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JARNA
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From the Editor's Desk

Melissa Ceely
Editor-in-Chief - Journal of ARNA
From the Editor's Desk

Know of a member of staff that will benefit from the opportunities that come with being an ARNA member?

Let them know they are welcome to join and attend study days free of charge!

ARNA's Aims and Objectives:

- To promote Rehabilitation Nursing as a specialist field
- To serve as a forum for the exchange of ideas related to Rehabilitation Nursing
- To strive to update rehabilitation services in line with current advances in the field of rehabilitation
- To create opportunities to advance knowledge and skill in Rehabilitation Nursing through continuing education
- To develop the awareness of the role and functions of Rehabilitation Nurses within the multidisciplinary rehabilitation team

Nurses working in the rehabilitation field significantly influence the level of function and quality of life achieved by their clients, many with disabilities.

For more information on how to join
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Where has the year gone? I can not believe I am seeing another year draw to an end. And what a year is was! JARNA has continued strong through 2010 and ARNA too, with a very successful conference in Wollongong where we all returned to ARNA's roots. At this years conference we were privileged to meet four of the founding members of ARNA, Robyn Ashe, Carmel Kennedy, Annette Taylor and Lesley Brennan. Stories of what they have been up to since founding ARNA are within this edition.

This edition also sees two articles. The first is by Renee McMillan who explores the role of the Enrolled Nurse within the Rehabilitation setting. This is a thought-provoking article and one that affect us all. The second is a case study by Chen and Bradley looking into rehabilitation of the terminally ill. This article has great ideas of how to incorporate rehabilitation processes into the care of the dying.

Along with this edition are the abstracts of the papers presented at our Wollongong conference in October of this year. As you will see, there were many interesting papers, a lot of which we hope to see as full articles in JARNA for 2011.

Finally a word on the development of JARNA. Many of you will have heard me speak at the last two conferences on how we would like to see JARNA improve. Well this will be the final edition of JARNA in its current format. In 2011, JARNA will be professionally published by Cambridge Publishing. This is an Australian-owned company that specialises in publishing on behalf of organisations like ARNA. They currently publish the ACORN journal, Australian and New Zealand Continence Journal and Australian Journal of Cancer Nursing to name a few. If you would like more information about this company you can find this at www.cambridgemedia.com.au .

So what will this change mean for you? From next year JARNA will only publish 3 editions a year. This decision was made by the National Committee as a trial to see how this new arrangement will work both for the members and financially for ARNA. So you will receive a JARNA every 4 months instead of every 3 months. The journal will look more professional and hopefully the change will improve the readability of the publication. ARNA will still have full control over all content of the journal. Cambridge will only be providing editing, formatting, publishing and distribution of JARNA.

Lastly, I wish you all a very safe and fulfilling holiday period. Enjoy time with family and friends, and see you again in 2011.

Take Care
Melissa

If you would like to send feedback or comments on JARNA about any articles you have read or any suggestions please email them to editor@arna.com.au

President's Report

It is with great delight and honour that I continue to report to you as President of the Australasian Rehabilitation Nurses' Association. Following the Annual General Meeting in October in Wollongong I can confirm the leadership team of ARNA moving forward:

President: Anthony Black (Victoria)

Vice President: Melissa Ceely (QLD)
(also Editor in Chief – JARNA)

Secretary: Wendy Harper (QLD)

Treasurer: Suzie Hooper (Victoria)

Committee Members:

Kay Stevens (NT)

Carolyn Wilson (QLD)

Maria Draper (QLD)

Trish Spreadborough (QLD)

Melissa Ceely was appointed by the ARNA Committee to the position of Editor in Chief of JARNA. Congratulations to Melissa, who is leading tremendous reform of our Journal.

Chapter Presidents were elected through respective local/specialty AGMs prior to the ARNA Annual General Meeting and automatically become members of the ARNA Committee:

Illawarra: Tracey Weir

NSW / ACT : Gillian Garrett

QLD: Wendy Harper (also ARNA Treasurer)

SA/WA/NT: Terry Wells

VIC/TAS: Lisa Street

Spinal Chapter: Pam Heskath

On behalf of all ARNA Members I extend my congratulations and thanks to the Office Bearers. These leadership positions bring with them exciting opportunities for the individuals as well as great responsibility. They will require your support and commitment to achieve the objectives that they bring to office and to ensure the continuation of the vibrant and forward thinking nature of our Association. I would also like to extend my sincere thanks to Garry Fehring, Penny Kearney and Erika Schlemmer for their significant contributions to ARNA as leaders over long periods. We will miss them and their contributions at the ARNA Committee level.

The 20th ARNA Conference was an outstanding success. In all of my years of being part of the ARNA Committee I doubt that I have read such positive feedback from delegates. This is a real tribute to the wonderful organising committee and in particular the efforts of Gillian Garrett as Chair of this Committee and the tireless efforts of the Illawarra Chapter. Unfortunately due to personal circumstances I was unable to attend the Conference or AGM. I would like to personally thank and commend the work that happened to continue the leadership of both events by the members of the ARNA Committee and ably supported by Felicity Shiel-Jones. I am very grateful and this was a reflection of the great team-sense at the ARNA leadership level.

Since October the new Committee has met in Melbourne for a day of planning the term ahead. This was a particularly fruitful day from a number of perspectives. To provide solid leadership a team needs to know each other's strengths and abilities well and this session provided us with a chance to get to know each other (from different areas of this big country) better. We also reviewed the strategy in action plan that ARNA commenced two years ago and added additional aspects to it to drive our focus for the term ahead. In line with our Business and Quality Framework Senior Members of the Committee worked with Committee Members to scope the key priorities moving forward and teams have been established to drive these. An accountability framework has been designed so that reporting against strategies have a high level of focus at all ARNA Committee Meetings throughout the year. Preparatory work continues with these plans and the work required and to support this the ARNA Committee will again meet together face-to-face in Brisbane at the end of March. I will keep you informed of some of the very exciting work ahead in future editions of JARNA.

As the political worlds around us continue to change and in many instances remain unsteady, the times ahead for Health and Rehabilitation within Health must use its political platforms to drive an agenda of improvement for the health and well being of vulnerable people in our communities. ARNA remains committed to growing its political profile and in the year ahead will strengthen its involvement and leadership as a member of the newly established Australian Rehabilitation Alliance. At local levels ARNA relies on its membership to 'spread the word of good' with all that ARNA can do if the support of its membership is strong and vibrant and interested and committed. My challenge is to work with talented leaders to deliver the strategy and performance of ARNA. Your challenge is to drive the change at the clinical interface level, through calling upon the expertise available to you from ARNA and by encouraging strong interest in the mission and objectives of our Association to enhance Rehabilitation Nursing and Health Services broadly.

My best wishes to you and your families for health and happiness in 2011. I look forward to seeing many of you and I remain committed to the prosperity of our wonderful Association.

Anthony Black

President - ARNA

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ARTICLE

A critique of the roles of registered and enrolled nurses in designated rehabilitation services

Renee McMillan, RN, BNurse, GradCertClinRehab

ABSTRACT

The roles of registered nurses (RN's) and enrolled nurses (EN's) in designated rehabilitation settings are yet to be clearly defined. Recent literature including journal articles, the Australasian Rehabilitation Nursing Association (ARNA) competency standards for registered nurses and the Australian Nursing and Midwifery Council (ANMC) competency standards for RN's and EN's are used collectively to critique the roles of RN's and EN's in the rehabilitation setting.

INTRODUCTION

Rehabilitation is increasingly recognised as an integral component in managing the health and social care of people with chronic and disabling conditions (McPherson, 2006). The numbers of rehabilitation services in Australia have increased over the past decade due to several factors including early diagnosis and trauma management, innovation in acute care and advances in technology, the increasing ageing population and increased prevalence in chronic conditions (Pryor, 2008). Consequently, strategies that promote recovery, independence and restoration of function are increasingly important. However, as the ageing population increases, so too does the demand for nurses. The nursing shortage is both a national and global public health problem (Nathenson, Schafer, & Anderson, 2007). This increased demand for nurses, together with the ageing population, the ageing nursing population and decreased number of new nurses entering the workforce makes it important for rehabilitation facilities to define the roles of registered nurses (Nathenson et al, 2007). Rehabilitation nursing is a specialty area with a functional independence focus requiring a different skill mix than that of an acute care setting (Nathenson et al, 2007). The therapeutic relationship between nurses and patients is one where the nurse is the primary advocate and support to the patient and family and this is mainly because the rehabilitation nurse has a 24 hour presence, 7 days a week (McPherson, 2010). It is important to find ways to define the roles of registered and enrolled nurses in the rehabilitation setting in order to best utilise the limited resource that is RN's whilst preserving and improving quality patient care (Nathenson et al, 2007).

LITERATURE REVIEW

Rehabilitation nursing goals include the prevention of chronic, disabling or developmental disorders, the prevention of further disability or complications, the promotion of optimal levels of function and independence and the reinforcement of effective coping and adaptation (Hoeman, 2008). The role of the rehabilitation nurse also includes the provision of personal and procedural care in a manner which focuses on enabling patients to self-care (Pryor, 2007). This 'hands off' teaching approach adopted by rehabilitation nurses enables patients to reclaim self-care. This strategy is used alongside methods of assisting patients and families to cope and adjust to what has happened to them (Pryor, 2007). Further literature includes the description of nurses in rehabilitation settings as having a co-ordination role within the multidisciplinary team (Pryor, 2007). As the demand for rehabilitation increases, the role of the rehabilitation nurse, particularly the RN, grows immensely. This is because of the complexity of disabling conditions and the need to manage secondary health issues which affect many rehabilitation patients (McPherson, 2010). This growing responsibility demands advanced knowledge and skills and demonstrate how RN's can

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contribute to goal setting, collaboration and teamwork within rehabilitation. RN's add increasing value to the rehabilitation team by effectively communicating important patient information and sharing expert knowledge with the multi disciplinary team (MDT) (McPherson, 2010).

INTRODUCTION OF ARNA COMPETENCY STANDARDS FOR RN's

The Australasian Rehabilitation Nurses' Association (ARNA) has developed the first set of competency standards for registered nurses. These standards were implemented in 2003 and reflect the expertise and commitment of rehabilitation nurses. These competency standards are used in conjunction with the Australian Nursing Council Competency Standards for Registered Nurses and Midwives and can also be used for both professional and curriculum development (ARNA, 2003). The ARNA competencies were created though research of the role of the registered nurse in rehabilitation and developed a framework for the practice of rehabilitation nursing (ARNA, 2003). The competencies consist of 7 domains of rehabilitation nursing practice:

1. The rehabilitative approach
2. The teaching and coaching role
3. Observation, assessment and interpretation
4. Administering and monitoring therapeutic interventions
5. Managing rapidly changing situations
6. Management, advocacy and co-ordination role
7. Monitoring and ensuring the quality of health care practices (ARNA, 2003).

These 7 domains are described as encompassing the what and how of rehabilitation nursing practice (ARNA, 2003). The what refers to what nurses do in their everyday practice in rehabilitation and includes the two domains: Administering and monitoring therapeutic intervention and Management of rapidly changing situations. These domains relate to practices dealing directly with patient care and the technical features of nursing such as administration of medications, application of foot splints, etc. The how of rehabilitation nursing is described in the remaining 5 domains which are continuous and not sporadic like the activities associated with the what domains (ARNA, 2003). It is necessary to consider all domains weaving together as representing the specialty practice of rehabilitation nursing, much like the weaves in fabric (ARNA, 2003).

ROLE AMBIGUITY

It is interesting to note that ARNA has yet to develop a framework of competencies for Enrolled Nurses in the rehabilitation setting. The competencies outlined by ARNA for Registered Nurses were developed based on a need for a framework for rehabilitation nursing practice as a specialty. However, because rehabilitation nursing is a sub-acute field, many nurses working in rehabilitation settings are Enrolled Nurses and Assistants–in–Nursing (AIN's). It seems necessary that a set of competencies for Enrolled Nurses be developed by ARNA in order to create a sense of belonging and ownership of the rehabilitation nursing role and to create expectations of nursing care.

Rehabilitation nursing is sub-acute care; therefore distinguishing the roles of the Registered and Enrolled nurse should be clearly defined within the inherent nature of rehabilitation nursing. This uncertainty reflects role ambiguity and relates to the uncertainty surrounding the role of nursing in inpatient rehabilitation settings and influences how nurses contribute to patient care (Pryor, 2007). Many nurses working in rehabilitation units learn their skills on the job. These skills are either taught by colleagues or worked out for themselves (Pryor, 2007). This role ambiguity impedes the development of a professional role for both the RN and the EN. Role ambiguity impacts more upon RN's than EN's and the responsibility for the patients' rehabilitation and the management of the patients' secondary health concerns was carried more by RN's than EN's (Pryor, 2007).

The roles of RN's and EN's in rehabilitation settings is blurry and lacks clear definition. However, many nurses state that the RN has more responsibility for decision making and overall patient management (Pryor, 2007). This lack of definition between the roles of RN's and EN's can be related to several factors. Firstly, there is a larger proportion of EN's working in rehabilitation settings providing rehabilitative care similar to that of RN's. In addition, RN's are coaching patients to self care at the level of EN's or perhaps both are somewhere in between (Pryor, 2007). In addition, the role of the RN in the management of patients' secondary health concerns is becoming increasingly complex due to the earlier intervention of rehabilitation and shorter acute phase.

There are eight essential functions of RN's including assessments, care planning, IV therapy, patient education, documentation, reporting/communicating, staff education and supervision/delegation (Nathenson, 2007). However, in many rehabilitation settings, these activities are not limited to the RN but also overlap into the roles undertaken by EN's such as documentation and care planning which is also further complicated by the roles undertaken by EN with an Advanced Diploma. It is still important for EN's to be a part of these processes in order to maintain a sense of teamwork and skills.

There are four domains outlined in the ANMC competency standards for EN's and these are:

1. Professional and Ethical Practice
2. Critical Thinking and Analysis
3. Management of Care
4. Enabling

Enrolled nursing practice requires the EN to work directly under the supervision and direction of an RN. EN responsibilities include providing patient centred nursing care, identifying deviations from normal in assessments, intervention and evaluation of individual health and functional status (ANMC, 2007). The role of the EN also includes providing support and comfort (physical and emotional) and assisting with activities of daily living (ADL's) to achieve an optimal level of independence (ANMC, 2007). These responsibilities outlined by the ANMC encompass the role of all EN's in any nursing environment. They are not specific to rehabilitation nursing practice. However they can be implemented in the same way. An interpretation and expansion on the ANMC competencies for EN's by ARNA could be of benefit to EN's by helping to reinforce the field of rehabilitation nursing as a specialty.

In previous years, patients viewed the role of nurses in rehabilitation settings as deficient and were unable to recognise it as nursing (Pryor, 2005). Many patients have expectations when they are in hospital of having things done to and for them, particularly on the acute wards. Once transferred to a rehabilitation setting – a sub-acute setting – the nursing care changes to a more 'do it yourself' approach (Pryor, 2005). When this transition from acute care to the rehabilitation setting occurs, patients need to be informed of the changes in nursing styles. Evidence suggests that patients prefer to be guided through rehabilitation and not subjected to an imposing 'do it yourself' nursing policy (Pryor, 2005).

SUMMARY

ARNA developed competency standards for the registered nurse in 2003 to reflect the expertise and commitment of rehabilitation nursing. However, role ambiguity still exists within the rehabilitation setting between the RN and the EN. Until ARNA develops a set of competency standards for the enrolled nurse, this uncertainty will continue to cause concern for nurses working in the rehabilitation setting. Rehabilitation units are staffed predominantly by EN's and this trend will continue in the future due to the increasing need for rehabilitation units, the global shortage of nurses and the increasing ageing population. Developing competency standards for both RN's and EN's will create defined nursing roles and attract more nursing staff to the exciting specialty of rehabilitation nursing.

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CASE STUDY

Rehabilitation goal-setting for a terminally ill patient – a case study

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ABSTRACT

Research indicates that terminally ill patients can benefit from rehabilitative interventions. Assisting the terminally ill person to meet rehabilitation goals prior to end of life can improve the quality of the life that remains. To help set appropriate and realistic goals, an approach involving the multidisciplinary care team, patient and family around goal setting is necessary. Additionally, timely adjustment of rehabilitation goals tailored to the patient's medical, physical and psychosocial conditions will assist in advancing rehabilitation goals even when there are setbacks encountered as the disease progresses. This article describes a case study where the aim was to provide enough rehabilitation in an acute care setting to enable a terminally ill patient to die at home and the rehabilitative processes required for that transition.

Key words: Rehabilitation, Terminally ill patient, Goal setting, Quality of life

INTRODUCTION

Research has shown that rehabilitation interventions can improve quality of life for terminally ill patients (Michael, 2001; Nusbaum, 2004; Ruff, Ruff and Wang 2007; Pace Parisi, and Lelio 2007; McCluskey, 2007). However, for interventions to be successful, it is vital to set appropriate goals that are based on the patient's psychosocial situation and are tailored to the patient's medical condition throughout the whole rehabilitation process. Siegert (2010) describes how goal-setting seems to be a fundamental core of rehabilitation yet little is known about how these goals actually impact on the person involved in the rehabilitation. Understanding and involving patient and carers in the decision making process through a multidisciplinary approach when setting goals can facilitate achievement of quality of life objectives and a smooth discharge for terminally ill patients who seek to die at home (McClain, 2005; Black, Brock, Kennedy and Mackenzie, 2010; Duff, Evans and Kennedy, 2004).

This case study describes the goal setting and discharge planning of a terminally ill patient requesting rehabilitation. The aim of the study is to share the experience of providing rehabilitative interventions for this patient based on defined goals and the factors that influenced the ability of the patient to achieve those goals.

CASE BACKGROUND

Jane (a pseudonym) was a 60+ year old woman who normally resided at home with her sister. She had progressive multifocal leukoencephalopathy (PML) with a background of Non-Hodgkin's Lymphoma (NHL) involving most of the right side of her brain and some of the left side. From the perspective of treating the NHL, she was responding well to chemotherapy but there was a noticeable deterioration in gait with left-sided weakness. Jane was admitted to the rehabilitation ward with the following presentations:

- Flaccid left upper and lower limbs
- Left side neglect and inattention
- Left homonymous hemianopia
- Cognitive changes manifested by distractibility, reduced verbal fluency and emotional lability.

The goal for rehabilitation was to improve Jane's transfer ability between bed and chair so she could return home with her sister who would act as Jane's full time carer.

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Sandra L Bradley

REHABILITATION GOALS

Setting individualised rehabilitation goals is considered an integral, essential and effective element of the rehabilitation process (Black et al 2010). Individual care plans provide a guideline for health care professionals and patients on how to evaluate the effectiveness of interventions and measure patient progress towards established goals during the rehabilitation process (Wade 2009).

However, establishing specific and achievable goals for terminally ill patients can be very challenging. The rehabilitation goals need to be carefully weighed and time-adjusted to the patient's changing medical and physical conditions (Cheville, 2000; Santiago-Palma and Payne, 2001; Schleinich, Warren, Nekolaichuk, Kaasa and Watanabe, 2008). Short-term goals are more appropriate in this patient group given the uncertainty of the progress of the disease and the importance to balance optimal function with patient comfort (Nusbaum, 2004). Before admission, Jane was assessed by the Rehabilitation Triage Consultant for her suitability for rehabilitation. Based on the initial assessment, a family meeting was held to discuss Jane's rehabilitation goals and what would be required of her family. It was explained to Jane and her family that:

- A three week in-patient rehabilitation program would be offered
- The aim would be to improve transfer from bed to chair so the current designation of two to three person-assist could be reduced to one-person assist (with slide board considered) to meet mobility objectives for home care.
- Wheelchair mobility would be aimed for
- Improved scanning techniques would be practiced to increase cognitive and mobility functions
- Strengthening of upper limb function would be concentrated upon to improve manoeuvrability; and finally
- Should returning home become impossible, options of placement would need to be considered.

A palliative care specialist was also involved in the the discussion for assistance when appropriate to increase support at home for as long as possible.

During the early stages of admission to the rehabilitation unit, Jane was able to transfer with a slide board and two-person assistance which increased Jane's motivation and participation in the physiotherapy program designed for her. She became brighter and slept better at night. Unfortunately, her condition then deteriorated quite rapidly. Her transfer ability declined from two-person assistance to three-person assistance with slide board and sling lifter. Discussion with the oncologist revealed that Jane's prognosis suggested survival of only weeks. In view of Jane's and her family's determination for her return to home, a family meeting was held to explore additional options in supporting this goal.

PLANNING FOR RETURN HOME

Though individualised rehabilitation goals can provide a clear direction of interventions for the patient, family and the multidisciplinary team, the goals for terminally ill patients must be realistic. To achieve this, the patient and family must be involved in the goal setting process with clear communication of what can be accomplished and clarification of any unrealistic expectations which could be interpreted as a means of returning to a previous health status (Michael, 2001; Santiago-Palma and Payne, 2001). In accounting for the terminally ill patient's medical, physical and mental status, the rehabilitation goals should be reviewed and adjusted regularly. In this way, the patient's and family's concerns can be identified promptly and the multidisciplinary team can address issues arising to the satisfaction of all involved.

Jane and her sister participated in all discussions throughout the rehabilitation process and were well informed of any progress, prognosis and options for discharge. Before admission, the length of stay, achievable goals and the worst-case scenario of possible placement were communicated thoroughly to Jane and her sister and these were reviewed when Jane's health declined. During this time of decline, family meetings involving palliative care professionals and community nursing service providers were held to envisage the practicalities required to make Jane's return home a possibility.

In this final stage of planning for discharge home, a thorough assessment of Jane's equipment needs was conducted.

This home visit was necessary not only to determine what equipment was already available or needed but also to determine how Jane's sister would manage the mobility and personal care activities. During the visit, education was also provided to the sister not only on how to use the equipment, but also strategies for getting Jane into and out of the bed for activities of daily living (ADLs). Once this visit concluded, urgent referrals were made to different service providers to facilitate the discharge requirements.

During this time, additional discussions were held about provision of a sling lifter and the waiting period required before the equipment could be delivered. Over the course of these discussions, Jane's condition deteriorated further and she became emotionally labile. It was then decided that she would be nursed in bed when discharged home. Education was then tailored to provide Jane's sister instruction on pressure ulcer prevention.

As was her wish, Jane was discharged home to her sister's care with additional support from the community nursing and palliative care services. During this time, the focus of care shifted from rehabilitation to palliation and comfort care became the core of Jane's home care. One month later Jane died in the company of her family and the family expressed their gratitude to the rehabilitation team on enabling Jane's request to die at home with the dignity and comfort she valued so highly.

IMPLICATIONS FOR PRACTICE

This case study provides detailed information of how rehabilitation programs in acute care settings can create a positive impact on the quality of life for the terminally ill person. Tailoring rehabilitation goals to the stage of disease, prognosis and personal definition of quality of life allows for establishment of realistic and attainable goals during the terminal phase of illness through the utilisation of a multi-disciplinary, patient and family-centred approach to provision of rehabilitation care. This care encompasses open communication with the patient and family and continual review and adjustment of realistically attainable goals. When conducted in this manner, rehabilitation goals of the terminally ill can be achieved even when the goal is simply to return home to die.

Acknowledgements

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...in the beginning!

Attending this conference was four of ARNA's original founding members, and we celebrated this achievement with them over a birthday cake and lunch.

From left to right – Robyn Ashe, Carmel Kennedy, Annette Taylor and Lesley Brennan.

Robyn Ashe commenced her professional affiliation with rehab nursing and ARNA more than 20 years ago, starting as a NUM at Lawrence Hargrave Private Hospital (LHPH). After wearing many hats and job titles she was appointed CEO/DON 13 years ago and continues to work in that role. LHPH is a private 54 bed rehabilitation hospital located in Thirroul, north of Wollongong. Robyn has been a continual member of ARNA since the beginning, and actively involved in the local chapter. Family and grandchildren keep her busy outside work.

Carmel Kennedy continued in a rehabilitation role, firstly as Nurse Unit Manager then Deputy Director of Nursing of the South Highlands Private Hospital. She then continued her career in nursing management, firstly as Director of Clinical Services at Westmead Private Hospital for 7 years and for the last two years she has held the position of CEO and Director of Nursing at Mt Wilga Private Hospital. Mt Wilga is located in Sydney's upper north shore, and is an 80 bed specialist rehabilitation facility. Carmel balances her career with a husband and two young children aged 4 and 8. She has also taken up golf, about which she states "I am extremely bad at it, but loving it".

Since retiring from ARNA, Annette Taylor has been "people sitting" for a small local organisation that has now closed down due to lack of funds. "It was great", she informed me. "It gave their carers a nice little break. One lady I had was 96 when I started reading to her and she was 102 when she passed away." Annette has also started painting, she said "I did a few art classes and found I had a little gift that I didn't know I had, I painted from dawn to dark, and ended up at an exhibition in Wollongong. I sold two paintings and that was a huge boost to my ego already huge at the time!" It seems retirement has not slowed Annette at all, with helping out the Salvation Army Shell Harbour Corps with street ministry along side her husband Jock and granddaughter Maddison, swimming and walking three times a week, and gardening. Although there had been a couple health concerns recently, Annette and Jock look forward to celebrating their 45th Wedding anniversary in 2011.

One of the faces of ARNA is Lesley Brennan. Lesley has been Chapter President of the Illawarra Chapter and then was the driving force behind the development of the Spinal Chapter and became their Chapter President. She has been an active member at both a chapter and national level since the very beginning. Lesley was the Manager of the Foothills Day Centre, a part of The Disability Trust in Wollongong and has recently gone part time doing education and assessments for spinal clients. This service provides activities, support and development training to people with high support needs. She is enjoying the extra free time with family and grandchildren.

JARNA 2010: 13 (4), PP 11-12

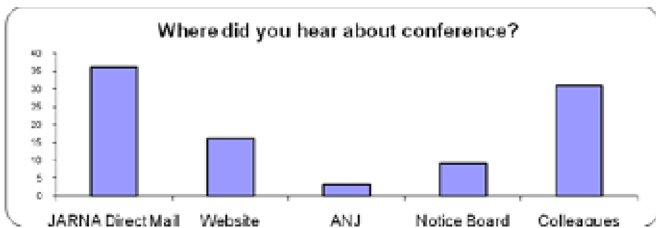
20th Annual Conference – What you said! The feedback from your evaluation forms.

The ARNA 20th Annual Conference was held at The Novotel, Wollongong, New South Wales on the 14th and 15th of October 2010. The conference organising committee ask for feedback every year to ensure that we take your views into consideration when we are making our decisions in the planning of the subsequent year's conference. Thank you to everyone who took the time to fill out the evaluation form.

There were 102 evaluation forms filled out and returned. There were 216 delegates registered for the conference.

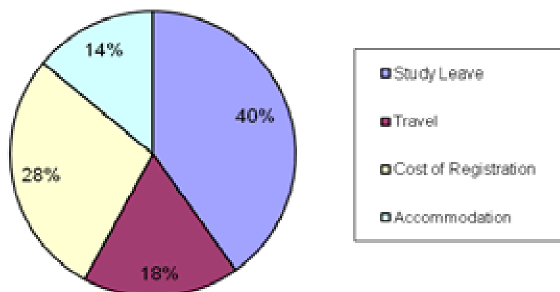
Delegates heard about the conference from various sources. Direct mail JARNA was the most common tool to notify delegates. (Figure 1)

Figure 1



Delegates represented a variety of organisations: Public 63% (n=101), Private 34% and Stand alone facility (2%). This represents an increase in the public representation at this conference compared with last year.

Financial assistance to attend the conference was received by 75% (n=102) of delegates. Assistance included various combinations of study leave, travel, registration or accommodation costs.



Delegates rated the following items as excellent or good (n=101):

91 %	Assistance from organisers	91%	Value for money
97%	Audio-visuals	84%	Pre-conference information
99%	Venue	96%	Catering
91%	Program format	55%	Duration of Conference just right

Delegates comments

The following are a summary of all the comments received by the delegates.

Major strengths of the conference (n=92)

- Speakers (31)
- Presentation Topics (28)
- Dr Caroline Ellis-Hill (25)
- Venue (16)
- Food (16)
- Atmosphere (14)
- Networking (14)
- Well organised (13)
- Tania and Warren Hayes (10)
- Panel Discussion (9)

Major Limitations (n=59)

- No limitations fabulous venue and great speakers (13)
- Connecting transport to travel to venue (10)
- Panel discussion could have been more interactive/ relevant (8)
- Cold room, poor lighting (4)
- Some topics too specific and lost relevance for the majority of delegates (3)
- A lot of subject matter to cover over a short period of time (2)

What topics would you like to hear about next year (n=64)

- Another forum/panel discussion (6)
- Research being done in Australia / New Zealand (5)
- Goal Setting (4)
- Management/leadership (4)
- Spinal Nursing (3)
- How the ageing population will change nursing practices (3)
- Continence (3)
- Strategies for nurse-led change (3)

General Common Comments were summarised as below (n=78)

Common Comment
Excellent topics overall very inspiring (21)
Congratulations to the organising committee (14)
Seating with an aisle down the middle (10)
This was my first ARNA conference and I now hope to attend many more (10)
Thank you and see you next year (9)
The dinner food, staff and acoustics were terrible (7)
Excellent venue (6)
Food was excellent (4)
Please have Dr Ellis-Hill back (2)
Include references in the Book of Abstracts (2)
Thank you for the opportunity to attend 20th Conferece. It has been a great experience. Great for gaining knowledge & networking. Great to get away from busy rehab ward (at own cost) which is understaffed. Thank you for your email contact prior to the conference. The catering was excellent & yummy. Thank you for all your hard work. ARNA is a gentle giant. Thank you for the journey. Looking forward to the Gold Coast.
Another great conference. I've never been to a bad ARNA conference yet! Well done!
Excellent conference. Didn't fall asleep once!
Beneficial spinal nurse study day followed on
Always a great opportunity to network and share experiences
Enjoyed the focus on personal improvements

CONFERENCE ABSTRACTS

KEYNOTE ADDRESS

IDENTITY AND SENSE OF SELF: THE SIGNIFICANCE OF PERSONHOOD IN REHABILITATION

Presenter Information

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Abstract

Recovery from conditions leading to illness/disability is often defined in terms of physical improvement; however people themselves describe their own recovery as more than this alone: it is a returning to the life they led before their illness. These two approaches highlight a potential mismatch between the way we as health care professionals perceive our world (the observable) and the way the people we are caring for perceive their world (often hidden from us). In this presentation I will explore how we can access the subjective world of those who use our services by exploring the role of life narratives within rehabilitation. I will share ideas from research linked to life changes, sense of self, and agency which we can use to inform our practice and support people in their recovery and rehabilitation.

THE PSYCHOSOCIAL MANAGEMENT OF CHALLENGING BEHAVIOURS IN REHABILITATION SETTINGS: THE IMPORTANCE OF NURSING STAFF INVOLVEMENT

Presenter Information

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Abstract

Patients admitted for rehabilitation can display behaviours that challenge professional caregivers. Whether this is a direct consequence of the primary medical condition (for example, closed head injury) or other co morbidity (dementia) or a manifestation of adjustment difficulties faced by patients, a co-operative approach to the psychosocial management of behaviours such as aggression can be highly effective.

Abstract

Little has been reported in the scientific literature regarding the recommendations of direct care nursing staff on the management of challenging behaviours in rehabilitation settings. Often a consultancy model is used with nurses simply requiring to follow a program of strategies that may not always be implemented. The present paper describes an investigation into nursing recommendations regarding preferred practice in managing challenging behaviours on an in-patient aged care rehabilitation unit. Focus groups and the results of a survey containing the Revised Nursing Satisfaction Scale highlighted the importance of clear communication and direct involvement of nursing staff as key elements of success in implementing strategies to manage behaviourally disturbed patients. The survey also confirmed the significant stress on nursing staff when caring for a patient with challenging behaviours. Autonomy and staff co-operation were factors related to nursing satisfaction following formal statistical analysis of survey items.

The presence of a list of behavioural strategies in a patient's file does not always equate to these actually being carried out. The study highlights the relationship between the level of direct involvement of nursing staff in the development of management suggestions and their actual implementation.

OVERCOMING OBSTACLES ALONG THE REHABILITATION PATHWAY

Presenter Information

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Abstract

As Rehabilitation Nurses with Central Northern Adelaide Health Service Transitional Care Program we are often faced with many challenges and obstacles in creating a plan of care for elderly clients post an acute care episode. Such was the situation with Mr M, an elderly Indigenous gentleman who was severely deconditioned and confused post a 12 week admission to an acute care facility where he had been diagnosed with Crytococcal meningitis. Mr M was well known to several community health services due to having medical co-morbidities including renal impairment, diabetes type 2 (on insulin), partial blindness and IHD. Mr M was generally regarded as having managed quite well living independently without formal services until undergoing a partial foot amputation the month prior to this particular admission. The feeling at the acute care facility was that he was a difficult client on many levels and that his care needs would be better met by being placed in long term care. Through facilitating a rehabilitation pathway that was sensitive to Mr M's cultural needs and comprised of a multi - faceted team which included Indigenous liaison and support workers, Mr M was able to explore the possibility of achieving his primary goals to return to living independently within the community. Although the pathway was fraught with many obstacles both of a medical and social nature, through continuing to advocate, support and facilitate the rehabilitation process Mr M was enabled to achieve his goal.

RESILIENCE – AN UNTAPPED ASPECT OF THE REHABILITATION JOURNEY

Presenter Information

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Abstract

The presentation will describe how a resilience risk screen tool for rehabilitation nursing staff is being developed following a detailed analysis of a sentinel event.

Sometimes it is very hard to see the forest for the trees when caring for rehabilitation patients. Sometimes it takes an outsider to see what we as nurses recognize and experience daily but often fail to clearly identify, assess and manage appropriately. During their rehabilitation journey our patients have days when they are flat; they offer us cues and clues that today could have been better for them. As diligent care workers we offer support, we record such observations, hand over and move on to another day. These observations are not necessarily reviewed or analysed on a systematic basis - and hence a positive management plan may not be developed. On reflection, there are moments in all patient journeys where differences can be made.

A multidisciplinary clinical practice group was brought together to consider how the rehabilitation team could best develop a system to enable and empower staff to act upon their clinical observations, 'gut' feelings and experience in relation to how grief and loss affected our patients. The varied responses of patients to similar physical circumstances appeared to reflect their personal 'resilience'. We examined the implications of life changing events for patients and the trigger points at which these patients were most vulnerable and from this began to develop that risk screen tool.

A PILOT RANDOMISED CONTROLLED TRIAL OF 7 DAYS PER WEEK PHYSIOTHERAPY FOR INPATIENT REHABILITATION PATIENTS: A FEASIBILITY STUDY

Presenter Information

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Abstract

Background: Current funding models in Australian subacute public rehabilitation settings typically provide staffing for only 5 days per week of physiotherapy. A large proportion of inpatient rehabilitation patients are admitted for intensive physiotherapy. This study aimed to conduct a pilot randomised controlled trial (RCT) of a weekend physiotherapy service compared to usual care for inpatient rehabilitation patients.

Methods: All patients admitted to a 28-bed hospital rehabilitation ward over a 10-week period were invited to participate and recruited by nursing staff. Patients were randomly allocated to receive either usual care of 5 days per week (Mon-Fri) of physiotherapy or 7 days per week of physiotherapy, usual care physiotherapy plus Saturday and Sunday therapy.

Weekend programs were prescribed by the weekday physiotherapist for all patients in the study and were delivered to the intervention patients by an Allied Health Assistant. The primary outcome measures were project feasibility and trends in length of stay and patient mobility (using the DEMMI) at hospital discharge.

Results: 43 consecutive rehabilitation patients were included (22 in the control & 21 in the intervention). Feasibility data indicated that a future large RCT is feasible. Multiple regression analysis identified that the larger proportion of stroke patients in the control group explained the significantly shorter hospital length of stay in the intervention group in this pilot sample. There were no significant differences in mobility outcomes at hospital discharge.

Conclusion: This study supports the need for a future large RCT comparing 7 days per week of physiotherapy with 5 days.

LEADERSHIP FORUM

Presenter Information

1) **Debra Thoms,** BA, MNA, GradCert Bioethics, Adv Dip Arts. Chief Nursing and Midwifery Officer, NSW Department of Health; Fellow (Hon) at ACHSM, NSW

2) **Angela Brown,** RN, RM, Dip Nursing (London), Cert Ed Professional Education (Nottingham), BSc Nursing (Leeds), MA Health Care Ethics (Leeds), PGDip Health Services Research and Technology Assessment (Sheffield), PhD Candidate.

3) **Tracey Osmond,** NSWRN, Cert Orth (NSWCN), GradCert Experiential Learning (UTS), MEd (Adult) (UTS), FCN, AFACHSE, MAICD

4) **Bob Weaver**, RN, Dip.Admin (Nursing), Grad Cert Nursing (Disability)

WHAT ABOUT US? - DEVELOPING A POST REGISTRATION COURSE FOR SPECIALTY NURSING PRACTICE FOR ENROLLED NURSES WORKING IN REHABILITATION.

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Abstract

The specialty of rehabilitation nursing is still evolving and if nurses working in specialist rehabilitation facilities are to become active and empowered members of the team who lead the rehabilitation process, they must be adequately prepared for their role in rehabilitation and as leaders. Enrolled nurses are integral to the provision of specialised rehabilitation care but there has been a lack of opportunities for them to participate in a recognised post-registration course in rehabilitation nursing.

The development of the Vocational Graduate Certificate in Rehabilitation Nursing in collaboration with the Chisholm Institute of TAFE in Frankston is a first vocationally based course for EN's in Australia. The course has been developed utilising the ARNA Rehabilitation Nursing Competency Standards as the framework for the development of the competency units.

The course is delivered in several modes, self directed learning, facility based vocational experience, and face to face study days at the hospital and TAFE. The hospital face to face study days are based on an interprofessional learning philosophy and therefore they are combined with the RN's doing the Graduate Certificate in Clinical Nursing – Rehabilitation through ACU. This initiative has been very successful in facilitating meaningful exploration of the students' sense of team and of being leaders of clinical excellence.

This paper outlines the course development process with the TAFE, details and implementation of the course and early evaluation.

COMPLEX EQUIPMENT + CONTRASTING ENVIRONMENTS = CRITICAL PROCUREMENT

Presenter Information

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Abstract

Rehabilitation nursing involves a plethora of equipment for a myriad of conditions. Spinal Cord Injury nursing is complex due to the varying degrees of spinal cord impairment and the contrasting environments involved in the patient journey. This includes acute care in an intensive care unit and/or orthopaedic trauma unit, the rehabilitation unit and community re-integration which encompasses a variety of environments such as home, work, school, social and sports settings. Complex equipment and consumables is essential and is used by highly skilled health-care professionals and carers. Therefore critical procurement of complex equipment is essential for all settings.

A retrospective review of the purchase of a ventilator suitable for home use, but used across all environments involved for a person with ventilator dependent tetraplegia identified what we did, who was involved and what we learnt and why it was important to know for future procurement.

While this process involved one specialised piece of equipment, aspects of the purchase, training and the ongoing education process are applicable for other equipment or consumables used by a variety of trained and untrained health professionals in contrasting environments for a multitude of health conditions. Due to the amount of equipment involved in the rehabilitation process this information is particularly applicable to rehabilitation nursing care. Thus imparting this knowledge also has the potential for improving patient outcomes.

A DESCRIPTIVE REPORT ON THE USE OF CYSTOMETROGRAMS IN A SPINAL REHABILITATION SETTING TO ENHANCE BLADDER MANAGEMENT

Presenter Information

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Abstract

Testing bladder function in the rehabilitation setting enables clients to gain valuable information about bladder changes that occur as a result of spinal cord injury. The information gained also helps the medical and nursing teams determine the most effective ways to manage the bladder post-testing and in the longer term.

A cystometrogram (CMG) is a procedure which measures how the bladder detrusor muscle behaves during bladder filling. Testing determines if the detrusor muscle pressures are within safe limits, the amount of urine the bladder can hold (i.e. the bladder capacity), and whether current bladder management is appropriate or requires a different approach and changes to medication and/or dosage.

Testing within the rehabilitation unit is advantageous to the client and the multi-disciplinary team as more time can be spent participating in therapy with less time lost travelling or waiting for an appointment. The results are also more readily accessible. Knowing how to manage bladder function effectively can prevent infections, incontinence, and long-term renal tract complications, as well as improve management of pain, spasticity and autonomic dysreflexia. Cystometrograms performed within the spinal unit are not useful for studying the voiding phase; referral out for videourodynamics is indicated.

Our presentation will review CMG tests performed at Moorong Spinal Unit (Royal Rehabilitation Centre Sydney) between 2007 and 2010. The presenter will outline the CMG protocol used in the unit and provide illustrations using several interesting case examples.

THE VALUE OF EARLY INTERVENTION FOR MODERATE AND SEVERE TRAUMATIC BRAIN INJURY

Presenter Information

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Abstract

For clients with traumatic brain injury (TBI), initiation of rehabilitation programs soon after injury has been associated with better client outcomes, such as reduced lengths of stay and higher FIM scores (Kunik, Flowers and Kazanjian, 2006).

Many hospitals have acknowledged procedural challenges associated with the tasks surrounding identifying TBI clients when they first present at ED, performing initial rehabilitation assessments, and then arranging for the start of rehabilitation services within the time frames that are presumed to optimise outcomes.

ABI Rehabilitation provides an integrated system of rehabilitation for all moderate to severe TBI clients located in the northern half of the North Island in New Zealand (catchment population 1.9 million). This organisation introduced the role of the Acute Rehabilitation Coordinator (ARC), which functions within the five regional hospitals to identify potential clients soon after presentation to ED. Through an efficient decision-making and notification system, ARCs initiate individual rehabilitation plans while the client is in hospital and ensure seamless transfer to post-acute rehabilitation or home.

ARCs shorten the time between injury and the start of rehabilitation services; a recent organisational survey showed that length of stay in hospital has reduced by 11 days on average with introduction of this role. This presentation will comprise retrospective analysis of approximately 175 consecutive clients enrolled over a 10-month period. The association of the injury-to-rehabilitation delay time with length of stay (including acute and post-acute rehabilitation) and TBI-specific gains in FIM-FAM-DOM will be calculated. Information regarding demographics and injuries will also be included.

MAKING SENSE OF THE STATE OF REHABILITATION IN AUSTRALIA AND NEW ZEALAND IN 2009: THE TOOLS FOR IMPROVING CLINICAL PRACTICE

Presenter Information

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Abstract
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The Australasian Rehabilitation Outcomes Centre (AROC) provides a national benchmarking system whose aim is to improve clinical outcomes of rehabilitation. AROC, which commenced in 2002, is a joint initiative of the Australian rehabilitation sector and the Australasian Faculty of Rehabilitation Medicine. The prime objective of AROC is the collection of a standardised data set against each and every rehabilitation episode of care.

AROC now has more than 400,000 episodes of Australian inpatient care in its database, collected from 162 of the 170 known rehabilitation units in Australia. In addition the dataset contains around 2,500 episodes of New Zealand data, collected from 13 of the estimated 35 rehabilitation units in New Zealand. AROC provides six monthly reports to all its members - both facilities and payer organisations. A key feature of these reports is the comparison of facility data with an appropriate benchmark group.

This paper will present summary data from the core AROC dataset for overnight episodes in 2009, as well as trend data over the time period of data collection. Also highlighted will be the industry derived impairment specific outcome targets (#NOF, Stroke, Brain Injury, and Reconditioning) and any available summary data from the adjunct datasets collected against some impairments (Brain Injury, Spinal Cord Injury, Reconditioning).

In 2009 AROC undertook a project for the the Australian Commission on Safety and Quality in Health Care. The project involved testing and validating Draft Operating Principles and Technical Standards for Australian Clinical Registries. There were several important activities in the project which assisted AROC to evaluate their own quality processes. This paper will discuss how AROC developed its quality processes, and recommendations will be put forward that may assist the audience to improve the quality of their data and to make better use of the information that AROC provide in its reports.

The future of AROC looks bright. Membership of Australian units is almost at 100%, New Zealand membership is growing, and tentative approaches have been received from other Australasian countries. AROC is offering increasing support to rehabilitation research by providing researchers access to the data contained in its significant database, and by the continuation of the impairment specific outcome target setting workshops. The expansion of AROC into the ambulatory sector continues to grow with the roll out of the AROC ambulatory dataset.

KEYNOTE ADDRESS

COMPASSION AND LIFEWORLD LED CARE: AN EMERGING FIELD OF STUDY

Presenter Information

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Abstract

Over the last two decades health care has been increasingly influenced by technology and audit. In some instances the rise of this objective, mechanistic culture has led to a loss of humanity in staff, low staff morale and the 'objectification' or depersonalisation of those in our care. There is an international movement linked to compassion and human connection which has been growing as a response to these issues. This movement can help us to a) celebrate our shared humanity, b) recognise depersonalisation c) guide practice to recognise the importance of humanity and compassion and d) develop research approaches which can be used to enhance humanity in clinical practice and education.

In this presentation I will a) highlight the key ways that this area is beginning to be researched b) share findings from practice and research and c) provide an opportunity to explore the role of humanity and compassion in rehabilitation practice.

EYES, SMILES, BODY PIERCINGS & TATOOS: HOW NURSES INTERPRET SYMBOLS TO INFORM INTERACTIONS

Presenter Information

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Abstract

Improvements in medical management following catastrophic neurological injury and illness have led to an international increase in survival rates for this heterogeneous population. This increase in survival rates has resulted in a growth in the number of people with ABI living with physical and or cognitive disability. A sub group of the ABI population will have severely altered levels of consciousness from which they may or may not emerge. One of these disorders of consciousness following ABI is called the minimally responsive state (MRS). MRS is evidenced by purposeful responses, which may be inconsistent and difficult to detect on limited observation.

Given the high health care needs and their inconsistent responses, persons who are in MRS require others to care for them. Preliminary findings from research conducted as part of a Master of Clinical Rehabilitation through Flinders University, will discuss how nurses interpret symbols other than language, such as facial gestures, clothing, photographs and haircuts to inform their interactions. Symbolic interactionism as a theory will be discussed. Examples of interaction, interpretation and further interactions with the person who is in MRS will be central to the presentation.

A research grant from the Australasian Rehabilitation Nurses' Association in 2009, has provided financial assistance with this project.

INVITED SPEAKER

LOVE HAS NO LIMITS

Presenter Information

Ms Tania Hayes

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Abstract

Tania Hayes lives on the South Coast of New South Wales and became a carer at just 22, when her fiancé Warren was diagnosed with a life-threatening brain tumour. From the moment Warren fell sick, Tania gave up her job and the carefree life she knew to be by Warren's side. For the past 12 years Tania has devoted her life to rehabilitating Warren to learn to talk, eat and move once more. Even though Warren is still fully dependant on Tania 24 hours a day and lives a life in a wheelchair, they have rebuilt their lives, finally getting married and now have a beautiful son named Josh.

Despite all their tragedy, Tania has remained positive and optimistic for the future. She continues to put her energy into her family and has become a strong advocate for Carers and the disabled across Australia. She is regularly called on as a speaker sharing their amazing journey throughout the country. Tania is a Carer Ambassador for Carers Australia, Carers NSW, The Continence Foundation of Australia and Sir Roden Cutler Charities in Sydney. She is also the proud author of her family's inspiring story 'Love Has No Limits'.

TOWARD PATIENT CENTRED PRACTICE – REDESIGNING THE MODEL OF SERVICE DELIVERY ON AN INPATIENT REHABILITATION UNIT

Presenter Information

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Abstract

In 2009, the spinal injuries unit (SIU) commenced a change project to redesign the model of service delivery from its traditional medically focussed uni-disciplinary approach, to a patient centred multi professional approach. The motivation to change came from various sources including customer feedback. The aim of the redesign was to create a service model that would enable the delivery of a patient centered goal orientated rehabilitation program through a multi-disciplined approach. To achieve this both the formal and informal elements of the structure, systems and culture required change.

The resultant model symbolically places the patient at the centre of the rehabilitation process and through its five domains provides the framework upon which all unit processes are now based. This necessitated the review of existing processes such as goal planning in addition to the development of new systems to support the approach, for example, a multi-disciplinary assessment procedure.

A brief outline of the methodology employed (an action research design) will be presented before concentrating on the model and its application in practice. The SIU project is about to enter the evaluation stage of the change cycle.

LET'S TALK ABOUT DISCHARGE PLANNING: THE GOOD, THE BAD AND THE UNCOMFORTABLE

Presenter Information

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Abstract

We have all heard that discharge planning should start at day one. Many of us have also heard that the skills of rehabilitation nursing should be in every nurse's toolkit. Discharge planning for rehabilitation patients and their families may involve discussing news – good news, bad news and uncomfortable news.

I will challenge you to think about the many aspects of discharge planning. I will challenge you to think about what is 'normal', how we break challenging and confronting news, how we make decisions about other people's lives, as well as how we decide if someone is 'OK' to go home.

I will discuss the question: How do we ensure nurses become more confident when addressing challenging and confronting issues presented by rehabilitation patients and their families in the clinical setting?

PILOT STUDY USING ART THERAPY A REFLECTIVE TOOL FOR CLINICAL SUPERVISION

Presenter Information

Ms Beverley Marsh
Qualified RN, RM, MCHN, BA(HONS)Health Care Practice(Health visiting), Health Promotion Cert, Community Health care Nurse Dip, Masters in Nursing(ongoing completion Oct 2010).
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Ms Peta Greenough
MA(Creative and Expressive Arts Therapy), BFA(Major Ceramics), Nurse(Div 2), Art Therapist.
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Abstract

In the fast paced health service, two colleagues look at how to support professional staff in this often stressful setting. This whole project has been very personally driven and has been a counterbalance to the science measurability drive that is prolific within health care.

The colleagues are a nurse clinical care co-coordinator (NCCC) team leader and an art therapist in a public, sub acute hospital in Melbourne. The NCCCs, coordinate the discharge planning, patient care and liaise between families and interdisciplinary teams. The art therapist works with patients in the rehabilitation unit, using art therapy as an expressive tool to support them through their experiences around grief and adjustment issues.

There was a combined interest in exploring the creative arts as a clinical supervision tool. This is a new concept in supervision practices for nursing and specifically the NCCCs who decided to participate. In the past for the NCCCs, supervision had been management led and on a one:one basis. This pilot uses a peer group model of supervision with the main focus being on self reflection facilitated by creative/expressive arts. The pilot was conducted over a four week period and fully evaluated by the participants and the therapist.

This presentation will cover:

- Clinical supervision including different models
- Collaborative liaison across allied health and nursing professions
- Creative reflection
- Emergent themes
- Participant evaluation
- Future research and development

SERVICE PROVISION FOR PEOPLE WITH MULTIPLE SCLEROSIS. A QUALITATIVE STUDY OF ONE HEALTH DISTRICT IN THE UNITED KINGDOM

Presenter Information

Dr Quentine Green

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Abstract

Improved understanding of health service provision for people with Multiple Sclerosis (MS) in relation to their perspectives provides vital information guiding efforts to meet their ongoing needs. This paper discusses a qualitative study of service provision for people with MS in one health authority (pop. 590,000) in the UK carried out in the late 1990s and its continuing relevance to rehabilitation service provision. The study explored three key questions pertaining to service provision: how do people with MS utilise health services in this authority?; what problems occur in daily interactions between service users and providers that affect how needs are met for people with MS?; and how does the structure of current health services in this authority affect people with MS?

The study was carried out in four stages incorporating: initial exploration to examine unknown factors; initial data analysis; a retrospective examination of cases of people newly diagnosed with MS; and a prospective examination of service use which involved monitoring 226 people with clinically confirmed MS who used services over a 10-month period. Three main themes arose from the study: trust in the relationship between health professionals and people with MS; how health professionals and people with MS express their knowledge of MS; and service planning and design factors that influence whether and how the needs of people with MS are met. This paper will focus on the lessons learned in this study to assist rehabilitation practitioners in dealing with patients with MS and how best to address shortfalls in service provision that may exist.

EXPECT THE UNEXPECTED

Presenter Information

Pauline Clowes
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Abstract

Caring for the patient with an obvious complication but no diagnosis can be very frightening for the patient and frustrating for the nursing staff.

Mrs A was admitted for Rehabilitation following a Left Total Knee Replacement. Surgically her recovery was uneventful but the day following her transfer to the Rehabilitation Unit she developed a rash that, over the next week increased in severity and grew to cover her entire body. Her ability to undertake any rehabilitation was hampered and as her condition worsened, her coping skills were severely compromised. Her diagnosis when made presented her and her carers with yet another dilemma as she proved to be allergic to slow release Tobramycin, the antibiotic impregnated into the cement used in joint replacements.

This paper will present the events of this case study including symptomatic treatment and eventual diagnosis but will focus on how a holistic approach to Mrs A's care was the only way forward with her rehabilitation.

POSTER: MULTIDISCIPLINARY STROKE IN-PATIENT EDUCATION: A REVIEW OF CURRENT PRACTICES

Presenter Information

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Ms Sarah Moody
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Abstract

Background
Rankin Park Centre, Newcastle, NSW is a 40 bed inpatient general Rehabilitation Unit divided into two 20 bedded units. Approximately 8 beds are allocated to stroke patients in one unit. A six-week multidisciplinary education cycle aimed at stroke patients and carers had been run for a number of years.

Aim
The Stroke Nurses Working Party was set up in 2007 to provide evidence based direction to nursing staff working with stroke patients. Using the Clinical Guidelines for Stroke Rehabilitation and Recovery (2005) we identified a need to review the nursing content for stroke patient education to ensure it contained relevant information for stroke patients and their carers. This need was also identified at multidisciplinary team level.

Method
We used the Stroke Support strategy (2008) and the 'Walk in our shoes' report (2007) as frameworks and were able to identify what information to target at stroke survivors and their carers during the rehabilitation phase of care. Other educational resources were also reviewed and changes made accordingly to posters advertising sessions, display of factsheets in the ward and folders for patients to store information. Speech Therapy department reviewed content of presentations and evaluations were revised to ensure the format was appropriate for patients with communication difficulties. Dietician and Pharmacy sessions were added to the program.

Results
Patients and carers can more readily access fact sheets and information presented at Stroke Education is relevant to a rehabilitation phase of care.

Conclusion
Multidisciplinary evidence based education is delivered to the patients following stroke, and their carers.

POSTER: THE PIVOTAL ROLE OF NURSES IN RESPIRATORY REHABILITATION: REFLECTIONS FROM THE CANADIAN EXPERIENCE

Presenter Information

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Abstract
Background:

Three million Canadians, or almost 10% of the population, live with a respiratory disease/illness1. Respiratory diseases/illnesses often negatively impact a person's physical and emotional health. Respiratory rehabilitation aims to enhance functional capacity, reduce symptom intensity, decrease hospitalizations and improve quality of life.

Objectives: After viewing this poster participants will be able to:
• describe the aims and components of a respiratory rehabilitation program and
• identify the unique contributions of the rehabilitation nurses.

Program Components: Our four week adult inpatient respiratory program combines education, endurance training and disease symptom/disability management. The majority of patients admitted are pre/post lung transplant surgery or living with long-term respiratory diseases such as chronic obstructive pulmonary diseases, cystic fibrosis and farmer's lung.

Discussion: The respiratory rehabilitation program nurses are involved in the entire trajectory of care. Prior to admission a nurse meets individually with each patient to formulate goals. During the first week after admission a nurse, along with the patient and members of the interdisciplinary team, formulate a plan of care. Nurses play a pivotal role throughout the hospitalization delivering education sessions, monitoring responses to changes in treatment modalities and providing support as patients practise newly acquired skills. At the time of discharge a nurse coordinates follow-up to ensure optimal community reintegration.

Conclusion: The nurses fulfill an important leadership role in respiratory rehabilitation advocating for individualized treatment plans, coordinating care, providing education, supporting changes in behaviours and assessing progress.

1. **Life and Breath:** Respiratory Disease in Canada. (2007). Public Health Agency of Canada http://www.phac-aspc.gc.ca

ARNA Research Grant

The ARNA National Committee has made available a total of Au $10,000 for one or more research grants which may be awarded per annum.

1. Purpose

To provide financial assistance to members of the Australasian Rehabilitation Nurses' Association (ARNA) to undertake research relating to rehabilitation nursing and aimed at improving client outcomes.

2. Eligibility

The applicant must have been a financial member for a minimum of two (2) consecutive years at the time of this application.

3. Guidelines

- A grant will only be offered to fund projects with demonstrated relevance to rehabilitation nursing.
- The activities, for which the grant is obtained, should be completed within eighteen (18) months of the receipt of the grant.
- Applications must address the ARNA research grant guidelines and be received by the designated closing date. Incomplete or late applications are not considered. *See http://arna.com.au/research.html*
- Grant recipients are required to submit a report at the conclusion of the project and a progress report after eighteen (18) months if the research is ongoing.
- Grant recipients are required to give an undertaking to submit a paper for publication in JARNA within three (3) months of the completion of the research project.

4. Utilization of Funds

See http://arna.com.au/research.html

5. Duration

See http://arna.com.au/research.html

6. Acknowledgment of Funding

The funding support of the Australasian Rehabilitation Nurses' Association must be acknowledged in all publications, presentations etc. resulting from research funded by ARNA Inc.

7. Submission of Application

Using the Guidelines for Research Grant Application (link to PDF documentation is below), submit application as an email attachment to arna@pams.org.au. In the email header, state "ARNA Research Grant Application"

8. Selection

Assessment of the applications will be undertaken by the Education and Research Sub Committee within one (1) month of the closing date for applications. When necessary research expertise is co-opted to assist with this process. External peer review may be undertaken. Recommendations are made to the National Committee of ARNA Inc. The decision of the National Committee is final.

Successful applications will be announced at the ARNA Annual General Meeting October 2011.

Closing Date for applications: **30th June** annually, when research grant funds are available

Chapter Reports

ILLAWARRA Chapter

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Illawarra Chapter 2010/11 Committee

Chapter President	Tracey Weir
Chapter Secretary	Sue Andrusiow
Chapter Treasurer	Mandy Hoss
Committee Members	Robyn Ashe
	Cheryl Davies

CHAPTER NEWS

Committee will be advertising to all Illawarra rehab facilities about ARNA half yearly memberships to hopefully encourage increased membership.

The Illawarra chapter Committee will be holding meetings on the 2nd Friday, every 2 months, commencing in February.

The Committee will also be conducting an education day on the 18th February 2011—so please remember to save the date! The approximate cost will be $70 but free to ARNA members. this education day will include CPD points. Further details will be coming in early January.

NSW/ACT Chapter

CHAPTER CONTACT DETAILS:

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NSW/ACT Chapter 2010/11 Committee

Gillian Garrett	President
Sandra Lever	Vice President
Amanda Buzio	Secretary
Jhoven DeJesus	Committee Member
Bridget Lingane	Committee Member
Jessica Taviera	Committee Member

CHAPTER NEWS

Membership News

NSW/ACT Chapter membership is open to anyone with an interest in rehabilitation nursing. So do continue to advertise the benefits of ARNA membership to your colleagues. Membership of ARNA affords us access to valuable education and networking opportunities within our speciality that otherwise would not exist. In addition, we receive the quarterly JARNA and, importantly, our speciality is represented on local and national nursing bodies.

Annual Study Day

The NSW/ACT chapter committee is busy planning for the annual study day. This will take place on Friday 18th March and will once again be held at the Epping Club. As last year, the day will be themed around one of the rehabilitation nursing competencies – 'administering and monitoring therapeutic interventions'

The chapter study day provides a great opportunity for novice presenters to talk about their innovative work. So if you, or someone you know, would like to present a quality project or case study please let us know.

The study day is free to members of NSW/ACT. Non-members are welcome to attend at a cost of $80. This includes morning tea and lunch.

Chapter Committee Meetings:

Chapter committee meetings are held throughout the year with the minutes posted on the ARNA website. Chapter members are welcome to attend or to forward any items for consideration/discussion to a member of the committee.

Scholarships:

ARNA NSW/ACT offers two $1000 scholarships each year to members for the purposes of study/conference/research. Anyone who has been a member for two consecutive years or more is eligible to apply. Full details are available on the ARNA website. Please forward applications to the Chapter President or Secretary.

For Chapter Information Contact:

Please contact Gillian Garrett (gillian.garrett@royalrehab.com) or Amanda Buzio (amanda.buzio@royalrehab.com) if you would like further information.

QLD Chapter

ARNA – Q 2011 Education Workshop
Date: 25th March, 2011
Where: Princess Alexandra Hospital, Brisbane

CHAPTER CONTACT DETAILS:

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Chapter President
Rehabilitation Unit Manager
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QLD Chapter 2010/11 Committee

Chapter President	Wendy Harper
Chapter Vice President	Carolyn Wilson
Chapter Secretary	Pauline Blaney
Chapter Treasurer	Shaun Matthews
Committee Members	Pauline Blaney
	Alison New
	Renee McMillan

CHAPTER NEWS

The National Conference was held in October this year and many QLD members were present. It was great to get a chance to network with passionate Rehabilitation specialists from around the country, and New Zealand. Jeanette Harwood was successful in receiving an education scholarship from ARNA QLD to attend the conference, so we look forward to her feedback.

We will host the 2011 ARNA National Conference at the Gold Coast on Oct 6-7, so lock in those dates now.

Our annual one-day workshop will be in March at PA Hospital. Expressions of interest are open for any nurses, allied health staff or anyone who simply loves what they do to present at the workshop. So if you have an interesting topic, paper, poster or just something great you want to brag about, please contact us at qld@arna.com.au We look forward to your ideas... Details on registration are available on the web site now.

We are also planning another Saturday morning education session at Greenslopes Private Hospital in May, following the success of the one held this year.

A reminder that ARNA QLD has educational scholarships available. Please see the website for further information or contact one of the committee members.

Please feel free to contact any committee member at any time if you have an issue or something to discuss or request.

On behalf of the Committee I would like to wish you and your loved ones a very Merry Christmas and a safe and Happy 2011.

SA/NT/WA Chapter

CHAPTER CONTACT DETAILS:

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CHAPTER NEWS

2010 is almost at an end with the festive season fast approaching. The past twelve months has been busy for the SA/NT/WA Chapter with representation on the SA Rehabilitation Clinical Network Workforce Development, Education and Training Workgroup, and, Research Workshops. Our Chapter Study Day and AGM was held in July at the Repatriation General Hospital. And in October a number of the Chapter members attended the twentieth National ARNA conference held in Wollongong NSW, ARNA's birthplace.

Chapter committee meetings have changed venues moving from St Margaret's Rehabilitation Hospital's Boardroom to the Repatriation General Hospital's meeting room. Planning for next years Study day will commence early in the New Year. The next meeting in December will be via video conference with our Northern Territory members and an invitation to attend is extended to all Chapter members.

With the approaching Festive Season I would like to extend to all ARNA members and their Families a very Merry Christmas and a Great New Year on behalf of the SA/NT/WA Chapter Committee.

SA/NT/WA Chapter 2010/11 Committee

Chapter President	Terry Wells
Chapter Vice President	Denys Spencer
Chapter Secretary	Margaret de Hass
Chapter Treasurer	Denise Collopy
Committee Members	Justin Prendergast
	Rosalie Philcox
	Deidre Widdall
	Gill Sharp

Chapter Committee Meetings:
Meetings continue to be held at The Repatriation General Hospital and via teleconference for our NT committee members.

Sponsorships:
The Chapter is able to offer 2 x $250 scholarships per year. In line with National guidelines, applications must be received by 30th June 2010.

Applications are available from our state secretary Margaret de Haas

Spinal Nurses Chapter

CHAPTER CONTACT DETAILS

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Spinal Nurses Chapter 2010/11 Committee

Chapter President	Pam Hesketh
Chapter Vice President	Lesley Brennan
Chapter Secretary	Raewyn Buchanan
Chapter Treasurer	Erika Schlemmer
Committee Members	Karen Marshall
	Kylie Wicks
	Jen Greenaway
	Julienne Malt

CHAPTER NEWS
As spinal chapter members are a diverse group, and truly Australasian with our New Zealand links, this chapter continues to support each other with shared knowledge and ideas, and facilitates contact through emails and teleconferences. Research continues to be a high focus for members completing their Masters Degree and individual research projects.

Next General meeting;
Our next teleconference meeting is proposed for 1330 Eastern Daylight Saving Time on the 9/12/10. A significant ongoing issue for discussion involves the progress of the development and identification of skills and principles of Spinal Rehabilitation Nursing affiliated with ARNA Spinal Competencies using spinal case studies. Consequently members are asked to consider current ICF spinal case studies found on www.icf-casestudies.org , as these may add to the discussion about this 'spinal competencies" project.

Education:

I attach the Jarna report furnished by Laynie Pullen (a member of the Spinal Chapter), as a summary report of this wonderful education morning.

JARNA Report *(Spinal Chapter Education Study Day 16th Oct, 2010)*

By Laynie Hall Pullin *(recipient of 2010 ARNA Education Scholarship)*

The 20th annual ARNA conference in October 2010 was followed by the Spinal Injury Nurses Chapter (ARNA SINC) Education Day held on Saturday 16th October at the Corrimal Community Centre, Corrimal. The session was very well attended with over twenty participants and four presentations. Four papers were presented during the morning and a range of interesting discussion topics in relation to spinal rehabilitation nursing was facilitated. The proceedings were chaired by the Chapter President, Pam Hesketh, with Lesley Brennan and Kylie Wicks organising the stimulating program which was facilitated by the provision of a delicious morning tea!

Jennifer Greenaway gave a comprehensive update on the progress of the project to develop ARNA Spinal Competencies which was envisioned initially at the ARNA SINC Education Study day held this time last year in Melbourne. Jenny circulated a Case Study manuscript for comment which was written in association with Dr. Julie Pryor, and which embodied some of the skills and principles of Spinal Rehabilitation Nursing using a case study format. ARNA SINC, in consultation with Jenny Greenaway and Dr Julie Pryor, will now develop a method for feedback on draft ideas in relation to this project which aims to provide information for nurses about the care and support of clients with spinal cord injury and to define some consistencies in the wide scope of practice for this area of rehabilitation nursing. A small working party established during Jenny's presentation agreed to keep working on the format for the final project and the feasibility of different ideas to progress it. Following this, Wendy Jannings gave a fascinating insight into the lived experience and needs of 12 persons with a spinal cord injury who could walk. Results from Wendy's recent qualitative study has exposed some amazing new insights into the complexities that people with incomplete spinal cord injuries have throughout their daily lives, and her insightful paper led to much thoughtful dialogue among Chapter participants.

Members were equally engaged in a paper presented by Karen Marshall from NZ. Karen is planning to engage in professional doctorate studies in 2011 and her project is in standardizing nursing language for spinal cord injury nursing management. Karen's passion for spinal nursing was evident throughout her presentation, and the fact that she has already done so much preparatory thinking and research into her planned project. Examining broad issues from an international perspective gave us all insight into the use of standardising language in nursing contexts, and issues associated with understanding the impact on clients and staff in rehabilitation settings. Finally, I was also privileged to run a short presentation and discussion forum on aspects of methodology used in social and rehabilitation research based on my current doctoral research into the experiences and support needs of family members living with and supporting people with spinal cord injuries.

I would like to thank ARNA sincerely for the awarding of a 2010 ARNA National Educational Scholarship of $380.00 which allowed me to attend the 20th annual conference, and present a paper at the Chapter Study day following. Also, I wish to express a heartfelt thank you to organisers, other presenters, and participants at the ARNA SINC Education Study Day, who provided the forum for such a great professional networking morning.

Pam Hesketh

ARNA SINC

President; Spinal Nurse Chapter

VIC/TAS Chapter

CHAPTER CONTACT DETAILS:

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President

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President	Lisa Street
Vic-President	Lyn McBain
Secretary	Sara Alger
Assistant Secretary	Alison Dupuy
Treasurer	Rani Govender
Assistant Treasurer	vacant
Committee Members	Tasmanian Representative Chris Ashe
	Margaret Tardrew Caufield Hospital
	Shirley Dixon Royal Talbot Rehabilitation Centre
	Eileen Chapallaz Victorian Rehabilitation Centre
	Catherine Findlay Peter James Centre
	Karyn Mitchell Dorset Rehabilitation Centre
	Gillian Rowe Royal Talbot Rehabilitation Centre

CHAPTER NEWS

The Chapter Committee are meeting on a monthly basis and are looking at working on the following issues over the next few months; chapter scholarships, chapter study day costs, adding continuing professional development hours to the study day certificates, suggesting adding "BYO mug" to the chapter study days, as well as marketing of ARNA and the chapter study days. In addition we are planning to keep the ARNA chapter website up to date and promote more submissions to JARNA.

Chapter Meetings

Caufield Hospital Study Day

Our last Chapter Study Day and Chapter Meeting for the year was held on Friday 26th November at Caufield Hospital in Caufield, Victoria. Fifty four enthusiastic nurses, as well as one physiotherapist, attended from 14 different sites from Melbourne, Geelong, Ballarat and Tasmania.

We enjoyed a variety of topics presented by Caufield Hospital nurses, doctors, an orthotist & prosthetist, physiotherapist and librarian. Dr Fary Kahn, rehab consultant, challenged us to think about the big picture in orthopaedic rehab. Yvonne Sapies, orthotist and prosthetist, gave us practical tips on nursing management for common orthotics/braces in rehab. We had feedback from the experienced orthopaedic rehab nurses that they learnt some useful tricks, such as what to do if the patient says the brace is too tight but you feel that it needs to be tightened. Rod Sturt, neuro and spinal physio, showed us photos of his world tour investigating best practice spinal rehab in South Africa, Sweden, Switzerland, Holland, USA and Canada. We enjoyed hearing about the varied programs, such as the partial body weight support treadmill training and the number of staff to support this therapy, the loco-mat walking device, the wheelchair treadmill, the Swiss hippotherapy (horse riding therapy) as well as the cycling therapy in the hospital corridors in Holland. Veronica Delafosse, librarian, explained how using the Clinicians Health Channel, our workplace librarian and the search tool called CINAHL we can access a world of information. We were challenged to think about continuing professional development and our professional portfolios by Angela Casey, educator. After lunch Dr Mithu Palit, neurologist, told us about the treatment methods for spasticity and the Caufield Spasticity Clinic, staffed by a team of doctors, physios and occupational therapists.

Three nurses then gave us three case presentations about 'behaviours of concern – the nursing perspective'. They challenged us to think about how consistency and a team effort make a difference.

The feedback from the day was very positive, with some comments encouraging more nurses to present (hint, hint). If you are interested in presenting at a Chapter Study Day or the ARNA National Conference the ARNA-Victorian/Tasmanian Chapter Committee are available to assist and support you to do so.

Thank you very much to Margaret Tardrew, Chapter Committee Member, and her team for organising the day. Caufield Hospital offered a lucky door prize of a 2011 ARNA membership. This was drawn by lucky dip and won by Shirley Dixon. Thank you very much to our sponsors Belinda and Stan from Ipsen for the delicious morning tea and lunch, as well as EBSCOHost for the showbags and flyers. Thank you also to the Caufield Hospital nursing management for the tea and coffee.

Diary Dates

Friday 18 March 2011. ARNA-Victorian/Tasmanian Chapter Study Day at St John of God Hospital, Ballarat, Victoria. Enquiries to Fiona Thomas on (03) 5320 2171 or fiona.thomas@sjog.org.au
The program will be available on the website closer to the event.

Chapter Study Days are free for ARNA members and a small cost for non-members. Morning tea, lunch, afternoon tea and certificate of attendance are supplied. Registration forms and topics will be advertised closer to the event. We aim to have at least one regional or Tasmanian Study Day each year.

If you have an event at your workplace that you would like us to advertise to ARNA members please let us know.

Welcome to New Members

The ARNA National Committee and members, take great pleasure in welcoming the following people who have become ARNA members.

INDIVIDUAL MEMBERS	CHAPTER
Grant Cavanough	ILLAWARRA
Kirsty Blake	NSW/ACT
Rohini A. Kiran	NSW/ACT
Carolyn Lambeth	NSW/ACT
Anne O'Connor	NSW/ACT
Teresa Tsang	NSW/ACT
Tanya Bankier	QLD
Anne Bradley	QLD
Cecilia Howat	QLD
Sandra Hurley	QLD
Wendy Keogh	QLD
Scott Lowe	QLD
Sue Newell	QLD
Maria Pardoen	QLD
Sarah Ramsay	QLD
Michael Arthur	SN
Nicola Bennett	SN
Tonina Harvey A.M.	SN
Caroline Andrew	VIC/TAS
Karina Britton	VIC/TAS
Bernadette Drysdale	VIC/TAS
Susan Harvey	VIC/TAS
Nancy Herrett	VIC/TAS
Lyn Kent	VIC/TAS
Maija Kumpulainen	VIC/TAS
Collette Leech	VIC/TAS
Sue Maxwell	VIC/TAS
Anna Salan	VIC/TAS
Hannah Slevin	VIC/TAS
Rennie Vanderbom	VIC/TAS
Lidia Zampetti	VIC/TAS

ARNA Corporate Members

CORPORATE MEMBERS	CHAPTER
SOUTH COAST HOME HEALTH CARE	ILLAWARRA
CAMPBELLTOWN PRIVATE HOSPITAL	NSW/ACT
ST VINCENT'S HOSPITAL LISMORE	NSW/ACT
CALVARY HEALTH CARE SYDNEY	NSW/ACT
BALWYN REHABILITATION HOSPITAL	NSW/ACT
CALVARY JOHN JAMES HOSPITAL	NSW/ACT
SOUTHERN HIGHLANDS PRIVATE HOS	NSW/ACT
MT WILGA PRIVATE HOSPITAL	NSW/ACT
METROPOLITAN REHABILITATION HO	NSW/ACT
MAYO PRIVATE HOSPITAL	NSW/ACT
BRITISH LIBRARY	OVERSEAS
ROYAL BRISBANE & WOMEN'S HOSPI	QLD
PRINCESS ALEXANDRA HOSPITAL	QLD
MATER HOSPITAL	QLD
GREENSLOPES PRIVATE HOSPITAL	QLD
GYMPIE HEALTH	QLD
BRIGHTON REHABILITATION UNIT	QLD
EDEN REHABILITATION CENTRE	QLD
TOWNSVILLE HOSPITAL	QLD
SUNNYBANK PRIVATE HOSPITAL	QLD
BUNDABERG HOSP REHAB UNIT	QLD
CENTRAL NORTHERN ADELAIDE HEAL	SA/NT/WA
STRATHALBYN AND DISTRICT SOLDI	SA/NT/WA
FRANKSTON HOSPITAL	VIC/TAS
PETER JAMES CENTRE	VIC/TAS
CALVARY HEALTH CARE TASMANIA	VIC/TAS
ROYAL TALBOT REHABILIATION CEN	VIC/TAS
GOULBURN VALLEY HEALTH	VIC/TAS
EPWORTH HEALTHCARE	VIC/TAS
MONASH UNIVERSITY	VIC/TAS
ELSTERNWICK PRIVATE HOSPITAL	VIC/TAS
BROADMEADOWS HEALTH SERVICE	VIC/TAS
ST JOHN OF GOD HEALTH CARE	VIC/TAS
GEELONG PRIVATE HOSPITAL	VIC/TAS
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Guidelines for Submission of Articles in JARNA

The Journal of the Australasian Rehabilitation Nurses' Association is a peer reviewed journal that publishes original work in any area relevant to rehabilitation nursing. It welcomes contributions on contemporary practice, policy and professional issues.
The Journal publishes research articles (2000-3000 words), literature reviews (1500-2000 words), conference papers and case studies (1000-1500 words), book reviews and abstracts.

GUIDELINES FOR ALL SUBMISSIONS

Title page

The title page should contain the category of article, title of the article, name(s) of the author(s), professional qualifications, current position and, for the first author, the contact address, email address and telephone number.

Text

Use Arial font, 9 point, as the standard font. Manuscripts should be double-spaced with the top, bottom and side margins being 3cm.

Keep your sentences short and to the point. You may like to use headings and sub-headings as this will make it much easier for the reader to follow.

Abbreviations should be used sparingly and only where they ease the reader's task by reducing repetition of long, technical terms. Initially use the word in full followed by the abbreviation in parentheses. Abbreviations such as e.g., etc. and & should only be used in parentheses.

All pages of the manuscript must be numbered starting with the title page.

Illustrations, figures and tables

These should only be used if they add to the understanding of the text. Illustrations, figures, diagrams and tables should be included with each on a separate sheet.

Photographs

Please supply any photographs (originals only) with your submission. Make sure you enclose the permission of any person in the photograph. Photographs should be clearly labelled on the back by attaching a white label giving the names of people from LEFT to RIGHT and the appropriate caption. If you include a self-addressed stamped envelope, we will return your photograph promptly.

Referencing

The Harvard Style of referencing must be used throughout the article and conclude with a separate page for the reference list. For assistance with referencing, please refer to the Style Manual for Authors, Editors and Printers (6th edn, Wiley & Sons, 2002); or Web sites such as:

www.lib.monash.edu.au/tutorials/citing/harvard.html
www.library.uq.edu.au/training/citation/harvard_6.pdf
www.lc.unsw.edu.au/onlib/ref.html

Acknowledgments

The source of financial grants and the contribution of colleagues or institutions should be acknowledged.

GUIDELINES FOR SUBMISSION OF PAPERS FOR THE REFEREED SECTION

Title page

In addition to the title page outlined above, papers for peer review require a second title page with the title of the article only.

Abstract

All papers for review should include a brief but informative abstract of no more than 150 words. The abstract should describe the central argument or research study and the principal conclusions.

Text

Please ensure that the author(s) and specific organisations cannot be identified in the manuscript prior to it being sent for peer review.

GUIDELINES FOR SUBMISSION OF ARTICLES OTHER THAN THOSE FOR THE REFEREED SECTION

Book review

Book reviews are encouraged and should be of interest to the general readership of JARNA.

Conference paper

To be published in the Journal, conference papers need to be developed into a standard manuscript with abstract, introduction, background, main content, conclusion and reference list. Speaker's notes, slides, transparencies etc. are not acceptable.

Contemporary comment

Features submitted for this section are encouraged no matter how controversial or thought provoking they are. This is where people can challenge current thinking, provide a different perspective or debate topics related to rehabilitation nursing. A guide for length of a feature is 200-1000 words. However, shorter or longer material may be accepted.

Abstract

Presenters of conference papers are encouraged to submit their abstracts for publication, together with the details of the conference at which the paper was presented and contact details.

The Editorial Committee reserves the right to edit any article submission received. This Committee is also available to assist you if required.

Submissions will be considered at any time. They can be sent on disk or e-mailed as follows:

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Victoria, 3127

Or

Email to:

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ARNA
Australasian Rehabilitation Nurses' Association

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PO Box 193
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I acknowledge that by seeking to renew my membership of Australasian Rehabilitation Nurses Association (ARNA), I agree to be bound by the policies and procedures of the Incorporated association as set out in the ARNA constitution and policy.

ARNA

Australasian Rehabilitation Nurses' Association

NSW/ACT Chapter

Administering and monitoring therapeutic interventions

Annual Study Day

Trade displays will be present

Friday	18th	March	2011

Time: 0800-1600

Where: The Epping Club
45-47 Rawson St, Epping

RSVP and non member payment by:
Friday 4th of March 2011

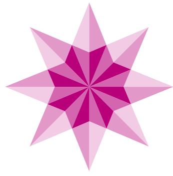
Please Note: to receive free registration to this event ARNA NSW/ACT Chapter individual membership must be current

Free for ARNA NSW/ ACT individual members

$80 for all other delegates

(Includes morning tea and lunch)

For Information and to RSVP please contact: Amanda.Buzio@royalrehab.com.au Tel: 9808 9687 or Sandra.Lever@royalrehab.com.au Tel: 9808 9347



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