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Steven Wells combines two professions to create a garden of tranquillity

Meet your National Committee

The power of touch

ARNA Education Scholarship Fund 2012 – report
Call For Abstracts

On behalf of the organising committee, we invite you to submit an abstract for either an oral or poster presentation at the Conference. We encourage abstracts from clinicians, managers, educators and researchers.

Oral presentations can be either long (30 mins) or short (15 mins) presentations. Both include 5 mins question time.

Please use the abstract template (available at www.arna.com.au) and email abstracts to arna@arna.com.au by the closing date.

Abstracts should be no longer than 250 words plus a speaker profile of no more than 100 words

Closing date: May 31st 2013

Keynote Speaker:
Professor Debbie Kralik (RN, PhD)
Head of Services & Innovation Silver Chain Group incorporating RDNS SA Ltd

Invited Speakers:
Steven Wells
Horticultural Therapist & Clinical Nurse Specialist Austin Health, 2012 - ABC Gardening Australia’s Gardener of the Year

Dr Kerry Reid-Searl (PhD,RN,RM,MClinEd,MRCNA,FCN)
Professor / Assistant-Dean Simulation School of Nursing & Midwifery CQUniversity Rockhampton Campus, Queensland

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Editorial

Julie Pryor RN, RM, BA, GradCertRemoteHlthPrac, MN, PhD, FACN
Editor-in-Chief

JARNA: its purpose and future

JARNA is the public face of ARNA. It makes available to ARNA and non-ARNA members information about ARNA’s professional activities and showcases rehabilitation nursing scholarship. For this reason, I have taken a strategic approach to the development of JARNA. This includes a review of all operating procedures and documentation. The starting point has been the Editorial Board and the aims and scope of JARNA.

This phase of JARNA’s development has begun with a review of JARNA’s Editorial Board functions and membership. The role of the JARNA Editorial Board is: 1) to assist the Editor-in-Chief in shaping the future direction and development of JARNA; 2) to solicit manuscripts as directed by the Editor-in-Chief; 3) to participate in the review of manuscripts; 4) to provide constructive feedback to authors to enhance the quality of their writing and increase the likelihood of reaching publication standard; and 5) to contribute scholarly content for inclusion in JARNA.

An Editorial Board of six to nine people would be ideal and the following criteria for membership of JARNA’s Editorial Board were agreed at a recent ARNA National Committee meeting to guide the selection process:

- all JARNA Editorial Board members will be members of ARNA;
- two-thirds of JARNA’s Editorial Board members will hold a Master’s level qualification;
- half of JARNA’s Editorial Board members will have a publication track record; and
- the professional activities of JARNA Editorial Board members will pose no apparent conflict of interest with the interests of ARNA.

To review the aims and scope of JARNA, I recently surveyed members of the ARNA National Committee for their views about the purpose of JARNA. Two specific themes were evident in their responses. The first was facilitating professional development through the sharing of information. Sharing information about current issues, research, innovations, best practice and trends was described as not only providing information but also as triggering reflection upon practice and providing collegiate support. The second purpose of JARNA was facilitating the development of ARNA members as writers for publication. JARNA’s aims and scope have been updated in the guidelines for submission of manuscripts to reflect these two purposes.

Facilitating professional development through the sharing of information is a purpose common to the journals of many professional organisations. The type of information to be
included in a journal is usually set out in a statement about the various types of articles the journal seeks to publish. Facilitating the development of members as writers for publication, while not unique to JARNA, is a far less common role for a professional journal; it has implications for decisions about the types of articles considered suitable for publication in JARNA and for many of JARNA’s operating procedures.

The work done to date to identify the article types for publication in JARNA has been very thought-provoking; therefore decisions about this require careful deliberation. Examination of the sub-processes relating to the decision to accept or reject a manuscript for publication is questioning the current practice whereby only some articles in JARNA are classified as “peer reviewed”. The current standard practice is for all manuscripts submitted to JARNA to go through a review process to decide: 1) if the content is within scope for JARNA; and 2) to screen for potential to meet the standard of professional writing required for publication in JARNA. While decisions about what fits within the scope of JARNA are editorial decisions, screening for potential to meet the standard of professional writing required for publication in JARNA is a form of peer review. As such, all manuscripts are already being peer reviewed, at least by one person.

Professional writing is frequently described as scholarly or academic writing. Setting criteria and standards for this form of writing in relation to the various types of articles that JARNA could publish is the next step in the development of JARNA. For example, different structure and content would be expected in a manuscript reporting on the conduct and findings of a research project than an individual’s perspective on a professional matter, such as career path options for enrolled nurses. This work will lead to a decision about whether all JARNA content will become peer reviewed.

In this issue of JARNA, a new segment called “Meet your National Committee” commences. Throughout the year, members of the National Committee will be introduced, some in each issue. This time you will get to know members of the National Executive and some of the Chapter presidents. It is hoped that putting a face to a name and knowing a little more about individual committee members will help with communication between ARNA members and their elected representatives, as well as enhance professional networking opportunities.

Also in this edition is an invited paper from Donald Kautz, who was the keynote speaker at our last national conference and abstracts from two other conference papers. These abstracts have been carefully selected, one from Joanne Lawrence because she won the best clinical/research paper and the other to enhance networking opportunities between paediatric rehabilitation nurses. In addition, Terry Wells, the ARNA national president, has shown leadership in the writing for publication arena with an article about constraint-induced movement therapy.

In the next edition of JARNA I look forward to introducing an expanded Editorial Board, the suite of article types JARNA seeks to publish and JARNA’s style guide.

Letter to the Editor

25th February 2013

Dear Julie

In response to "The Nurse Practitioner" by Shaw Multiple in the last edition of JARNAs I was excited to see he mentioned that younger people were at risk of acquiring disabilities. I was, however, disappointed to find that he was referring to young people aged 15-34 years. Every year, in Queensland alone we receive hundreds of referrals to see children 0-15 years who have been injured and require rehabilitation. We are a growing group of nurses who work in the paediatric rehabilitation community, and we are not alone in our mission to help prevent injuries and improve the lives of children and young adults.

With gratitude,

Jennifer Miller
Clinical Nurse Consultant
Queensland Paediatric Rehabilitation Service
President’s report

Since the last edition of JARNA the National Committee has been busy, commencing with a two-day planning meeting during the weekend of 24–25 November. The planning weekend began with a look at the development of ARNA from its conception to where it is today and acknowledging the achievements of past committees. During the course of the planning weekend the National Committee discussed a range of issues and set priorities and objectives for the next two years. Several key areas were identified and subcommittees were formed to review and formulate recommendations.

The national conference organising committee under the leadership of Sandra Lever has commenced planning for the 23rd ARNA National Conference to be held in Sydney in October this year – more information is included in this edition of JARNA and on the ARNA website.

In moving forward, a two-year conference schedule was set with selection of the destination for 2014 national conference being another first for ARNA. Having a two-year schedule allows for the sourcing of possible venues to occur earlier so that potential event clashes can be averted.

Other priorities include a review of the constitution to ensure that it reflects the current practices of the organisation and work on the ARNA website. Redevelopment of the website will be undertaken over the next few months, with the subcommittee presently reviewing a number of templates for suitability for our purposes. Some of the features under consideration are member-only access areas, event registration, and online access for JARNA.
The power of touch

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Abstract

This article is an excerpt from the opening address Don Kautz gave at the 22nd annual meeting of the Australasian Rehabilitation Nurses Association on 19 October 2012. The article defines both skin-to-skin contact touch and non-contact touch, through teamwork, leadership and evidence-based care. The power of touch is illustrated through Mem Fox’s children’s book *Possum Magic*, a Zen parable, and three patient scenarios. All of these illustrate the ability of the nurse and the rehab team to touch our patients in the moment when we provide care.

The power of touch

This manuscript is an excerpt from the opening address I gave at the 22nd annual meeting of the Australasian Rehabilitation Nurses Association (ARNA) on 19 October 2012 in Hobart, Tasmania. I gratefully acknowledge Susie Hooper, Melissa Ceely, and the other members of the conference planning committee for the invitation to present.

I believe we not only touch our patients through the care we provide, but also we touch patients’ lives and their families’ lives through our research and scholarship and through our evidence-based practice. As the editor of the JARNA, Julie Pryor pointed out at the meeting, we must publish our work in order to transform nursing and rehabilitation care. Staff nurses, nursing leaders and nurse educators all demonstrate the power of touch. Nursing leaders touch our patients’ lives through their day-to-day planning, organising, staffing, directing and controlling the work environments where we provide care. Nurse educators touch not only their students’ lives, but also the lives of patients by ensuring that there are new nurses who will take on the challenge of rehab nursing.

Many authors writing about touch have cited Fredriksson’s description of touch in nursing as a state of being there and being with a patient, either through being physically close to the patient, or being in touch with the patient for a flow of feelings to occur between the nurse and patient. Fredriksson differentiates between skin-to-skin contact touch and non-contact touch. Both types of touch can occur during “task-oriented” activity touch, non-verbal “caring touch,” in which feelings of comfort and caring are communicated, and “protective touch,” which is actually the opposite of “caring touch” since the purpose is to protect the patient and nurse through emotional distancing to preserve the energy resources of both. In this paper, touch refers to caring touch, provided both during skin-to-skin contact and in eye contact, when positive emotions are communicated to patients and families during care by being present in the moment.

We touch our patients and their families in our practice when we implement the best practices for pain relief, skin care, bowel and bladder management. Every nurse also practises the art of nursing every day, in the way we work with our patients, with special techniques we have found that work, and in the ways
we individualise our care to meet each patient’s and family’s needs. It is when we combine the science and art of nursing that we truly touch the lives of our patients and their families, as the following example illustrates.

Combining the art and science of nursing illustrates the power of touch

Don was called by Jan, an occupational therapist (OT) who was working with a client living at home. The client, “Sarah,” was moderately obese, had poor vision and had paresis in her hands due to multiple sclerosis. Sarah had become unable to empty her bladder, and she wanted to learn to in-and-out cath herself so she could become continent again. The OT and Don worked together to design a “labia spreader” out of orthoplast splint material which also held a magnifying mirror and a plastic urinal. The urinal had a small hole in the cover so that a catheter could be passed through. Sarah learned to cath herself after two sessions of working together, which included some tears of frustration, moments of encouragement to keep us all going, and some healthy doses of laughter over the silly equipment and positioning. At first Sarah was able to use this equipment to cath herself lying in bed. However, Sarah quickly got better and better, and within days she was cathing herself sitting on the toilet by feeling where to insert the catheter and then the urine running directly into the toilet. She called the OT two weeks later: “My husband and I went out for a romantic dinner and a show. I was able to cath myself in the rest rooms at the restaurant and theatre. We came home, and made love. It was the perfect evening”. The work that all of us did together provided this wonderful, touching moment! Making splints, understanding bladder management, and learning new techniques of self-care required the experience and science that all brought together. The touching moment occurred because the OT and nurse were able to share their collective art and science to empower the client and her partner to create their own future. But just as importantly, Don and Jan also experienced the power of touch, which reminded them of why they went into rehab. Sharing the story of a patient like this one also reinforces the power of the rehab team to touch patients.

We can also touch patients by telling them stories to motivate them and show the value of the rehab team, as is illustrated by the following children’s book.

Mem Fox’s book Possum Magic, lessons for nurses, patients, and families

In my speech, in order to illustrate the power of touch, I read Mem Fox’s Possum Magic, a bestselling children’s book in Australia. Children’s books like Possum Magic work well because they involve characters who are torn about what action to take, but then make a decision and seize the day. Such books focus on today, here and now². Possum Magic is a story of persistence. On her website, Mem Fox notes that the book was rejected by nine publishers when she first wrote it. Sharing this with nurses, patients and families helps them see the importance of persistence. Possum Magic is the touching story of “Hush” who has been made invisible by Grandma Poss’s magic. Hush wants to be seen again, but Grandma Poss can’t remember how to make Hush visible. Then she remembers that Hush must eat people food. They travel to several cities across Australia eating regional cooking. When they finally eat a lamington in Hobart, Hush can be seen from head to tail. Once a year, Hush eats several of the dishes she’s tried to be sure she remains visible.

This book has numerous lessons for rehab nurses, our patients and their families. Just like Hush, our patients have often undergone a major change, often suddenly. Patients with spinal cord injuries, brain injuries, amputations or strokes undergo major transformations and become disabled suddenly. Patients with multiple sclerosis, arthritis and other chronic, degenerative neurological and musculoskeletal diseases experience slower changes, but they also reach a point when they become disabled. And, just like Hush, they may feel they have become invisible to society because of their disability, and they themselves may no longer be able to “see” who they are. What the rehab team does is assist these patients to become visible. Like Hush and Grandma Poss, the patient and family often have to go on a long journey to become independent and get back to living in the community. Each day as nurses work with patients and their families, we can help them navigate this journey and make the transitions easier and more manageable, so that they feel more in control of their future. As nurses we can also help the patient and family to see that even though they have gone through a drastic transformation, they have not lost the essence of themselves. As Dana Reeve told Christopher Reeve in the days after his spinal cord injury, “You are still you, and I love you”³. (p. 28).

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Just like Hush, the patient and family may need to experience some of their old pleasures and family traditions to see that they are not invisible. At every stop on Hush’s journey, she stopped to enjoy the foods and experiences that each city offered. Research has shown that when patients and their families share cherished songs, books, jokes, movies, stories and memories of favourite events, and they engage in other favourite leisure activities during their rehabilitation, these activities help to maintain family integrity, which also makes patients more visible and reminds them of who they are. Each year, Hush ate some of the people foods to be sure she remained visible; similarly, our patients need periodic check-ups, and some rehab interventions to maintain their independence and functional ability.

Finally, the book reminds us that sometimes in the rehab process the patient may experience our touch from a distance as we coordinate interventions that others deliver. In essence, as rehab nurses, we may become invisible to our patients. They may not remember us, or even know we are working towards their independence. Sometimes our greatest successes occur when we are invisible – when patients have truly taken control of their rehabilitation and their future. I encourage you to read Possum Magic to your patients and their families, as well as to the staff on your rehab team, to “touch” them, and remind them of why they work in rehab. Just like Hush, who ate a vegemite sandwich, a piece of pavlova and half a lamington every year to remain visible, we all need occasional reminders of why we are here.

A Zen parable for rehab nursing

In my speech I also shared a Zen parable which may touch nurses, patients and families, and assist with the rehabilitation process. In this parable a man is being chased by a tiger. In order to get away, he has no choice but to jump off a cliff. Fortunately, he is able to grab a vine to stop his fall. He looks up, and there is the tiger snarling, 10 feet above him. He looks down, and 10 feet below him, another tiger is snarling. The man realises that in order to stay alive he must hang onto the vine. As he is hanging there, he sees a strawberry growing on the vine. He picks and eats the strawberry, enjoying its sweetness. This parable illustrates that even when there is nothing that can be done about the circumstances we find ourselves in, we can still stop and enjoy the moment. Nurses can assist patients to enjoy the strawberries that come to the patient each day. When rehab nurses help our patients and their families find meaning and enjoyment in the moment, we also find meaning in the moment for ourselves, providing ourselves with renewal. This is the wonder and joy in the power of our touch.

Touching patients and their families through our care, teamwork and leadership

Touching our patients is also enhanced through leadership and teamwork. Rehab nurses can become leaders by joining the Australasian Rehabilitation Nursing Association (ARNA), using materials from the ARNA website, implementing ideas from articles in JARNA, and working with the rehab team. When we combine leadership and teamwork with our personal care, our belief that growth and independence are possible, and our ability to make patients and families the centre of the rehab team, the power of our touch is multiplied manyfold, as is illustrated by the following patient scenario.

“Mary” was an intensive care unit (ICU) nurse in a small, rural hospital in a Midwestern state in the US. She had worked in the ICU for over 20 years, and she was one of the experts that everyone relied on in the ICU. Mary had been married to “John” for about 10 years. Mary and John had met by answering a farm journal advertisement. One day, John was “found down” on the farm by a neighbour, and admitted to the ICU, having suffered anoxic brain damage. His ICU stay was complicated by multiple infections and adult respiratory distress syndrome, which brought him to the brink of death three times during his prolonged ICU stay. Physical therapy was started in the ICU at Mary’s insistence and the nurses worked aggressively with him so that when he came off the ventilator and stabilised, he was ready to transfer directly to the rehab unit. Paula, the ICU nurse manager, said to the rehab unit staff, “We have let Mary run the show here in the ICU” and reported that all the ICU nurses had worked together to ensure John had lived and thrived in the ICU. She said: “All of you have to understand. We all love Mary and John. And it’s not just that, Mary and John are so in love, when any of us see them together, they restore our belief in marriage and what our own relationships might be. We could not let John die”. She then went on to say that we were going to have to let Mary be in charge on the rehab unit, and to expect that nurses from the ICU would be regularly coming to the rehab unit to help out with John’s care. Mary and the ICU nurses developed a full-day schedule of activities for John, which included additional exercises done in the evening to reinforce what was learned in his occupational, physical, speech and recreational therapy sessions during the day. The staff on the unit, with the help of the ICU nurses, ensured that every day John’s plan was completed and documented in a notebook they had created, which was
kept in John’s room. After six weeks, John had reached a plateau. Although he could perform all his activities of daily living (ADLs) with only minimal cueing, and he could walk with only stand-by assistance, he still had cognitive deficits which would prevent him from living independently at home. When he made no further improvement for another week, the rehab team had no choice but to discharge him. Mary then revealed for the first time to the rehab team that John had always been “a little slow” mentally and that he was actually close to baseline. When the team asked why Mary had not revealed his mental limitations earlier, she said, “Because if I had, you would have given up on him weeks ago”. Mary took John home, where, with the help of a young, adult neighbour who was home from college for the summer, he was able to resume many of the farm tasks he had always done. After six weeks, he was able to manage completely on his own.

John and Mary’s story illustrates three major principles of rehab. The first is the value of placing a family that is motivated to gain the most from rehab at the centre of the team. The second is the importance of believing in achieving the best outcome, and continuing to believe that independent living in the community may be possible if the rehab plan is instituted diligently every day, by everyone. The third is the value of reinforcing and following through with therapies by the nursing staff and family. Finally, Mary and John illustrate what is possible through the power of touch. Sometimes, however, a non-traditional approach is what is needed, as is illustrated in the following scenario about “Casey”.

A non-traditional approach illustrates the power of touch

“Casey” was a newly injured C 5-6 quadriplegic who had a prolonged stay in the ICU. He was so anxious that he “fought” the ventilator, resulting in several unsuccessful weanings. Twice he was completely weaned, but became so anxious that he tired out and came close to respiratory arrest before being placed back on the ventilator. The only nurse who could “stand” to work with Casey was Cindy, and even with Cindy caring for him, Casey had many more bad days than good. Then one evening, Cindy’s husband, Bill, came to pick Cindy up from work. Bill came into the ICU and went up to Casey’s bed. Bill said, “Casey, I am Bill. I am Cindy’s husband. Let me tell you, when you have a good day, I have a good day. When you have a bad day, I have a bad day. And you damn well better start having more good days”. This confrontation was transformative for Casey, as he saw how his anxiety and poor coping were affecting everyone around him. He learned how to control his anxiety, and within days, he stabilised, came off the ventilator for good, and was transferred out of the ICU. Casey said, “Cindy saved my life, many times. But Bill reminded me that I am a man”. It is important to point out that Bill’s intentions were good ones; he wanted Casey to do better, and he conveyed that Cindy would continue to care for Casey even on the bad days, but he truly wished for him to have better days. This non-traditional approach of non-contact caring illustrates that there is a wide range of interventions available to nurses to motivate patients, as long as these interventions are implemented in a spirit of caring.

The power of the moment

The scenarios and strategies presented here all show the power of the moment to touch patients and their families, as well as nurses and the rest of the rehab team. We have to be sure that we do not get so caught up in our tasks that we forget to see the reason behind the tasks. By focusing on how we are touching our patients as we provide care, we have the potential to transform experience for everyone while meeting our goals as rehab nurses. ARNA defines the “goals of rehab nursing as: the maximisation of self-determination; the restoration of function; and the optimisation of lifestyle choices for their clients” (www.ama.com.au). As we recognise the growth of our patients as they become independent and see their future, full of hope, we are reminded of why we became nurses in the first place. My hope is that each of you will continue to create touching moments in your practice and thus ensure the future of rehab nursing in Australasia.

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References

Abstract
The limited use or the inability to use the upper limb is a major impairment following stroke. Constraint-induced movement therapy (CIMT) is argued to be the means through which functional return of the affected limb can be achieved because it challenges the compensatory focus of traditional rehabilitation. Current stroke guidelines recommend CIMT to be incorporated within stroke rehabilitation programs. The purpose of this paper is to explain CIMT, present evidence supporting CIMT and to describe selection criteria for CIMT post-stroke.

Introduction
The inability to use or the limited use of an arm or hand can be a major impairment following stroke. Upper limb impairment is argued to have a high incidence amongst stroke survivors with only a small percentage regaining full function of the affected arm or hand. Traditional rehabilitation interventions have been reported to focus on the stroke survivor learning compensatory strategies with the unaffected or least affected arm and hand for a functional discharge home. There is, however, a suggestion within the literature that stroke rehabilitation should have a therapeutic focus on the restoration of functioning in the affected arm, with constraint-induced movement therapy (CIMT) as a recommended therapy. This challenges the compensative concepts of traditional stroke rehabilitation. With the aim of functional return to the hemiparetic arm and hand it is argued that CIMT fits with the rehabilitation goal of return to premorbid functional status. The purpose of this paper is to explain CIMT, present evidence supporting CIMT and to describe selection criteria for CIMT post-stroke.

What is CIMT?
CIMT is a means by which some stroke survivors can regain functional use of their hemiparetic upper limb and as a result experience improved quality of life. It has been described both...
as a physical therapy that facilitates improved motor functioning\(^5\) and a behavioural approach that requires stroke survivors to overcome learned non-use of an affected upper limb\(^6\)–\(^9\). Although research\(^1\)–\(^7\) has shown that CIMT facilitates functional return to the hemiparetic upper limb following stroke, Van der Lee\(^8\) argues that behavioural, learned, non-use theory is based on clinical assumptions and the non-use of the affected limb may be strongly related to sensory disorders rather than behavioural in nature.

CIMT is based on animal research where deafferentation of monkey forelimbs resulted in the non-use of that limb and through restriction of the unaffected limb the monkeys regained use of their deafferentated limb\(^3\)–\(^6\)–\(^9\). Van der Lee\(^8\) argues that non-use of the limb is a learned behaviour brought about by repeated failure in continued attempts to use the deafferentated limb, resulting in adaptation by the monkeys through development of compensatory strategies with the unaffected limb which supports and reinforces the non-use of the affected limb\(^3\)–\(^9\). Restriction of the unaffected limbs shortly after deafferentation forced the monkeys to use the affected limb and they regained use of that limb\(^3\)–\(^6\)–\(^9\). Non-use of the hemiparetic arm by humans following stroke is thought to be similar to the behaviour demonstrated by the monkeys which led to research into the application of CIMT with stroke survivors\(^3\).

CIMT post-stroke combines restraint of the unaffected or less affected upper limb with the repetitive use of the hemiparetic upper limb during retraining to perform activities of daily life for the majority of the person’s waking hours with a minimum of six hours per day\(^1\)–\(^3\)–\(^5\)–\(^9\). Varying methods of restraint to immobilise the unaffected upper limb have been reported, including slings\(^3\), resting splints\(^5\) and mitts\(^2\). While the unaffected arm is restrained the stroke survivor receives training and repetitive practice in adaptive tasks and usual, day-to-day activities such as grasping, pinching, lifting and moving objects\(^2\). Although therapy is reported to be administered for five out of seven days for a two-week period, participants are encouraged to wear the restraint and continue use of the affected arm outside of therapy for the entire two weeks\(^2\). Reduced upper limb impairment and improved motor function are reported outcomes of CIMT, with effects lasting long term.

CIMT challenges traditional stroke rehabilitation thinking through a shift of focus from compensation to functional restoration. Brogardh and Sjolund\(^1\) explain traditional stroke rehabilitation treatments as concentrating on compensatory technique training of the unaffected arm for independence, whereas CIMT requires intensive focus on the affected upper limb to regain functional use within day-to-day life. This view is shared by Dromerick, Edwards and Hahn\(^7\). CIMT is argued by these writers to require more resources in comparison to traditional rehabilitation interventions, especially given the amount of therapist time. Brogardh and Sjolund\(^1\)–\(^2\)–\(^4\) present this argument as a reason for its limited implementation in clinical practice stating that “physical and occupational therapist believe that their facilities did not have the resources to administer constraint-induced therapy”. They also believe that the implementation of CIMT is further limited by varying degrees of training amongst therapists and rehabilitation facilities. However, adaptation of CIMT for use in small group use is one means for increasing use of CIMT\(^1\).

**Evidence supporting CIMT**

Several studies into the implementation and effects of CIMT as a stroke treatment have been reported within the literature since the late 1990s. In their review of research into CIMT Taub et al.\(^9\) reported that CIMT had low risks, was medication free and recipients had an increased motor ability and had a greater hemiparetic arm use in everyday living. Blanton and Wolf\(^3\) also reported improved motor abilities within their case study participant and indicated that the participant was generally more active post-treatment than pre-treatment arguing that CIMT would be beneficial to around 25% of stroke victims. In their study of 23 patients, Dromerick et al.\(^7\) investigated if CIMT reduced arm impairment post-ischaemic stroke and using the functional independence measure (FIM) as an outcome measure identified that there was a significant difference in FIM scores for eating, grooming, bathing and upper and lower dressing in favour of the treatment group, thus suggesting improvement in upper limb functioning. From a preliminary study into motor recovery and cortical reorganisation following CIMT involving four patients,
Schaechter et al.\(^5\) concluded that improved motor functioning of the hemiparetic limb was associated with an increased motor cortices activation within the undamaged hemisphere of the brain. Wolf et al.\(^2\) reporting on a randomised controlled trial consisting of 222 participants (116 in the control group and 106 in the intervention group) investigating the effects of CIMT on upper limb function three to nine months post-stroke also concluded that CIMT resulted in improved motor function but added that the level of motor function remained at 12 months post-treatment. In a study assessing pain, fatigue and the intensity of practice on 41 stroke patients receiving CIMT Underwood, Clark, Blanton, Aycock and Wolf\(^10\) found that fatigue and pain were not increased due to the intensity of therapy and that CIMT resulted in a significant improvement of upper limb function as identified by changes between pre- and post-Wolf Motor Function Test (WMFT) and Fugi-Myer Assessments (FMA) scores. Brogardh and Sjolund\(^1\) used a pilot study to explore the effects of CIMT on small group training and concluded that the small group environment did not affect the positive effect of CIMT. The NSF\(^4\) clinical guidelines recommendation to the use of CIMT is based upon the evidence provided within the research.

**CIMT selection criteria**

The current national guidelines for stroke management in Australia recommend that stroke survivors be provided with opportunities to practise upper limb activity to facilitate functionality of the limb\(^6\). CIMT is one of the therapies recommended for selected stroke survivors. However, while no selection criteria are provided by the NSF\(^4\), they are reported in the various studies. Firstly, the recipient should be cognitively functional as the patient needs to understand the requirements of the therapy in order to give consent to participate. Wolf et al.\(^2\) suggested that three to nine months post-stroke onset is when CIMT should be implemented as this allows the period for spontaneous recovery to pass. On the other hand, Dromerick et al.\(^7\) and Grotta et al.\(^11\) suggest that CIMT should be introduced within the first weeks post-stroke. Other criteria include the presence of hemiparesis and restricted wrist and finger extension\(^2,8\). One could argue from this discussion that any stroke survivor with a resultant hemiparetic upper limb with some residual movement and who is cognitively able is eligible to participate within a CIMT treatment program.

**Conclusion**

As a therapy through which stroke survivors can regain the functional use of their hemiparetic upper limb, CIMT fits with one aim of rehabilitation, that is, to return patients to their premorbid functional status. For CIMT to become commonplace in stroke rehabilitation, reorientation from the compensatory approach to an emphasis on functional return is required.

**Acknowledgement**

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**References**

Failure to manage chronic constipation in community dwelling older people who have Parkinson’s disease (PD)

– An overt opportunity for the rehabilitation nurse

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Abstract

Aims This paper presents a mixed method PhD study, undertaken at the University of Sydney, School of Medicine. The findings from this study offer an overt opportunity for nurses to change current clinical management of chronic constipation and its negative effect on the quality of life of the person with a degenerative neurological disease.

Methods A convenience sample of 67 people was interviewed about their experiences of constipation. Quantitative measures of symptom severity and frequency were triangulated alongside qualitative data collected via telephone interview.

Results This study found 89% of study participants complained of chronic constipation. These people, in particular, experienced significant and prolonged straining at stool; 19% reported regular cyclical occurrences between constipation and diarrhoea; 16% were hospitalised with bowel obstruction; 16% were referred to medical specialists for colonoscopy; less than 5% followed a neurological bowel regime with most taking irregular and multiple prescribed and non-prescribed laxatives; 42% complained of social isolation due to fear of faecal incontinence resulting from this poor bowel management; and 46% complained of significant levels of pain which they directly attributed to constipation. Even though 79% reported constipation to their health practitioner, 95% stated they were either very unsatisfied or unsatisfied with the information or care they received.

Conclusion There is a failure to manage neurological induced constipation for those people living in the wider community. These people report that medical judgement is limited by stereotypical views of the older person; accordingly, there is a failure to treat symptoms of a degenerative neurological condition appropriately. This study also revealed that people with PD have insufficient understanding of how to use laxatives appropriately, which ultimately increased their social isolation and decreased their confidence in the continued use of laxatives.
Paediatric rehabilitation nursing innovations in Queensland

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Abstract

The Queensland Paediatric Rehabilitation Service is a statewide rehabilitation program and provides multidisciplinary, family-centred services to those children with acquired brain injury, spinal cord injury and/or limb deficiency.

Paediatric rehabilitation nursing begins in the acute phase of injury/illness or disease, continues through the ongoing rehabilitation phases, supporting the children to reach their full potential, and ends when children finish their schooling years and transition into adult services. Depending on the age the child at the time of injury, the paediatric rehabilitation journey can be a long road and involve many challenges before the child reaches adulthood.

In our work as paediatric rehabilitation nurses, we have initiated and/or been integral in the planning and implementation of new projects and services aimed at ‘touching’ the lives of our patients and their families in a way that will improve their experience and rehabilitation journey. Three of these initiatives were discussed including the outcomes and future of the services.

1. Transition project
developing a specific nursing care plan for this program to transition adolescents from paediatric to adult services

2. Limb deficiency projects
Limbs for Living Project (providing recreational limbs to improve the quality of life for children and their families)
New Limb Deficiency therapeutic play groups
‘The grief of growing up with a limb deficiency’ Case Study

3. Mild Traumatic brain injury case management service
A new model of delivering appropriate education and support whilst reducing the clinic waiting list, and ensuring no patient misses out on the required services

Speaker profile: Jennifer Miller
Jennifer Miller has extensive experience as a paediatric nurse in a variety of medical and surgical settings over the last 13 years. For the last seven years, Jennifer has worked as the Queensland Paediatric Rehabilitation Service Clinical Nurse Consultant, and for a year as the Program Manager of the Queensland Paediatric Rehabilitation Service. In 2007 she received a Churchill Fellowship for work in investigating paediatric rehabilitation services and models of care in America and Canada.

Speaker profile: Suzanne Simpson
Suzanne Simpson is celebrating her 20th year as a paediatric nurse working at the Royal Children’s Hospital in Brisbane. Suzanne has worked in a variety of complex care clinical settings during this time, most recently specialising as the Clinical Nurse Queensland Paediatric Rehabilitation Service. Suzanne has a special interest in limb deficiency and development of this service and potential research opportunities.
Abstract

In subacute services in Australia, enrolled nurses (ENs) make up a significant proportion of the nursing workforce, but their contribution is not clearly defined or documented. This descriptive, qualitative study engaged registered nurses (RNs) and ENs working in one Australian rehabilitation centre, in an exploration of their perceptions of the EN role, and, the articulation of the two levels of nurse registration in this clinical setting. Findings demonstrate that two types of ENs work in rehabilitation: those who actively practise within a rehabilitation philosophy (the rehabilitation EN) and those who focus on task completion (the non-rehabilitation EN). The rehabilitation EN is committed to enabling self-care and understands the roles of other members of the multiprofessional team. In addition, differing opinions regarding the relationship between RNs and ENs were uncovered. RNs report that ENs work under the direction of RNs, using language that suggests a hierarchical situation. However, in contrast, rehabilitation ENs describe this relationship as more collegial, suggesting that they perceive themselves to hold a similar level of responsibility. This finding has implications for RN and EN scopes of practice.

Keywords: enrolled nurse, rehabilitation, Australia.

Introduction

A growing interest in the second level or enrolled nurse (EN) role in Australia has highlighted that the relationship between the EN and the registered nurse (RN) has posed problems for health professionals for many years. In a national review of the role and function of the EN, Gibson et al.¹ identified ongoing reports of under and over-utilisation of the EN role suggesting that confusion exists. Inconsistencies in practice and role confusion continue to be reported in more recent state reports²-⁴ and a particular consequence of this confusion is that ENs have regularly been reported as practising beyond their regulated scope of practice¹,²,⁵,⁶.
Because ENs now work widely throughout the health system, with many in specialist practice settings, their roles have diversified. In particular, there appears to be a lack of recognition of the contribution of ENs in specialty practice settings. Rehabilitation is one such specialty setting, but the literature provides no guidance about the nature and extent of their specific contribution. Unlike their RN colleagues, who can look to the Rehabilitation Nursing Competency Standards for Registered Nurses for guidance about what is expected of them or their scope of practice, ENs must rely solely on the generic Competency Standards for Enrolled Nurses.

This situation is problematic for a number of reasons. Firstly, these standards are naturally broad as they apply to EN practice regardless of setting. Secondly, they are entry-level standards and do not indicate what should be expected from experienced ENs. Thirdly, they do not address practice in specialty settings. As such, there is no formal and agreed mechanism for standardising or developing the contribution of ENs to patient rehabilitation.

Two Australian studies provide more compelling reasons for clarification of the EN role in rehabilitation. Ambiguity about the roles of RNs and ENs is a major finding in a study conducted in five inpatient rehabilitation units in regional New South Wales. Further evidence of this ambiguity emerged in the findings of a study conducted in an inpatient rehabilitation unit in Melbourne. Specific examination of the EN contribution to patient rehabilitation in Australia is therefore warranted to help clarify the boundaries of and overlap between two roles. This paper is the second and final article reporting on this study.

Methods

As described in an earlier report of this study, a descriptive qualitative design was used to specifically explore EN and RN perceptions of the EN role and the articulation of the EN and RN roles in rehabilitation. The principal investigators, two RNs with rehabilitation expertise, collected and analysed all the data. The project began after approval was granted from the relevant institutional human research ethics committee.

The setting

This research was conducted at a stand-alone rehabilitation facility that provides inpatient and non-inpatient rehabilitation services. The nursing skill mix in the inpatient units includes RNs, ENs and assistants in nursing, supported by nurse managers, clinical nurse consultants, nurse educators and a nurse researcher.

Participants

Most of the 23 nurse participants were female. See Table 1 for demographic details of the EN and RN participants.

Data collection and analysis

Participants provided data through participation in a variety of group activities. One group comprised RNs and ENs in clinical roles, another comprised RNs in senior roles and a third involved ENs only in a one-day workshop. The Delphi technique was used to facilitate the engagement of the groups in an iterative process and provide feedback on each other’s perceptions and reports.

Data analysis was conducted by both researchers in an iterative manner. One would present a draft analysis of sections of data or stage of data analysis for comment by the second researcher. Both discussed the second researcher’s feedback which was used to further develop and refine the analysis. Data analysis stayed close to participants’ actual words to produce a rich thematic description of all the data collected.

Table 1: Demographic characteristics of participants

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Years of nursing experience</th>
<th>Years of rehabilitation nursing experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENs</td>
<td>23–60 years</td>
<td>0.33–35.5 years (mean 17.05)</td>
<td>0.33–19 years (mean 9.42)</td>
</tr>
<tr>
<td>RNs</td>
<td>25–57 years</td>
<td>3–30 years (mean 20.5)</td>
<td>3–20 years (mean 10.56)</td>
</tr>
<tr>
<td></td>
<td>(mean 47.26)</td>
<td>(mean 17.05)</td>
<td>(mean 9.42)</td>
</tr>
<tr>
<td></td>
<td>(mean 41.87)</td>
<td>(mean 20.5)</td>
<td>(mean 10.56)</td>
</tr>
</tbody>
</table>
Findings

Analysis of data revealed that ENs contribute to inpatient rehabilitation through direct and indirect patient care activities. Much of their time in the clinical setting is spent providing direct patient care, especially working with patients with activities of daily living. Study participants talked about two types of ENs working in rehabilitation services and about how their practice differed. These differences influenced the nature of the relationship between ENs and RNs.

Two types of ENs work in rehabilitation services

Study participants identified two types of ENs working in rehabilitation and described them as the "rehabilitation EN" and the "non-rehabilitation EN". Characteristics of the rehabilitation EN were reported to include having an understanding of rehabilitation as a philosophy and a commitment to enabling self-care. As such, the rehabilitation EN uses a collaborative approach where the nurse works in partnership with the patient. Communication is a key component of enabling self-care as knowledge of the individual patient is used to tailor nursing care. The practice of the rehabilitation EN is underpinned by the goal setting process and implemented using a 'hands-off' approach, where coaching patients forms a significant aspect of nursing care.

Findings reveal that it was not uncommon for very experienced rehabilitation ENs to require minimal direct supervision from RNs in relation to supporting medically stable patients on their rehabilitation journeys. This becomes possible when rehabilitation ENs develop an in-depth understanding of each patient’s individual goals, strengths and weaknesses, as well as an understanding of the roles of each of the disciplines on the multiprofessional rehabilitation team. In relation to medically stable patients, the relationship between the rehabilitation EN and the rehabilitation RN was described as more collegial than supervisory.

However, not all ENs who work in rehabilitation settings were reported as demonstrating or possessing rehabilitation knowledge and skills. These ENs were described as non-rehabilitation ENs. A non-rehabilitation EN is an EN who practises task-focused nursing, where nursing care is driven by the identification and completion of a series of tasks. These ENs were described as having little understanding of, or commitment to, the philosophy of rehabilitation. Participants also noted that an EN can work in rehabilitation for many years and still not demonstrate rehabilitation EN characteristics.

The nature of the relationship between ENs and RNs in rehabilitation

Exploration of the working relationship between ENs and RNs was facilitated by discussion of two specific clinical problems, namely functional urinary incontinence and impaired swallow. Within this context, rehabilitation ENs were described as providing more comprehensive nursing care than non-rehabilitation ENs. They are able to provide greater degrees of patient instruction and support, liaise more frequently with other members of the rehabilitation team, and contribute to the monitoring and evaluation of patient progress by reporting relevant details to the RN.

Participants acknowledged that the development of rehabilitation expertise required commitment on the part of individual ENs and there was no doubt that all participants valued the contribution of rehabilitation ENs to patient rehabilitation. Nevertheless, RNs and ENs described the relationship between RNs and ENs differently.

RNs reported that ENs work under the direction and supervision of the RN. According to RNs, ENs are required to gather information about the patient and report the information they gather back to the RN. ENs contribute to care planning but are not responsible for it. The information they gather during their close contact with the patient when assisting with daily routines is vital to the care planning and goal setting processes. They are required to implement patient care plans and follow instructions from RNs. They are responsible for documenting and reporting patient progress towards, or deviation from, goal attainment. They are also responsible for reporting directly to the RN any aspects of the planned care that potentially pose a risk to safety to the patient or others.

ENs, however, reported they work alongside RNs, using words like “consult with” rather than “as directed” or “instructed”. However, this relationship was noted to change when the patient’s condition changes. ENs were clear about their role boundaries when faced with a potentially dangerous change in
the patient’s condition. They saw themselves as responsible only until they reported the change to the RN.

**Discussion**

Collectively, participants in this study worked with patients who had a wide range of rehabilitation needs and they had many years of experience working as nurses in rehabilitation settings in Australia. In these settings, ENs account for a significant proportion of the nursing workforce and as such the participants were a valuable source of information about the EN role.

A most important finding of this study is the recognition of two types of ENs employed in inpatient rehabilitation. Rehabilitation ENs possess an understanding of rehabilitation as a philosophy and a commitment to enabling nursing self-care. In contrast, a non-rehabilitation EN practises task-focused nursing, where nursing care is driven by the identification and completion of a series of tasks. They possess little understanding of, or commitment to, the philosophy of rehabilitation. A major concern is that some ENs were reported to not demonstrate rehabilitation EN characteristics even after working in rehabilitation for many years. Nurse participants in another Australian study9 expressed the same view.

Rehabilitation ENs enhance the effectiveness of RN patient management and coordination of care and nursing’s overall contribution to patient rehabilitation is greatly dependent on the skills of the EN workforce. However, as recognised elsewhere9,10, the distinction between RN and EN roles becomes more blurred. It seems that very experienced rehabilitation ENs require minimal direct supervision from RNs in relation to supporting medically stable patients on their rehabilitation journeys. As such, in relation to medically stable patients, the relationship between the rehabilitation EN and the rehabilitation RN tends to be more collegial than supervisory. In contrast, the non-rehabilitation EN was generally considered to require greater and closer supervision from RNs than rehabilitation ENs. This second category of EN required instructions to complete basic aspects of care that a rehabilitation EN would automatically do.

This means a range of definitions of “supervision” is needed to operate as part of everyday nursing practice in rehabilitation. A lack of clarity around supervision and delegation requirements has been reported elsewhere as a significant contributor to tension between the two roles1,2,5,14,15. Interestingly, the findings of the current study suggest that in rehabilitation, the lack of clarity relates to not only the possession of rehabilitation expertise by the EN, but also to the acuity of individual patients.

A second key finding is that ENs and RNs working in rehabilitation seem to possess different understanding of the relationship between the two groups. ENs reported they work alongside RNs, using words which suggest they perceive themselves to have similar levels of responsibilities as RNs. However, when faced with a potentially dangerous change in the patient’s condition, this relationship seems to change, with ENs feeling responsible only until they had reported the change to the RN. Pryor9 reported a similar finding regarding the increased RN role and decreased EN role when patients are not medically stable. In that study, involving 53 nurses working in five inpatient rehabilitation units across NSW (18 of whom were ENs), Pryor9,10 found that difficulty identifying a rehabilitation-specific role for RNs was a major contributing factor of role ambiguity that nurses experienced in rehabilitation.

In the current study, RNs were much more explicit than ENs in describing the EN as working under the direction and supervision of the RN. The RN understanding reflects the Australian Nursing and Midwifery Council (ANMC)8 National Competency Standards for the Enrolled Nurse statement, namely:

> Core as opposed to minimum enrolled nursing practice requires the enrolled nurse to work under the direction and supervision of the registered nurse as stipulated by the relevant nurse registering authority8(p. 1).

At the same time, ENs working alongside RNs could indicate the EN is “an associate” to the RN as described in the National Competency Standards for the Enrolled Nurse8(p. 1). While this may seem initially confusing, the specific nature of this associate role is explained explicitly as the EN working under the direction and supervision of the RN.

Two studies exploring the perceptions of RNs who had previously practised as ENs14,16 provide further insight into these differing perceptions. Along with Pryor9, these two additional studies indicate ENs possess a limited understanding of the RN role.
Dixon’s qualitative study of a group of six New Zealand RNs who had previously worked as ENs (including herself) suggested that clinical knowledge and accountability were the primary reported differences. As ENs, Dixon’s study participants had limited responsibility, which finished once they had reported to an RN or doctor. Once working as an RN they understood this increased responsibility and accountability meant they had to “see things through from start to finish”\(^\text{14}\). They were now the nurse who was ultimately responsible for ensuring patients received safe and effective clinical care. In addition, their increased knowledge base enabled them to understand and rationalise changes in patient status and guide their decisions in clinical care. This was different from when they had worked as ENs. As ENs they did not have the assessment skills or knowledge base to make safe and appropriate, complex nursing decisions. The theme of increased accountability and responsibility is repeated in a phenomenological study\(^\text{16}\) examining the experiences and needs of nine nurses in a South Australian hospital during their transition from EN to RN.

The findings of this current study indicate an additional contributing factor to the ambiguity about the roles of RNs and ENs in rehabilitation, that is, the relationship between rehabilitation ENs and allied health staff. Rehabilitation ENs commonly communicate directly with their allied health colleagues about the rehabilitation needs of individual patients. In so doing, the RN can be left out of the communication loop. This can compromise the ability of individual RNs to fulfil their coordination responsibilities as described in the national RN competency standards\(^\text{17}\) and the rehabilitation competency standards for RNs\(^\text{7}\). Pryor\(^\text{9}\) also reported this finding.

**Implications of the findings**

**Implications for nursing practice and education**

While this study has illuminated the EN contribution to rehabilitation, at best this can only be regarded as the potential EN contribution. All ENs employed in inpatient rehabilitation wards need to contribute optimally to patient rehabilitation. They all need to be rehabilitation ENs. Support is needed for the development of all ENs working in rehabilitation to become rehabilitation ENs. This begins with a clear understanding of the role of the EN in individual rehabilitation wards.

Clarifying the EN scope of practice in this way is beyond the National Competency Standards for the Enrolled Nurse\(^\text{8}\). Within the bounds of relevant legislation, policy and national competency standards, this becomes an organisational responsibility as part of clinical risk management\(^\text{18,19}\).

This, however, will only go part of the way to addressing role ambiguity between RNs and ENs in rehabilitation. The RN scope of practice also needs clarification and RNs need guidance and support to develop their rehabilitation nursing leadership potential at an organisational level\(^\text{19}\). These actions are critical building blocks for optimising nursing’s contribution and for increasing RN and EN job satisfaction in rehabilitation. This, in turn, may help attract more nurses to work in rehabilitation.

**Implications for rehabilitation service delivery**

Rehabilitation service delivery is a complex phenomenon. It involves staff from an ever-growing range of disciplines seeking to use their expertise to improve patient outcomes. While the proliferation of clinical specialties in rehabilitation has been a strong feature of the past 50 years, the more immediate priority is not the development of expertise, but the bringing together of existing expertise in the most clinically effective and cost-efficient way. This must be done while ensuring that the person who is the patient is central to all the processes of rehabilitation service delivery, as everyone works towards goals that are personally meaningful to each patient.

While role expansion is not without its challenges\(^\text{20}\) and needs to be supported with educational preparation and clear practice guidelines\(^\text{15}\), the full potential of the EN in rehabilitation is yet to be fully realised. This current exploration of the EN role contributes to understanding their current involvement from which development of their potential can be explored.

Additionally, the findings of this study indicate a need to clarify the most effective communication channels for sharing with allied health staff the valuable information ENs possess about patients. While the National Competency Standards for the Enrolled Nurse\(^\text{8}\) encourage cross-disciplinary collaboration, exactly how this should happen is an organisational decision.
Limitations of the study and suggestions for further research

While the number of participants in this study was not small by qualitative research standards (n=23), the broad nature of the phenomenon under study and that all participants were recruited from the one organisation means that this should be considered an exploratory study. Furthermore, sole reliance on participants’ reports may also be considered a limitation.

Nonetheless, together with the findings of previous Australian studies, the findings of this exploratory investigation of the role of the EN in rehabilitation in Australia suggest ongoing research is warranted. In line with suggestions following a review of the literature about the differences between RNs and ENs in Australia, further investigation of the relative contributions of ENs and RNs to the rehabilitation of patients experiencing the full range of problems that typically bring patients to rehabilitation would be the ideal foundation for the systematic development of both levels of nurse. An alternative approach might be to pilot draft statements about the two roles developed using the Delphi technique involving rehabilitation nursing experts from across the country. Such statements could build upon the ARNA competency standards for RNs and include rehabilitation nursing assessment and planning tools, the evaluation and refinement of which would be part of the pilot.

Conclusion

In Australia, both RNs and ENs are required to work within nursing’s professional practice framework, which is explicit about ENs working under the direction and supervision of a RN. However, the findings of this study suggest that ENs can, and do, develop expertise in a particular field, which may expand their scope of practice, and alter the relationship between RNs to ENs. In rehabilitation, it appears that a specialist EN role can contribute to enhanced patient outcomes and provide support to non-specialist ENs. Further research is needed to explore the implications of a specialist EN role, especially the impact an expanded scope of practice might have on mandated RN supervision models.

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Preventing a job application – some do’s and don’t’s

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This article is one of an occasional series on topics of interest to the author; he has read many job applications.

Nurses applying for positions may have had little or no coaching in preparing employment applications. The intent of this article is to provide practical advice to ensure that an application is comprehensive and optimises the applicant’s chances of obtaining their ideal employment position.

An application contains a cover letter and curriculum vitae (CV). The cover letter contains your contact details and three paragraphs to:

• show that you understand the position you are applying for;
• state your aptitude and expectations from the position; and
• state what you expect from the employer.

The CV (sometimes called a resumé) is the documentation of your experience relevant to the position you are seeking. It will range from one to four pages depending on your experience. It must include:

• employment history;
• clinical, education, teaching or research experience/history that is relevant to the position;
• commissioning or special projects experience;
• publications;
• professional affiliations; and
• contact details for your referees.

On a more general note, here are some specific pointers:

• Imagine you are the recruiter – what does he/she need to know about you?
• Read any instructions carefully.
• Ask for the position description and selection criteria (you can then write specifically to those requirements).
• Make it easy for the recruiter to contact you – include landlines, mobile and email address.
• Be concise.
• Stress why you will be successful in the position.
• Write clearly about your motivation.
• Define your professional objectives: if you are weak in an area, make it an educational goal; the recruiter will respect a nurse who can define her/his learning needs.
• Highlight relevant experience: an example would be if you did volunteer work in a community setting; it may have relevance to the work scenario.

The style of writing used in an application is important:

• Use a standard format throughout your document.
• Get a knowledgeable person to proofread your application.
• Ensure there are no typographical errors (the recruiter will infer that your CV represents your documentation standard).
• Consider including a photograph; it may distinguish you from other applicants.
Address your application specifically to the recruiter with their correct title; attention to detail impresses: “To whom it may concern” will not get a favourable response.

Search the internet for a template that suits your writing style.

Deal with gaps in employment; add concise information that indicates your choices (travelling, family, other activity).

Here are a few common errors to be avoided:

- Repeating the same information in the cover letter and CV (because the applicant isn’t sure what to write).
- Including details of marital status, age or hobbies (the recruiter is not entitled to ask about these details; what they want to know is that you are a reliable worker and manage yourself well).
- Using large-size font and spreading the text over unnecessary pages.
- Making the pages too ‘busy’ with complex overwritten paragraphs.

Finally, here are a few words on referees:

- Most recruiters will be required to check two references/referees.
- Select referees who can attest to the quality of your work.
- It is your prerogative to select referees and the recruiter’s to accept or reject them in that role.
- Friends are not particularly useful referees.
- One of the referees should be a senior staff member who knows about your work performance.
- Coach your referees: tell them about your application, who will contact them and what they are going to say about you.

Vale

Susan Julie JONES passed away at Bendigo Hospice on 16 June 2012. She was passionate about rehabilitation and before her death she was responsible for managing Bendigo Health’s inpatient rehabilitation beds.
Steven Wells combines two professions to create a garden of tranquillity

Lyn McBain
Chapter President Victoria/Tasmania
Email victas@arna.com.au

Steven Wells, a clinical nurse specialist at the Royal Talbot Rehabilitation Centre campus of Austin Hospital located in Kew Victoria and silver medallist at the 2010 Melbourne International Garden Show, has won the prestigious ABC Gardening Australia award for the 2012 Gardener of the Year. Steven is also a sessional lecturer at The University of Melbourne, lecturing in therapeutic horticulture and a past president of the Horticultural Therapy Association of Victoria. Steven is an enthusiastic photographer and has produced a coffee table book and photographs of his garden. The photos in this story are from his collection. Steven uniquely combines nursing and horticulture at Royal Talbot.

Steven’s passion for gardening began in the orchard and market gardens of his parents and grandparents in Murray Bridge in South Australia; however, it was a nursing career he embarked upon in the late 1980s. After 12 years of nursing, Steven took leave of absence to study horticulture. Returning to nursing at the Acquired Brain Injury Unit (ABI Unit) at Royal Talbot in 2003, Steven saw the potential to combine his enthusiasm for horticulture and nursing skills to provide a therapeutic environment for the hospital and sought permission to grow a few plants in an otherwise barren area of ground outside the ABI Unit. From those small beginnings, Steven and a team of volunteers and donors transformed the area to a tranquil and serene garden, creating a peaceful environment for patients, staff and visitors. The grounds came alive with an eclectic array of plants and artwork where patients recovering from an acquired brain or spinal cord injury, amputation or stroke, can sit or stroll among fragrant herbs, succulents, shrubs, flowering perennials and bulbs.

In their horticultural therapy sessions, patients handle the plants, help to propagate cuttings, taste and smell. Steven sees the garden in its combination of colour, aroma and textures with quirky, little features delighting young and old as having a twofold benefit; firstly, for Royal Talbot’s spinal, acquired brain injury and
orthopaedic patients it provides gardening and sensory activities to assist rehabilitation; and, secondly, for stressed families and busy staff it is an area of serenity and tranquillity to unwind, relax and for a while forget you are in a hospital. The garden features quiet spaces of reflection and peace, a colourful rainbow wall and quirky features like dinosaur eggs, which children love finding. Steven paid particular attention to adding a quirky aspect to the garden to make the visit to Royal Talbot less threatening and boring for children, saying, “All the art, the quirky bits and pieces – kids love that”. The garden has also been the setting for weddings and family celebrations. A visitor to the garden once described Steven as, “a stage manager creating theatre-like spaces within the garden where different stories can unfold”.

Steven sees the medical benefits of horticulture not only as improving motor, balance and planning skills, but also confidence boosting for the eventual return to life outside the hospital. Stephens explains that combining his horticultural nursing with that of a clinical nurse can have its humorous moments, whereby on one occasion a patient exclaimed, “The gardener showered me this morning”.

The successful merging of two careers has more recently seen Steven appointed to a new role within Austin Health as the gardens and grounds project officer. Whilst continuing to nurse and also engage in horticultural therapy at Royal Talbot, the expanded role will give Steven the opportunity to increase gardens and natural environments for the benefit of patients, staff and visitors throughout Austin Health campuses.

Steven was unassuming but excited to be the ABC Gardening Australia’s 2012 gardener of the year. He sees it as an opportunity to raise the profile of gardening therapy in the wider community.

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Benchmarking Reports

By the time you read this all AROC members will have received notification that their Calendar Year 2012 Benchmarking Report is available for download. This is the first time that AROC has reported on data collected using the v4 dataset (implemented 1 July 2012). The need to evolve the AROC Benchmarking Reports to reflect the v4 dataset presented us with an opportunity to design and implement some structural changes as well as content changes.

Structurally we will now present three separate types of reports:

- the Core Report
- the Impairment-Specific Reports
- the Outcome Target Reports.

The Core Report includes the standard analysis of all impairments, presenting the facilities data and comparing that to either all public or all private data (whichever is relevant to each facility) and the national data.

Impairment-Specific Reports have been generated for Stroke, Brain Injury, Spinal Cord Injury, Amputee, Orthopaedic Replacements, Orthopaedic Fractures and Reconditioning. These provide greater analysis at an impairment level, and include analysis of the impairment-specific data items that are included in the v4 dataset. They present each facility’s data and compare that to either all public or all private data (whichever is relevant to each facility) and the national data.

Reporting against the impairment-specific outcome target has been removed from the Core Report and now becomes a stand-alone report. The structure has changed dramatically to become a graphical representation of the spread of achievement of the outcome target across all facilities, and where in the continuum of achievement across all facilities the individual facility is situated. An example of this type of representation is shown in Graph 1. The horizontal line across the graph is the agreed target for the particular measure being graphed. The columns reflect the achievement of each AROC member facility, and the arrow points to the facility that is the subject of the individual report.

Benchmarking workshops

This year AROC will be running two different sorts of benchmarking workshops. We will continue to run impairment-specific benchmarking workshops, with a Spinal Cord Workshop scheduled for 8 April in Melbourne (this workshop follows on from the original SCI workshop held in 2008), and a Brain Injury workshop to be held sometime in the second half of the year.

In addition, AROC will be running jurisdictional benchmarking workshops in liaison with the appropriate clinical networks in each state. At present in South Australia and Western Australia workshops are planned for late May and in New South Wales workshops are planned for the second half of the year. Discussions with New Zealand, Queensland and Victoria are underway. These workshops will provide the opportunity for all providers of rehabilitation to come together and see how the outcomes (case mix adjusted of course) they achieve for their patients compares with the outcomes achieved by other facilities in their state.
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Meet your National Committee

Terry Wells – President

I am a registered nurse with a Diploma of Nursing followed by a Bachelor of Nursing from Flinders University. Currently I am studying the Graduate Diploma of Clinical Rehabilitation at Flinders University. I have worked in the field of rehabilitation since graduating in 1992, working in rehabilitation centres in South Australia and the Northern Territory.

I have been a member of ARNA since 2002 in the SA/NT/WA Chapter. I held a committee member position on the SA/NT/WA Chapter prior to taking on the Chapter President role in 2007. Gaining a greater understanding of rehabilitation nursing and the rehabilitation process, and accessing opportunities to network with other rehabilitation nurses were my initial reasons for joining ARNA.

I was elected to the position of National President at the 2012 AGM for a two-year term. The President works with the members of the National Committee to scope the priorities and services for the association to ensure ARNA achieves its mission, goals and service plans. The role brings great opportunities to work with other professional bodies and to work closely with members from all Chapters. I bring to the role a varied rehabilitation knowledge and experience, and a belief that rehabilitation nurses are the ones to determine the direction of rehabilitation nursing.

I am currently employed by St Margaret's Rehabilitation Hospital as an associate clinical service coordinator (ACSC) in the Orthopaedic and General Rehabilitation Unit. My role includes case management of the orthopaedic rehabilitation patients, admission coordination and bed management.

St Margaret's Rehabilitation Hospital is a heritage-listed building located a five-minute walk from the beach at Semaphore, a western suburb of Adelaide and some 20 minutes from the CBD. The hospital was built as a convalescence hospital, opening with a bed capacity of four beds in 1875. During its 137-year history, St Margaret’s health service focus has made the transition from convalescence through post-acute and respite care to rehabilitation. Today, the hospital has a capacity of 42 beds and provides inpatient rehabilitation programs for cardiac, respiratory, amputee, orthopaedic (including fractures and joint replacement), neurological and stroke patients.

On a personal note, I am married with three adult children and have community involvement through a local scout group where I hold the position of Group Leader.

Erika Schlemmer – Vice-President

When people ask me why I work in rehabilitation, I answer, “I don’t like sick people”. That’s not exactly true, but I never felt really comfortable in acute nursing. I fell into rehabilitation nursing via the area of spinal cord injury (SCI) where I worked in acute, rehabilitation and community settings. I’ve worked in all of the eastern states of Australia as well as in Canada, but now, after 18 years, I call the Northern Territory (NT) home.

Following a stint in the newly established rehabilitation ward at Royal Darwin Hospital (RDH), I followed my passion of SCI nursing and dived into the NT spinal nurse position, where I had the privilege of visiting many of the remote Indigenous communities across the NT. After 10 years I was back at RDH as clinical nurse consultant (CNC) rehabilitation, working with a brilliant team of rehabilitation nurses in the newly refurbished and expanded Rehabilitation, Restorative and GEM ward. I am also currently undertaking a Master of Clinical Rehabilitation by research at Flinders University. The focus of my research is urinary incontinence and Machado Joseph disease. I am extremely fortunate to have been sponsored by the Machado Joseph Disease Foundation.
I moved around a lot in my early working years and as a result was an intermittent member of ARNA, but I am now a committed member having served as an ordinary member on the National Committee for two years, and a year each as Secretary and Treasurer for ARNA SINC. When asked to nominate for Vice-President, a two-year term, my immediate reaction was, “not on your life”; I was far too busy with work and study. I decided, however, that ARNA was important me and I wanted to be more involved with my professional association. I also wanted to support the foundations laid by rehabilitation nursing leaders in Australia.

Lesley Brennan – Secretary

I am a Life Member and founding member of ARNA and have been involved since 1989, with the exception of two years. During that time, I have been involved at National and Chapter levels many times. I have numerous fond memories of:

- being rostered on night shift in the early days so I could go through a book listing addresses of rehab facilities across Australia to contact (by mail) to gauge the interest, or lack of, in forming a group of nurses interested in rehab and of the excitement when some of these actually replied;
- more night shifts each time there was a mail out to do (we had at least 45 members by then!); thank goodness for technology – mail merge, emails and so on;
- numerous lunch and dinner meetings in the Illawarra in the early and more recent days;
- interviewing and employing our first admin worker – no more addressing and putting letters in envelopes and fewer night shifts 😞😞😞;
- handing over the office and many committee positions to the Royal Rehabilitation Centre Sydney;
- a committee meeting where Helen Eccles (the recently elected President) and I (Secretary) were the only two to attend. Helen’s comments I remember clearly were, “Lesley, I think I have become President of nothing”;
- transformation of our little, two-bit newsletter into the professional journal, JARNA, which we now enjoy;
- the very adventurous idea of forming separate state Chapters – now most members don’t remember any different structure;
- moving the ARNA office and admin work to PAMS in Melbourne; and
- formation of the Spinal Chapter – a whole new concept.

I am currently semi-retired and working part-time as a trainer at the Disability Trust. I am still a member of ARNA and have in October 2012 accepted the position of National Secretary. I still believe in the whole reason ARNA was originally formed, to provide a forum for rehab nurses at all levels from the bedside to senior management to exchange ideas, communicate and to learn from each other.

David Parsons – National Treasurer

I was elected to the National Committee in October 2012 as Treasurer. This is my first time on the National Executive, having previously been elected to each of the Chapter committee roles at various times since joining ARNA in 1991.

I currently work for Castlemaine Health in Victoria as a registered nurse on night duty where I work across the hospital’s various wards as rostered. I enjoy rehabilitation nursing because it allows me to share some of my “being in the world” with the patients I care for and not just to focus on the clinical aspects of nursing with the care that I give.

My experiences of rehabilitation nursing began on a spinal ward where I also got to experience the practice of team and primary nursing. My next and most significant experience was to be invited to assist in the development of a Rehabilitation Head Injury Unit where I was introduced to the practice of interdisciplinary teamwork.

The earliest inspirations in my nursing practice came from the academic works of Virginia Henderson, Dorothea Orem and Patricia Benner. Others to inspire me have been a number of
I am a rehabilitation nurse because I believe that in this role I can make a difference to the outcome of a patient’s journey. Being a member of ARNA connects me to what I call the community of Australasian rehabilitation nurses. Through this community I can learn, develop and share all aspects of rehabilitation nursing.

I chose to nominate as a member of the National Committee because I am passionate about maintaining what I believe was the vision the founding members of ARNA had for the Chapters of ARNA. I also nominated for the position of Treasurer to take on the challenge of learning the role and the responsibility that is required of a treasurer for a small, not-for-profit organisation such as ARNA.

I first became inspired to choose rehab nursing as my specialty when I worked in a large medical ward at Prince Henry Hospital. The ward was for stroke patients mainly and I loved nursing the patient from their acute medical phase right through to discharge. It was the most holistic nursing I have ever done. I am very privileged at Lawrence Hargrave to work with an exceptional, multidisciplinary team of health professionals, who are just as committed as I am to our roles in this specialty of rehabilitation.

**Lyn McBain – Chapter President Victoria/Tasmania Chapter**

Beginning my nursing career at St Vincent’s Hospital, Melbourne, I graduated as an enrolled nurse from Austin Hospital in 1972. I first experienced rehabilitation nursing at Florence Nightingale Rehabilitation Hospital in Brighton, Victoria, in 1992. Further rehabilitation experience was gained at Kingston Rehabilitation Centre and the Victorian Rehabilitation Centre (VRC). It was at the VRC that I was introduced to and developed a passion for acquired brain injury (ABI) nursing; this proved a challenging and rewarding career path, requiring not only engagement with the client but, importantly, their family, friends and community. I found working with other rehabilitation professionals to maximise a person’s potential post-severe trauma a very broadening experience. The challenges and rewards of ABI nursing inspired me to undertake a Bachelor of Nursing Degree at Charles Darwin University as an external student. My majors included drug and alcohol studies, strengthening my competency in ABI rehabilitation and also understanding the strains placed on other family members. After graduation I joined the ABI Unit at the Royal Talbot Rehabilitation Centre in Kew, Victoria. Since then, I completed a Master of Clinical Rehabilitation at Flinders University with a specialty in ABI and undertook two pharmacology subjects at master’s level. Currently I am a care coordinator with Kinder Caring, a home-based rehabilitation nursing service catering for work and road injury rehabilitation, some private clients and palliative care. My role as coordinator encompasses assessment of client suitability for home-based rehabilitation; coordination of the care plan with client and other specialised team members; selection and management of carers; providing ongoing training...
and development of carers’ skills; and liaison with WorkSafety Victoria and the Transport Accident Commission.

I have been a member of ARNA since 1996 and a regular conference attendee. I was a member of the National Committee in 2008–9 and I have been on the Chapter Committee since 2009; I am currently in my second term as Chapter President.

The Victorian Chapter has a very strong and active membership. I am committed to ARNA not only for the benefits I’ve derived from the specialised professional development opportunities of conferences and study days, but because I see its premier role in raising the competency, profile and professionalism of rehabilitation nursing and providing a forum for like-minded nurses to encourage others to consider a career in rehabilitation nursing. A particular highlight of my term of office as Chapter President has been an invited address to graduating nurses; of course I spoke about rehab nursing and ARNA.

Sandra Lever — NSW/ACT Chapter President

I am currently the President of the ARNA NSW/ACT Chapter. I took up this position in 2011 while I was Vice-President when the President’s position was vacant. In 2012 I accepted the nomination as President at the Chapter AGM and am now in the position for a two-year term. I previously served as the National President of ARNA from October 2002 to October 2006. I have been a passionate member of ARNA for many years and have enjoyed being part of the growing professionalism and achievements of the association.

I am currently the clinical nurse consultant Grade 3 in rehabilitation at the Royal Rehabilitation Centre Sydney, NSW, and my qualifications include a Bachelor of Health Administration, a Master of Nursing-Rehabilitation and a Graduate Diploma in Sexual Health.

I currently represent ARNA on the Australian Rehabilitation Outcomes Committee (AROC) Scientific and Clinical Advisory Committee. I also represent the Australian College of Nursing on the Australian Stroke Coalition and am the Co-Chair (Nursing and Allied Health) of the Agency for Clinical Innovations (ACI) Statewide Stroke Services (SSS) NSW Stroke Coordinating Committee. A working party of the SSS includes the Stroke Rehabilitation and Stroke Recovery working party which I also co-chair. I was actively involved in the National Stroke Foundation Stroke Audit – Post Acute Services Advisory Committee and the NSW Health Rehabilitation Redesign Project. I am a member of the Australian Society of Sex Educators, Researchers and Therapists and participate in a monthly supervision group run through the Australian Centre for Sexual Health. In all these representations, I try to ensure that the rehabilitation nursing voice is heard.

My research interests include rehabilitation nursing’s role in increasing activity for stroke survivors participating in inpatient rehabilitation programs and female sexuality following stroke. I have been awarded an $18,000 research grant to undertake a research project about the sexuality concerns of females following stroke. I also developed and coordinate the Royal Rehabilitation Centre Sydney Sexuality Clinic, which is an outpatient clinic for people with acquired disability.

I frequently teach throughout NSW about the post-acute management of stroke through the Australian College of Nursing and SSS NSW as well as present at state and national conferences. I am also developing my publication skills and have recently co-authored an editorial in the International Journal of Therapy and Rehabilitation and a book chapter in a comprehensive rehabilitation nursing text.

I am very passionate about rehabilitation nursing and in particular the approach and principles that underlie its practice. I believe that it is important for all rehabilitation nurses to be a member of ARNA as this is their specialty professional body. Without a strong membership, ARNA is less able to achieve its objectives, tackle issues of relevance to rehabilitation nursing as well as the patients/clients that we work with and be a loud voice for our specialty.

I am more than happy to receive suggestions and questions on matters related to rehabilitation nursing from Chapter members and can be contacted at nswact@arna.com.au
Thank you very much to ARNA for providing a $600 scholarship to attend the ARNA 22nd Annual Conference in Hobart, Tasmania.

Expected outcomes

My goals were to learn the latest rehabilitative nursing practices and principles, learn more about reading and interpreting the AROC report, network with rehabilitative nurses from Australia and New Zealand throughout the conference and during the conference dinner. I achieved all of these and had fun.

Evaluation

The keynote and invited speakers were terrific. The program was relevant for rehabilitation nurses, with interesting presentations, posters and sponsors/trade displays for the novice to the expert. The conference provided value for money. The venue overlooked the beautiful port of Hobart where an international Antarctic ship was in port.

If you haven’t been to an ARNA conference I suggest that you plan to attend the next one in October 2013 in Sydney, New South Wales. I achieved all of my goals and more. I left with renewed enthusiasm and passion for ARNA and rehabilitation nursing.

Resources

I will mention three presenters that stood out for me.

The power of touch by Donald Kautz — keynote speaker

I was fascinated by Donald who demonstrated his practice of reading a children’s book, aimed at four- to eight-year-olds, to his nursing students during each teaching session, to “awe and inspire” them. He read Possum Magic by Mem Fox and suggested many things that we can learn from the story, such as “we all need a buddy to be successful”. Donald also demonstrated how the Zen parable of the tiger and the strawberry can be useful when we discuss pertinent issues with nursing students.

Preventing falls: What QI and research really tells us about what works by Donald Kautz

When discussing preventing falls, Donald demonstrated the benefits of knowing how to read statistics. He told us that falls statistics are often not reported positively or in a meaningful way for nurses to understand. For instance, the statistics may report that 0.5% of patients fall, when it would be more positive to report that 99.5% of patients don’t fall. Donald pointed out that the loud noise from a bed or chair alarm may remind some veterans of the war and not be a positive experience for them. Donald stated he will email references and articles on request.
**Workshop: It's like learning to read a map — Outcome measures and benchmark reporting by Monique Berger and Melissa Ceely**

I am a novice AROC report reader/interpreter and I enhanced my knowledge in this area. This will help me to improve processes and outcomes for the rehabilitation inpatients at the five hospitals where I work. (We have nearly twice as many rehab beds as Tasmania as a whole.) In addition, I networked with rehabilitation nurses from Australia and New Zealand, and learnt how they use FIM in their workplaces.


**Collaboratively engaging our consumers in the delivery of safe, quality rehabilitation care by Adam Dowell**

Adam from St John of God Frankston Rehabilitation Hospital told us about their successful volunteer program. One aspect of their program was the “admission volunteer” who visits all new patients within 24 hours of admission. Volunteers are an important part of any organisation. In my health network volunteers staff the kiosk, fundraise, spend time with the palliative patients and participate in a falls reduction program with high-risk patients. In other facilities volunteers assist in the horticulture program or look after the “sensory garden”.

In addition, I enjoyed the 15-minute sessions as we heard a snapshot and could follow up with the presenter afterwards. I also enjoyed the structured opportunity to meet the authors of the posters.

**Implementation**

I have commenced using knowledge and skills that I have learnt from attending the conference. I have liaised with sponsors and new contacts that I met at the conference. I have commenced promoting what I have learnt at my workplace. Thank you ARNA.

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Guidelines for submission of manuscripts to JARNA

Aims and scope
Rehabilitation nursing is a recognised specialty area of nursing within Australia with a broad and expanding knowledge base. As the official Journal of the Australasian Rehabilitation Nurses’ Association (ARNA), JARNA seeks to enhance this expanding knowledge base through the publication of information pertaining to rehabilitation nursing. An equally important purpose of JARNA is to facilitate the development of ARNA members as writers for publication by providing constructive feedback to authors.

Prospective authors are asked to follow the following guidelines when compiling a manuscript they wish to submit for consideration for publication in JARNA.

Terms of submission
JARNA is published three times a year and all manuscripts pertaining to rehabilitation nursing are invited. The Editor welcomes manuscripts on research, quality activities, innovative practice, education, management, case studies and any other item of interest to rehabilitation nurses. JARNA also invites new and first-time authors, with mentoring provided by the Editorial Board to assist in achieving publication standards.

Authors are asked to nominate if they wish their manuscript to be peer reviewed. All manuscripts are reviewed by at least one member of the Editorial Board for relevance, accuracy, currency and applicability to rehabilitation nursing practice.

Accompanying each submission must be a letter signed by all authors, stating that the work has not been previously published and will not be published elsewhere. Once it is published, the manuscript and its illustrations become the property of JARNA, unless rights are reserved before the publication.

All work will be sub-edited to journal style. The editor reserves the right to modify the style and length of any manuscript submitted, so that it conforms to journal format. Major changes to a manuscript will be referred to the author for approval prior to publication.

Authorship
All authors must make a substantial contribution to the manuscript and will be required to indicate their contribution. Participation solely in the acquisition of funding, collection of data or supervision of such does not justify authorship. All participating authors must be acknowledged as such: proof of authorship may be requested by the editors.

The first-named author is responsible for ensuring that any other authors have seen and approved the manuscript and is fully conversant with its contents. If the author wishes to reproduce material subject to copyright, it is the responsibility of that author to obtain written permission from the copyright holder and to acknowledge this permission within the manuscript.

Conflict of interest It is the responsibility of the submitting author to disclose to the Editor any significant financial interests they may have in products mentioned in their manuscript before the references section.

Regulatory requirements
Research protocol Approval of protocol by the appropriate ethics committee of the institution within which the research was carried out must be stated within the manuscript.

Human investigations All work must be stated that it conformed to the “National Statement on Ethical Conduct in Research involving Humans” by the National Health and Medical Research Council of Australia, or equivalent in other countries or the Declaration of Helsinki.

Humane animal care All work involving animals must contain a statement that it conformed with the “Statement on Animal Experimentation” by the National Health and Medical Research Council of Australia or equivalent in other countries.

Manuscript types
Submitted work may take any of the following forms:

Original articles These articles should be 1500–3000 words in length and, where appropriate, may include photographs or tables.

Reviews articles These articles should be 1500–2000 words in length.

Case reports These articles should be 1000–1500 words in length. These articles should ensure patient confidentiality is maintained.

Book reviews Book or monograph reviews will be included depending on the interest to the subscribers. Books or monographs to be reviewed can be sent directly to the Editor. No books will be returned.

Peer-review process
JARNA accepts both peer-reviewed and non–peer reviewed articles. If you would like your article to be peer reviewed, please indicate this on your title page.

All manuscripts are initially reviewed by the Editorial Board and those deemed unsuitable (insufficient originality, serious scientific or methodological flaws, or a message that is of limited interest to the audience of JARNA) are returned to the author(s), usually within four weeks. If the manuscript does not conform to the submission guidelines, the author will be asked to amend prior to peer review.

All manuscripts are reviewed by peers with rehabilitation nursing experience for relevance, construction, flow, style and grammar. All reviewers spend considerable time reviewing manuscripts and providing feedback to authors. The length of time of the review...
Process can vary and depends on the quality of the work submitted. Several revisions may be required to bring the manuscript to a standard acceptable for publication. Proofs of articles about to be published will be sent to the corresponding author for review. This requires rapid response; if such a response is not forthcoming, the article will be published without the author’s reply. Providing email addresses facilitates this process. This final decision about publication is made by the Editor.

The peer-review process is managed online. Decisions are communicated by email to the corresponding author. Submitted manuscripts are acknowledged by email.

Preparation of manuscripts

Manuscripts should use double spacing with Times Roman 12 font and margins 2.5 cm.

Title page To include the title of the manuscript, the author’s or authors’ names, qualifications and affiliations, corresponding author’s details including email address and contact phone number, total word count and up to five keywords. An indication if you would like your manuscript to be peer reviewed is needed here.

Abstract All manuscripts should include an abstract of no more than 250 words. Include the title of work on the abstract page.

Main body text For research and quality article, subheadings should be utilised as follows:

Introduction – Purpose of study and brief overview of background.

Methods – Described in detail.

Results – Concisely reported in tables and figures with brief descriptions.

Discussion – Clear and concise interpretation of results.

Tables and figures To be presented on separate pages, one per page. Tables should be clearly typed, showing columns and lines. Number tables consecutively in the order of their first citation in the text and supply a brief title for each. Illustrations and figures must be clear, well-drawn and large enough to be legible when reproduced.

Photographs These must be submitted in .jpeg format. Patients or other individual subjects should not be identifiable from photos unless they have given written permission for their identity to be disclosed. If permission is provided, this must be supplied.

Referencing guidelines

The referencing format is based on the Vancouver style, the main feature of which is the use of numbers at the point of reference so as not to interfere with the flow of words. Each number corresponds to a single reference provided in the reference list at the end of the manuscript and, once assigned a number, a reference retains that number throughout the text, even if cited more than once. If more than one work is quoted in a reference, each work must be assigned a number. That is, at any point in the text the reference may be one or several numbers.

To follow are examples of references from different sources:

Standard journal articles – list all authors


Books and other monographs


Submissions of manuscripts

Manuscripts are accepted as an electronic submission with an attachment as a Word document. All tables, figures and photographs are to be included in the one attachment. Please ensure image files are no larger than 700KB. The manuscript must be accompanied by a cover letter indicating that the manuscript has not been submitted elsewhere.

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Follow the steps for submitting an article

Step 1. Type the title, type of paper and abstract. JARNA requires an abstract for all submissions. Select publication – JARNA.

Step 2. Confirm author. Add co-author details (all fields) if applicable.

Step 3. Upload files. Only Word documents are accepted by JARNA. Please ensure your documents contain the required information and that they are formatted according to the author guidelines.

Step 4. Add any comments for the Editor.

Step 5. Review your information, then click submit.

Once submitted, the manuscript is reviewed by the Editor and, if acceptable, sent for review or peer review. You will be notified by email once your manuscript has been selected for review.
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