could be challenged and explored in a shared and cooperative manner. RNEG agreed this would be an excellent forum for discussion and information sharing.

Conclusion:
The Learning Circle is an open forum, attended by rehabilitation nurses across Qld. It continues to grow as an opportunity for rehabilitation nurses to meet and reflect upon and inform current and future practice.

Notes:
CHANGING THE WAY NURSES THINK ABOUT CLINICAL HANDOVER USING THE DIGITAL SYSTEM

Kirsty Gray | Bachelor of Nursing, final year Masters in Rehabilitation and Gerontology
Clinical Nurse Consultant

Background:
Clinical handover processes can reduce health professional communication errors and improve safety and care (NSQHS 2012). Standardisation of clinical handover continues an international priority to improve handover safety after being identified as a major preventable cause of patient harm, reduced wasted resources, prevent unnecessary delays in diagnosis, and medication errors (NSQHS 2010).

Aim / Purpose:
There were changes to clinical handover due to the changes following digital implementation. Our goal was to identify how nursing staff interpreted this change and adapted to the changing environment of a digital world.

Methods / Activities:
• Clinical Handover observation audits using standardized audit tool that included digital implementation.
• Staff surveyed to gauge current self-awareness of performance with and knowledge of clinical handover.

Results / Findings:
• Audits indicated inconsistent use of computers and patient summaries.
• Survey results noted inconsistent university education or ward based learning re clinical handover.

Discussion:
Although clinical handover is part of the National Safety Standards, there appears little research on staff education in readiness for this and patient involvement, in, the digital setting. Audits and education resources ensured staff were aware of the importance of transferring patient information correctly, engaging in clinical handover and reducing the risk of poor carryover with underutilization of the digital information and patient interaction.

Conclusion:
Staff must utilize patient summary screens and review medication digital information. Digital platforms allow access of comprehensive patient information from one screen, easy navigation and accurate clinical handover information.
TRANSITIONING FROM NURSING IN REHABILITATION TO REHABILITATION NURSING IN A RURAL SETTING

Maree Delaney | Registered Nurse
Nurse Unit Manager

Additional Authors:
Helen Harrington, Occupational Therapist, Northeast Health

Speaker Profile:
Maree Delaney, Nurse Unit Manager, Thomas Hogan Rehabilitation Centre manages an interdisciplinary team providing innovative rural inpatient rehabilitation. Maree draws upon her 30 years of dedicated nursing to develop a team based, rural rehabilitation centre of excellence.

Background:
Research identifies an important factor is the team based implementation of inpatient rehabilitation’s aim to reduce patients’ level of impairment. Together the team provides comprehensive rehabilitation enabling patients the opportunity to gain skills. However despite the recent development defining rehabilitation nurse role and providing 24 hours care, nursing staff role is often under developed in rural rehabilitation.

Aim / Purpose:
This paper outlines the developmental process implemented in a rural inpatient setting to assist staff gain skills provide team based rehabilitation nursing.

Methods / Activities:
A review was completed of the stroke rehabilitation at Northeast Health, Wangaratta. Patient outcomes, staff feedback and service standards were examined. The review highlighted the segmentation of the team approach impacting the service with some nursing staff feeling under skilled and undervalued. In response a service development plan was designed based upon action research principles for training programs and team based service development projects.

Results / Findings:
Significant changes were created over the 2 years including forming a designated stroke room, team based ward intervention, oral hygiene process, patient weekend activities and a responsive training plan. Nursing staff changed their segmented role to become an equal active team member with enhanced skills, confidence and increased role in team projects.

Discussion:
Significantly the project created a culture of development. Staff continues to implement team based service improvements including developing an incontinence assessment, enriched environment and new graduate training plan.

Conclusion:
Rehabilitation nurses form an integral thread within the rehabilitation inpatient team approach. This project offers insights how a rural setting has assisted nursing in rehabilitation transform to practice rehabilitation nursing.

Notes:
USING PROGRAM LOGIC TO UNDERSTAND REHABILITATION SERVICE DELIVERY

Sandra Lever | RN, BHM, MN (Rehabilitation), GradDipHlthSciences (Sexual Health), MACN
Clinical Nurse Consultant Rehabilitation

Speaker Profile:
Sandra is a Life Member of ARNA and has previously served as the National President. Sandra is the Co-Chair of the NSW Agency for Clinical Innovation Rehabilitation Network and the Stroke Rehabilitation and Stroke Recovery working party. Sandra has been part of the team that has developed the new NSW Rehabilitation Model of Care. Sandra is a member of the Sydney Sexuality Group which has been awarded research grants to address sexuality and stroke. Sandra’s full-time position is as the Clinical Nurse Consultant in Rehabilitation at Ryde Hospital, NSW and she holds a Clinical Lecturer appointment at the University of Sydney.

Julie Pryor | RN, BA, GradCertRemoteHlthPrac, MN, PhD, FACN
Nursing Research and Development Leader (Royal Rehab) and clinical Associate Professor (University of Sydney)

Speaker Profile:
Julie is a life member of ARNA, best known for her research and publications about rehabilitation and nursing. As a supervisor of research higher degree students, she mentors the next generation of rehabilitation nurse researchers. As the editor of JARNA, she encourages and supports nurses to record rehabilitation nursing’s body of knowledge. Her substantive position is Nursing Research & Development Leader at Royal Rehab in Sydney and she has an academic appointment with the University of Sydney.

Background:
The Agency for Clinical Innovation (ACI) Rehabilitation Network was established in 2012. The network provides a forum for clinicians, consumers and managers to develop initiatives including models of care for improving rehabilitation care in NSW. This paper will provide the background which lead to the development of the Rehabilitation Model of Care and how program logic was applied to understand rehabilitation service delivery. The presenters will introduce and provide an overview of the Program Logic Model of Rehabilitation.

Activities:
Following a Rehabilitation Network Research Workshop and a discussion on program theory and program logic, the ACI Rehabilitation Network Executive endorsed the formation of a multidisciplinary project team to apply Program Logic for understanding rehabilitation service delivery. From November 2014, the Project Team has used strategies learnt through Program Theory and Program Logic workshops including many consultations with clinicians, consumers and customers of rehabilitation services to achieve the current Program Logic Model of Rehabilitation.

Results:
The NSW Rehabilitation Model of Care outlines the values that underpin good rehabilitation as well as the essential inputs and activities that are required to support the delivery of good rehabilitation in NSW.
Essential to the delivery of this model in NSW are the elements of access and service availability, clinicians with specialist skills and a supportive infrastructure. In addition, there are complex interdependencies between the components of the Rehabilitation Model of Care which are both within and beyond the rehabilitation service.

Conclusion:
The NSW Rehabilitation Model of Care may be applicable to any rehabilitation setting in Australia. The overview within this paper may provide other rehabilitation services some insights into understanding and developing best practice rehabilitation service delivery.
TRANSFORMING ACUTE CARE CULTURE: INTRODUCING AS STANDARD CARE PREVENTATIVE / REHABILITATIVE CARE PRINCIPLES

Deidre Widdall | RN, GradCertStomalTherapyNurs, MClinRehab
Cognitive Care Project Officer

Speaker Profile:

Deidre has had a varied clinical background in the NT and SA mainly in rehabilitation and community nursing. With post graduate qualifications in stoma, wound, and continence and Masters by research in Clinical Rehabilitation. Deidre is currently working as the Project Officer for the Top End Health Service Cognitive and Delirium Care in Hospital Project.

Background:

Research, programs and developed guidelines verify consensus for a multi-component approach for delirium prevention. Delirium prevention and care are grounded in predominantly nursing care/actions, such as maintaining hydration/nutrition, early mobilisation, re-orientation, adequate sleep and involvement of family. In addition, there is a growing body of work on the missing fundamentals of nursing care generally, and Australian research reporting the effect upon adverse event rates for complex care patients, described as ‘a failure to maintain’ (Bail & Grealish, 2016). A key component of The Top End Health Service Cognitive and Delirium Care in Hospital Project has been the development and inclusion of essential prevention care.

Aim / Purpose:

To introduce a culture change in thinking and practice in the acute care setting by incorporating as standard care, essential prevention care strategies for reducing delirium and a range of preventable hospital complications.

Methods / Activities:

The project methods include three phases for development, implementation and evaluation of a multi-component ‘Integrated Cognitive Care Pathway’. In Phase Two: Evaluated Implementation, as well as data collection, qualitative work has enabled modification and innovation derived from experiences. An outcome has been CHAMEOS, an anacronym for prevention care that is good care for all patients, which prevents delirium and other adverse events such as falls, pressure injury, dehydration, malnutrition and functional decline.

C ommunication : H ydration : A ctivate
M obilise : E vacuate : O rientate : S leep

Results / Findings:

Results of the impact upon patient outcomes is pending as this evaluation occurs in Phase Three of the Project. This presentation describes and discusses ‘CHAMEOS’ and its relevance to rehabilitative nursing and acute care practice.

Discussion:

CHAMEOS is relevant for all patients, but particularly the more vulnerable with cognition and delirium risk. Rehabilitative nursing practice defines and incorporates preventative care as core universal rehabilitation nursing principles, and has advocated the benefit of application in all health care settings.

Conclusion:

This comprehensive multi-component project is tackling the challenge of reshaping and transforming acute care hospital culture. Central to this effort are preventative / rehabilitative principles of care being applied systematically from admission.

Notes:
DEVELOPMENT OF THE SYDNEY FALLS RISK SCREENING TOOL: A TWO PHASE PROJECT

Duncan McKechnie | RN, BN(Hons), DipPublicSafety, GradCertRehabNurse
Acting Clinical Nurse Consultant

Background:
The inpatient traumatic brain injury (TBI) rehabilitation population is one particular population that has been identified as at high risk of falls. However, no falls risk screening tool (FRST) has been developed for, or validated in, this patient population. This study, the last of four studies in a two phase project, aimed to develop a FRST for the TBI rehabilitation population.

Aim:
To develop a FRST sensitive to the TBI rehabilitation population.

Methods:
Multisite prospective cohort study that used univariate and multiple logistic regression modeling techniques (backward elimination, elastic net and hierarchical) to examine each variable’s association with patients who fell.

Results:
Of the 140 patients in the study, 41 (29%) fell. Twenty of the twenty-one independent variables studied were significantly associated with patients who fell. Through multiple logistic regression modeling, 11 variables were identified as statistically significant predictors for falls. Using hierarchical logistic regression, 5 of these were identified for inclusion in the resulting falls risk screening tool: prescribed mobility aid (such as, wheelchair or frame) (OR = 9.13; 95% CI, 2.05-40.66), a fall since admission to hospital (OR = 4.41; 95% CI, 0.96-20.21), impulsive behaviour (OR = 3.32; 95% CI, 1.20-9.21), impaired orientation (OR = 3.83; 95% CI, 0.89-16.52) and bladder and/or bowel incontinence (OR = 1.93; 95% CI, 0.48-7.83). The resulting FRST has good clinical validity (sensitivity = 0.9; specificity = 0.64; area under the curve = 0.87; Youden index = 0.54). The tool's clinical validity was significantly different (p = .037 on DeLong test) than the Ontario Modified STRATIFY FRST.

Discussion:
A FRST has been developed using a comprehensive statistical framework. This paper highlights that nurses should question the efficacy of their FRST.

Conclusion:
The developed tool, the Sydney Falls Risk Screening Tool (SFRST), should be considered for use in brain injury rehabilitation populations.
I AM WOMAN – TRANSITION AND TRANSFORMATION FOLLOWING TRAUMATIC BRAIN INJURY

Kate O'Reilly | BN, Grad Cert Comm Nurs; M ClinRehab (Research)

Associate Lecturer

Additional Authors:
Associate Professor Kath Peters, RN, BN(Hons), PhD
Dr Nathan Wilson, Dip Health Sc; Nursing; B.Soc.Sc; M.Sc; PhD
Dr Cannas Kwok, RN, BHS (Nursing), MPH, MEd, PhD

Speaker Profile:
Kate is an Associate Lecturer and PhD candidate with the School of Nursing and Midwifery at Western Sydney University. She has a special interest in people’s experiences following Traumatic Brain Injury and working with patients to achieve long term goals. Kate’s research interests include exploring suitable accommodation for young people following brain injury, how paid carers show compassion when working with young people with disorders of consciousness, and the gendered experience of women following traumatic brain injury.

Background:
There is a wide-ranging body of research about traumatic brain injury with the higher incidence of brain injury among males reflected in this body of work. As a result, the specific gendered issues facing women with traumatic brain injury is not as well understood.

Aim / Purpose:
This paper aims to draw attention to the current limitations within the literature related to women following traumatic brain injury in order to stimulate discussion and inform future directions for research.

Methods / Activities:
A search of electronic databases was conducted to complete a narrative review of the health activity and participation issues for women following traumatic brain injury.

Results / Findings:
The papers from the above search revealed the following five themes:
1) Relationships and life satisfaction;
2) Perception of self and body image;
3) Meaningful occupation;
4) Sexuality and sexual health; and
5) Physical function.

Discussion:
Exploring the gendered issues women may experience following traumatic brain injury will enhance clinicians understanding of the unique challenges they face. Such information has the potential to guide future directions for research, policy and practice. Screening women for hormonal imbalances such as hypopituitarism following traumatic brain injury is recommended as this may assist clinicians in addressing the far-reaching implications in regard to disability, quality of life and mood. The growing literature regarding the cumulative effect of repeat concussions following domestic violence and women’s increased risk of sport-related concussion may assist clinicians in advocating for appropriate rehabilitation and community support services

Conclusion:
Without research which focuses specifically on the experience of women and girls with traumatic brain injury there is a risk that clinical care, policy development and advocacy services will not effectively accommodate them.
ROLES AND GOALS: PLANNING FOR LIFE AFTER SEVERE ABI

Valerie Pick | Graduate Certificate in Health Service Management
Nurse Unit Manager Jasmine Unit Slow to Recover ABI Service

Background:
Slow to Recover (STR) ABI patients experience complex rehabilitation needs (Hawley & Newman, 2014). They also experience significant alterations to life roles and future life plans result from their injury. In light of this, a role-based goal planning approach was adopted as a core component of the specialist Jasmine Unit. STR-ABI rehabilitation model of care.

Aim / Purpose:
An innovative Model of Care to enable people with severe ABI to engage in meaningful life roles and successfully reintegrate to live in the community with appropriate support was needed. Role based goal planning (RBGP) which focuses on life roles important to the person and individualizes rehabilitation care and optimizes quality of life, was developed.

Methods / Activities:
Based on work by the Westmead ABI service, a working group designed the JU MoC and all staff undertook initial training in role based goal planning. In April 2015 the pilot MoC was implemented for two patients to inform refinement of the model and future direction.

Results / Findings:
Preliminary evaluation supports role based goal planning, with patients and families reporting high levels of satisfaction, and most patients returning to community. Evaluation involving patient satisfaction data, FIM change and GAS-lite have demonstrated functional improvement. Future research has been approved and will commence soon.

Discussion:
Although there is much research about functional goal planning after severe ABI, there is little related to role-based goal planning. Role based goal planning while taking a functional approach to therapy provision, emphasizes the resumption of and participation in meaningful life roles and community reintegration.

Conclusion:
Eighteen months post implementation of RBGP, some challenges continue. However, we believe that role based goal planning makes a valuable difference in people's lives after severe ABI. Further research is needed to ascertain whether evidence supports this view, and to inform ABI STR rehabilitation into the future.

Speaker Profile:
Val is the Nurse Unit Manager of Jasmine Unit, and has completed a Post graduate Certificate in Health Service Management. Ali is Nurse Educator for BIRS Qld, and holds qualifications in clinical rehabilitation and education.

Notes:
BOWEL CARE PRACTICES IN AUSTRALIAN AND NEW ZEALAND SPINAL INJURY UNITS: A CROSS-SECTIONAL SURVEY.

Murray Fisher | PhD
Associate Professor, Nursing Scholar in Residence (Royal Rehab)

Additional Authors:
Associate Professor Julie Pryor

Speaker Profile:
Associate Professor Fisher is a senior nurse academic at the University of Sydney and is a Resident Scholar at Royal Rehab. He is a member of the national committee of ARNA, a member of the conference committee and the abstract committee for the 2017 conference. Murray is also a member of the Nursing and Midwifery Council of NSW.

Background:
Bowel care practices vary between spinal units internationally and locally. While some guidelines exist in the USA and Canada, there are no such guidelines in Australia and each spinal unit seems to follow its own approach.

Aim / Purpose:
To map bowel care practices recommended for people with SCI by specialist inpatient spinal injury services.

Methods / Activities:
A cross-sectional survey of specialist inpatient spinal injury units (n=12) about typical bowel care practices for people with SCI was undertaken. Structured telephone interviews were undertaken with a senior nurse clinician from each inpatient unit. Each interview took approximately 1 hour to complete. The structured interview consisted of 5 sections, with a total 168 items, that comprehensively explored pharmacological and non-pharmacological neurogenic bowel interventions.

Results / Findings:
Preliminary results indicate that all SCI inpatient units have standardized bowel care practices for upper motor (UMN) and lower motor neuron (LMN) bowels, yet not all units have specific policies. In most units the determination of bowel care practices are jointly made by medical officers and registered nurses. The majority of units have target Bristol stool types for bowel management, the most frequent being 3-4 for UMN and 2-3 for LMN. There is variability in the use of the gastro-colic reflex, abdominal massage and the use of the valsalva maneuver. Most units have a minimum daily fluid intake of 2 litres. All units routinely use oral medications in their bowel management programs, however there is variability in the pharmacological agent used. The use of rectal medications is more varied and less frequent in the management of LMN bowels.

Conclusion:
All units have standardized bowel care practices, however there is variability in these practices across units.
PROBLEMS ACCESSING HELP WITH BOWEL CARE PRACTICES FOLLOWING SPINAL CORD INJURY: A QUALITATIVE STUDY

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Speaker Profile:
Julie is a life member of ARNA, best known for her research and publications about rehabilitation and nursing. As a supervisor of research higher degree students, she mentors the next generation of rehabilitation nurse researchers. As the editor of JARNA, she encourages and supports nurses to record rehabilitation nursing’s body of knowledge. Her substantive position is Nursing Research & Development Leader at Royal Rehab in Sydney and she has an academic appointment with the University of Sydney.

Background:
Bowel dysfunction is a particularly undesirable aspect of life with a spinal cord injury (SCI) and during rehabilitation the person with SCI is guided and supported to take charge of the management of their bowels.

Aim / Purpose:
What is the nature of problems experienced by people with SCI when accessing help to maintain recommended bowel care regimes outside specialist spinal injury services?

Methods / Activities:
A descriptive, mixed methods study comprising a survey and individual interviews was conducted in NSW. Clinicians working in specialist spinal injury services across NSW completed an online survey about issues that people with SCI had reported to them about accessing help to perform bowel care in hospitals, community care services and residential aged care services. People with SCI participated in digitally recorded interviews to tell of their experiences of problems accessing help with bowel care. The data comprised 24 stories from clinicians and interviews with 11 people with SCI. The data were analysed using thematic analysis.

Results / Findings:
People with SCI experience problems accessing help in community and aged care settings, but mostly when hospital inpatients where their needs do not fit with the pace and processes of the acute hospital environment. People with SCI experience significant repercussions as a result of these problems, including bowel accidents, incomplete bowel emptying or constipation and autonomic dysreflexia, as well as new injuries such as skin injuries and anal sphincter damage. In addition to embarrassment and stigma they suffer psychological effects such as uncertainty, fear, worry, distress, feeling unsafe, anger and feeling down.

Discussion:
This comprehensive multi-component project is part way through effecting a culture change in the acute hospital setting.

Conclusion:
There appears to be a widespread failure of the system to meet the bowel care needs of people with SCI. Rather than restoring their health, being admitted to hospital can represent a significant health risk for people with SCI.

Notes:
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