RACING TO THE CHALLENGE
A CELEBRATION OF ORTHOPAEDIC NURSING

WEDNESDAY 30 OCTOBER TO FRIDAY 1 NOVEMBER 2013
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The Orthopaedic Nurses Association of Victoria warmly invites you to attend the 6th ANZONA Conference, at Hilton on the Park Hotel, Melbourne, Victoria, Australia.

About the Conference

Conference Theme: Racing to the Challenge: A Celebration of Orthopaedic Nursing

Is Orthopaedic nursing a specialty? Of course it is and we need to make sure the world knows!

We need to work towards recognition of the expertise required to ensure that the orthopaedic patient receives optimal care and great outcomes.

Orthopaedic nurses are at the bedside 24/7, and also hold other roles that are important in the care of these patients. This conference aims to provide nurses interested in musculo-skeletal nursing with an opportunity to collaborate and influence the care that we provide. ANZONA 2013 will offer a chance to meet with like-minded health care workers, whilst learning in an environment to challenge your thoughts, and also have some fun.

Conference Sub-themes:
1. Professional expertise
2. Outcome based clinical practice
3. Professional development

Who Should Attend?
The aim of the Conference is to bring together people involved in Orthopaedics from Australia, New Zealand and beyond to network with industry colleagues. These include but are not limited to:
• Nurse Clinicians
• Nursing Leaders
• Managers
• Nurse Practitioners
• Practice Nurses
• Nursing Students
• Operating Room Nurses
• Paediatric Nurses
• Trauma Nurses and Coordinators
• Rehabilitation Staff
• Primary Care Nurses
• Medical Representatives and Suppliers

The Conference Aims to:
Develop networks and understanding, leading to collaboration in the development of best practice pathways to improve patient outcomes.

Why Attend?
• Build connections and take advantage of the networking opportunities
• Collaborative Learning
• Continuing Professional Development
• Validate your practice
Sharpening the Image of Nursing
Beverly A Morris, RN, CNP, MBA Nurse Practitioner; Director of National Association of Orthopaedic Nursing, University of California, San Diego Medical Center, USA

Abstract: When thinking about becoming a nurse, you probably imagined yourself providing care and comfort to your patients in need. And yet, for today’s nurses throughout the world, that image of patient care continues to expand.

With approximately five million registered nurses worldwide at the bedside, they span five different generations that range from 20- to 75-years-old. Each one of these nurses brings their rich and diverse experiences to the nursing profession. For example, in some countries nurses receive a lifetime licence and do not have a renewal process. While in other countries, nursing students aren’t allowed to speak to their professors or folk healers are still sought for medical care. While the global nursing profession has many mutual connections, such as the desire to provide quality care, there are many notable differences among them. Some nurses are silent and conforming, for instance, while others want to change the world and still others really don’t care for the rules. No matter what generation or unique experience we bring to bedside care, every day nurses look for ways to save lives and improve patient safety. As we go about our daily duties, we must ask ourselves: How can we sharpen our image?

In 2010 Beverly was elected Executive Director of the National Association of Orthopaedic Nurses (NAON) by her colleagues. Over the past 25 years as a leader within NAON, she has served as a content development expert of clinical practice guidelines, joint replacement, deep vein thrombosis and pain management. She has won several national awards including the Nan Hill Distinguished Writers Award from the Journal of Orthopaedic Nursing and an award from the American Academy of Orthopaedic Surgeons for a study evaluating post-operative pain management.

Some highlights of her responsibilities include Chair of the Interdisciplinary Pain Management Task Force. She develops the educational content for the award winning annual BONES Symposium sponsored by the bedside nurses for the city of San Diego, California. Beverly was chosen by her University of California peers as Advanced Practice Nurse of the Year in 2012.

Effective Reduction in Hospital Acquired Conditions
Preparing for the Changing Landscape of Specialty Orthopaedic Nursing Practice

Emeritus Professor Judith M Parker, AM RN BA Hons PhD MD (Honoris causa)

Professor Judith Parker was the foundation Professor and Head of the School of Nursing at the University of Melbourne from 1996 to 2004 where she set up higher degree programs and a strong research agenda, post graduate coursework programs in mental health and acute care nursing and in case management. Before that, she held a similar position at La Trobe University for a number of years. She spent 18 months as a Visiting Professor at the University of Hong Kong during 2004 and 2005 and continues there as a Visiting Professor advising on strategic, curriculum and accreditation initiatives at the School of Nursing. In late 2006 until the end of 2008, she was Head of the School of Nursing and Midwifery at Victoria University and subsequently spent time there examining the interface between vocational and higher education in nursing. She was awarded the title of Emeritus Professor when she left the University of Melbourne and until recently she has been working in a part time capacity back at the University. She has served as a Director on the Board of the Nursing and Midwifery Health Program Victoria, (formerly the Victorian Nurses Health Programme) since 2010 and is currently Board Chair.

In 2012 she undertook a review of the governance structure of the Faculty of Nursing at the University of Toronto, chaired three ANMAC Accreditation Committees and participated in undertaking a review of the Cabrini Health Institute. She was appointed as CEO of the Institute of Health and Management in September 2012.

She has served on a hospital Board of Management and on the Nurses Board of Victoria. She has a long standing interest in nursing work and is internationally renowned for her research into the nursing handover, which was funded by the Australian Research Council (ARC) Large Grants Scheme. She has also participated as a Principal Investigator in research funded by the National Health & Medical Research Council. Professor Parker established and was foundation editor and later editor in chief of the highly regarded international scholarly journal Nursing Inquiry. In 2001 Professor Parker was included on the inaugural Victorian Honour Roll for Women and in 2002 she was made a Member of the General Division of the Order of Australia. In 2006 she was awarded an honorary Doctor of Medicine by the University of Melbourne in recognition of her contribution to nursing scholarship.

Abstract: This presentation explores the changing landscape of nursing practice in Australia that is occurring as a consequence of the ageing population and the ensuing demands upon health care services. The paper will then examine the implications of these trends for orthopaedic nursing practice and education. The trends being discussed are, by and large, global and thus, while the focus is upon the Australian context, there will be resonances for other practice contexts.
SESSION ABSTRACTS
THURSDAY 31 OCTOBER 2013

PLENARY SESSIONS

9.45am – 10.05am Orthopaedic Nursing in 2010s
Paul McLiesh, Lecturer, BN, GDip Orth, MNSc, University of Adelaide, South Australia
This research aims to provide a view of Orthopaedic Nursing as it finds itself in the second decade of the 21st Century. Orthopaedic nurses are a specialised group with unique skills and knowledge. In a rapidly changing healthcare environment some traditional Orthopaedic nursing skills may be required less frequently. However, Orthopaedic nurses still possess unique skills that ensure their patients receive the care that best matches their unique needs. Threats to the specialty exist and have the potential to expose the speciality to erosion. It is important then that the group should identify what is inherent about being an orthopaedic nurse and best prepare the group and its members to protect what it values and advocates for the Orthopaedic patient. This research aims to inform practice, direct specific education, guide further research and improve health outcomes for Orthopaedic patients. It identifies what is important to Orthopaedic nurses today, what the group needs to perform/grow, and provides an understanding of how Orthopaedic nurses see themselves, as part of a broader group, within today’s healthcare environment. It describes the needs of the group, how leaders can promote and foster growth of Orthopaedic nursing at all levels. It articulates the hopes and fears of the members of the group and then identifies strategies to achieve those hopes and reduce those fears. Recommendations for practice, education, leadership and the professional Orthopaedic nursing groups are made.

10.10am – 10.30am The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings
Anita Taylor, Orthopaedic Nurse, Practitioner, Royal Adelaide Hospital, South Australia
A Comprehensive Systematic Review: This presentation will report on a Systematic Review of the literature undertaken in fulfilment of the requirements for the award of Masters Clinical Science undertaken at The Joanna Briggs Institute, Faculty of Health Sciences, The University of Adelaide.
This review asks “What is the experience and effectiveness of Nurse Practitioners in orthopaedic settings” and aims to explore the role and clinical practice of Nurse Practitioners in Orthopaedic settings.
This review will focus on Orthopaedic Nurse Practitioners (ONP) in an international context with a specific orientation to “ONP specific care”. By looking at primary and secondary outcomes such as: nurse-sensitive & other quality outcomes data, LOS, cost, time-to-theatre, other process (of care) indicators, patient encounter & consultation, satisfaction data within the quantitative component of the review and considering issues around role transition, including facilitators and barriers to the experience of becoming or being an orthopaedic nurse practitioner, within the qualitative component of this review, it is envisaged a better understanding of what is required to develop advanced practice roles within orthopaedic nursing will be discussed.

11.05am – 11.25am Journey to the Finish Line: Fast Track Joint Replacements in The Queen Elizabeth Hospital
Lesley Thomas, Orthopaedic Nurse Practitioner, The Queen Elizabeth Hospital, South Australia
The Queen Elizabeth Hospital performs between 300-350 joint replacement procedures per year. Health round table data indicated average length of stay (LOS) to be between 7 and 8 days, with best practice benchmarks being 5 days. Our objective was to reduce average LOS to between 4 and 5 days. We developed clinical guidelines tailored to our hospital based on proven fast track programs. The guidelines spanned the entire patient journey from pre-op through surgery and the post-operative periods. Education on the guidelines was delivered to everyone involved in the patient journey, including the patients, so as to provide a clear and consistent pathway everyone could follow. Lean thinking methodology provided a basis for this multidisciplinary project to be successful, by ensuring everyone worked together to get to the finish line.
Local Infiltration Analgesia Reduces Length of Stay and Complications
David Mitchell, Director of Orthopaedics, Ballarat Base Hospital, Victoria

The complications of joint replacement surgery invariably relate to immobility and the subsequent pharmacological manoeuvres to reduce thromboembolic complications. This paper explores the evolving technique of local infiltration analgesia (LIA) and its impact on immobility, pain, and eventual result.

LIA is a technique of injecting a cocktail of ropivicaine, ketorolac, adrenaline and often dexamethasone in the periarticular tissues at the time of joint replacement surgery. Typically, top up doses are also performed via a wound catheter (epidural catheter into the joint), and some oral and transdermal medications augment the technique. This technique easily removes the risk of severe post-operative pain, and patients no longer require patient controlled analgesia. The patients no longer require being “tied to the bed” by drips, oxygen, urinary catheters, indeed the patients are typically mobilised two hours from surgery, and are independently mobile at 24 hours from surgery, street ready, and able to be discharged. Chronic pain after knee replacement surgery can be avoided by properly treating acute post-surgical pain.

If patients are not immobilised, do they need powerful anticoagulants? The author believes no. Abolition of swelling, reduction of blood transfusion is a further step in right direction. Getting patients home and on with their life was always the intent of joint replacement surgery. With this technique, patients are able to do so after a single night in hospital. With this technique, the incidence of chronic pain after knee replacement surgery is dramatically reduced.

Getting Published - Writing for Publication for Orthopaedic and Trauma Nurses
Peter Davis, Emeritus Editor, International Journal of Orthopaedic and Trauma Nursing and Julie Santy-Tomlinson, Co-Editor, International Journal of Orthopaedic and Trauma Nursing

There is a need for orthopaedic and trauma nurses to share their ideas, practice innovations, research and debate with their colleagues around the world. One important way to do this is publication of journal papers in high quality journals which can be accessed by the international nursing community.

However, many nurses choose not to publish their work. One reason for this is a lack of confidence in their ability to produce work which is likely to be accepted for publication. Not all journal papers are research reports or lengthy discussion papers and few nurses realise that many journals also like to receive short reports of practice innovations, letters to the editor and other shorter items as well as full length papers and research reports.

The aim of this workshop is to provide nurses attending the ANZONA conference with an opportunity to develop their ideas for a paper [style of their own choice] for publication and increase its likelihood of acceptance by the journal of its choice thus increasing their confidence.

The workshop, restricted to 20 attendees, will be facilitated by two journal editors. It will include:

- Developing and focusing ideas for a journal paper
- Background reading for the paper
- Choosing the right journal
- Writing your paper
- Seeking support and advice
- Submitting your paper
- Increasing the likelihood of success

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2.05pm - 2.20pm PARALLEL SESSION A (Please indicate your session preferences on your registration form)

**Professional A1.** Orthopaedic Nurse Practitioner in the Acute Care Environment: A Western Australian Perspective
Sharon Pickles, Nurse Practitioner, Sir Charles Gairdner Hospital, Western Australia

It became evident that an Nurse Practitioner (NP) would be beneficial in supporting the clinical care of all orthopaedic inpatients and particularly the elderly patients with minimal trauma fractures. In 2012 an Orthopaedic Nurse Practitioner was designated to Sir Charles Gairdner Hospital (SCGH) Orthopaedic unit. SCGH is a 600 bed tertiary hospital that has both orthopaedic trauma and elective patients.

A collaborative care model was developed with the orthopaedic surgeons, geriatrician and allied health. A business case was proposed and financial support was granted with funding made available until 2014. It is hoped that the benefits of this role will ensure the position becomes permanent. The Orthopaedic NP coordinates the clinical management of all orthopaedic minimal trauma fracture patients as part of the collaborative care model. The NP provides clinical support for all the orthopaedic patients within the hospital including ED and facilitates discharge planning. The NP peri-operative has a number of clinical guidelines which range from managing urinary tract infection to peri-operative management and pain management. These clinical guidelines are supported by a drug formulary all of which are a requirement of the WA Department of Health.

The Ortho NP provides expert clinical support and guidance to all staff of the large teaching hospital and is able to support the patient care in a timely manner.

This presentation will provide an overview of the role and outline the documentation required for practising as an Orthopaedic NP in WA.

**Clinical A2.** Acute Nursing Care of the Adult with Fragility Hip Fracture
Ami Hommel and Anita Taylor and other International Collaborators, Orthopaedic Nurse Practitioners, The Royal Adelaide Hospital, South Australia

Hip fracture is a devastating injury for both patient and family often resulting in impaired mobility, increased reliance on others, diminished health and sometimes death. In many countries hip fracture is the most important issue facing trauma services in the 21st century. Under the auspices of the International Collaboration of Orthopaedic Nursing (ICON), nurse experts guided by a range of information from research and clinical practice have written a document focusing on nurse sensitive quality indicators during the acute hospitalisation for patients with a fragility hip fracture.

**Aim:** To provide those who care for orthopaedic patients with evidence-based, international perspectives, about acute nursing care of the older adult with fragility hip fracture, on nurse sensitive quality indicators, during the acute hospitalisation.

**Result:** The nurse experts agreed on 5 nurse sensitive quality indicators, pain, delirium, pressure ulcers, fluid balance/nutrition and constipation/catheter associated urinary tract infection. Scope of the problem, prevention strategies, detection, assessment, treatment and self-care strategies are presented in the document.

**Conclusion:** Vigilant nursing assessment and prompt intervention may prevent the development of complications. If they do occur and are identified early on, they may resolve with appropriate and timely nursing management. This presentation will elaborate upon the “tool kit”, the intent of which is to provide those caring for this vulnerable group of older people with sound, evidence-based advice on the best ways to ensure that care is as sensitive and effective as possible and equip the nurse to ‘meet the challenge’ of caring for the older adult with fragility hip fracture.

**Research and Education A3.** Effect of Tranexamic Acid use in Orthopaedic Patients Undergoing Hip and Knee Arthroplasty
Chris Schutz, Clinical Research Coordinator, Wakefield Orthopaedic Clinic, South Australia

**Objectives of this Paper:** To review the effects of Tranexamic acid use and its effect on blood transfusion use in patients having hip and knee arthroplasty at a private Orthopaedic Hospital. Tranexamic acid use has been associated with reduced blood loss and blood transfusions however differing indications for blood transfusions reported in clinical practice highlights the difficulties of making broad assumptions and reflects some limitations of this observational study.

**Design:** This was a systematic review of 100 consecutive patients admitted to a private orthopaedic hospital to review clinical practice and current use of Tranexamic acid in patients scheduled for hip and knee arthroplasty. Patients were seen in Preadmission clinic and the preoperative data included age, gender, comorbidities, haemoglobin levels. Post-operative data recorded included timing and dosing of Tranexamic acid, amount of blood transfused, drain usage and volume of drainage and any complications.

**Method:** This was a consecutive collection of data on patient admissions for knee arthroplasty or hip arthroplasty with primary osteoarthritis. Simultaneous bilateral TKA, known allergy to Tranexamic acid and those patients already receiving anticoagulant therapy were excluded.

**Results:** This study is still in progress but results will be collated and reported and mean results will be recorded as to blood loss, transfusions and observation of patient outcomes during hospitalisation for these procedures. Any observed complications will be reported.
**Professional B1.** Protocols: Their Role in Changing Practice  
Cheryl Kimber, Orthopaedic Nurse Practitioner, Flinders Medical Centre, South Australia

Protocols are part of the framework that supports our practice. They provide structure for clinicians, clinical units and area health services to effectively govern quality of care and to ensure that the clinical care and services are safe, effective, appropriate, consumer focussed, accessible and efficient.

This presentation discusses clinical practice improvement built on protocol development, integration into practice and the strategy of using medical students in auditing clinical practice. In addition to practice improvement, involving students in auditing adherence to protocols has facilitated and enhanced their educational learning experience and integrating into the health system. As a result of having these processes in place our protocols are dynamic, evidence based and reflect evolving changes in our health system.

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**Clinical B2.** The Impact of Septic Arthritis and Osteomyelitis in Paediatrics  
Kerry Houghton, Clinical Nurse, Consultant Orthopaedics, Nicole Mangion, Clinical Educator, Orthopaedics and Penny Brown, Registered Nurse, The Children’s Hospital Westmead, New South Wales

Septic arthritis and osteomyelitis are not uncommon conditions in children. These conditions generally have good outcomes and effective management plans. The diagnosis and treatment is standardised in most countries around the world.

There are some children who present to hospital with infections involving the bone and joints that have an extreme disease process. The number of children with severe infection is small, but their length of stay in hospital is long and the potential for ongoing health needs is high. This presentation will outline some case histories of children that have presented health professionals with challenges that will continue into adulthood. As nurses we need to identify and consider outcomes that may affect the child across their life span.

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**Research and Education B3.** Is it Possible to Introduce UKA as One Day Surgery and Still Get Satisfied Patients?  
Henriette Appel Brun, Research Nurse, and Education Vejle Hospital, Denmark

**Background:** Since 2001 the Oxford partial knee replacement (UKA) has been performed at Vejle Hospital, Denmark. In 2011 a total of 117 UKA were performed, LOS 2.2. In spring 2012 we introduced UKA as one-day surgery. Besides a patient seminar an individual interview with a nurse, focusing on pain management and a physiotherapist focusing on rehabilitation is introduced. The day after surgery the patient is called by a nurse; 3-5 days postoperatively an outpatient control is given.

**Purpose:** To investigate patient satisfaction with care and treatment of partial knee replacement in one-day surgery

**Method:** Satisfaction survey using questionnaires (22 items), filled out 3 weeks after surgery. 64 UKA were operated. 28 patients (17 women), age 58 (44-74). Response rate was 100%.

**Results:** Overall satisfaction with one-day surgery. Numerical Rating Scale (NRS): Mean 9.2 (8-10). Fulfilment of expectations for one-day surgery: 43% Much better than expected, 32% better than expected, 18%, as expected, 7% worse than expected. Would you choose one-day surgery again: 79% Absolutely, 21% Yes - with few modifications. All patients would choose it again. Well informed on how to exercise at home: 93% strongly agree, 7% somewhat agree. Well informed about the use of morphine: 70% strongly agree, 30% somewhat agree. Ready to discharge: 71% strongly agree, 25% somewhat agree. 4% did not agree.

**Conclusions:** NRS mean 9.2 (8-10) on total satisfaction shows that patients are extremely satisfied with one-day surgery. 93% had their expectations fulfilled and all would choose one-day surgery again. More patient education in pain management is needed. The investigation is still ongoing and further results will be presented at the conference.

**Learning:** It seems to be possible to perform UKA as one-day surgery provided an interdisciplinary collaboration, an extremely high level of patient information and education.
PARALLEL SESSION C

Professional C1. So you Thought Developing a Procedure Was Going to be Easy? My Journey
Lorissa Bailey, Clinical Nurse, RN, Grad. Dip. Ortho, Flinders Medical Centre, SA

Written nursing procedures/guidelines are essential for clinical practice. They provide a framework and reference tool for nurses while they provide ongoing care to patients. These procedures are supported by scientific and clinical evidence. Although they may present resource implications for health authorities, ultimately their integration into practice must focus on patient safety and quality of care.

This presentation explores the clinical practice experience gained by the presenter while undertaking portfolio work. From a novice procedure developer, it will provide insight to what was undertaken, knowledge and skills developed and resources that were utilised during this experience.

Clinical C2. Bone and Soft Tissue Sarcoma Service - Virtual Clinic
Helen Findlay, Clinical Nurse Specialist, Orthopaedic Surgical Oncology, Glasgow Royal Infirmary, Scotland

This paper will provide an overview of the Bone & Soft Tissue Sarcoma Service for the West of Scotland based in Glasgow Royal Infirmary.

The main aim is to showcase the introduction of a ‘virtual clinic’ where the Consultant Orthopaedic Oncologists and the Musculoskeletal Radiologists meet weekly to discuss new referrals. This allows patients who may have a suspicious bony lump or soft tissue swelling to have their clinical presentation and scans discussed; an action plan agreed which may include further imaging and / or biopsy for tissue diagnosis planned. It also provides timely feedback to all referrers highlighting the agreed plan or simply giving reassurance and information about the lesion with discharge back to referring consultants if no intervention is required.

Previously all patients were given an out-patient appointment with potential and actual delays in investigations being requested or treatment commencing.

The role of the Clinical Nurse Specialist (CNS) is pivotal in contacting patients and their clinical referrers to update them on the outcome of this virtual clinic. The patient’s perspective was paramount when considering the introduction of this part of the service. By ensuring follow up telephone calls are made on the same day as the meeting can minimise patient anxieties, allow detailed explanation of the agreed plan and provide direct contact telephone numbers.

This service change has been a challenging and rewarding additional to the CNS role within Bone & Soft Tissue Sarcoma Service with very positive feedback from the patients and the clinical staff that refer patients for discussion.

Research and Education C3. Developing multidisciplinary evidence based guidelines for the management of Acute Compartment Syndrome - Hannah Pugh

Abstract: Presenting on behalf of the guideline development group, and they are co-authors:
- Hannah Pugh, Orthopaedic CNS, Princess Grace Hospital, London
- Brian Lucas, Lead Nurse for Practice and Innovation at The Queen Elizabeth Hospital, Kings Lynne NHS trust
- Alison Louise Armstrong, Consultant Orthopaedic and Trauma Surgeon and Honorary Senior Lecturer in Medical Education, University Hospitals Of Leicester NHS Trust
- Julie Sancy-Tomlinson, Editor International Journal of Orthopaedic and Trauma Nursing and Senior Lecturer, Faculty of Health and Social Care,University of Hull
- Lynsey Brown, Trauma Nurse Co-ordinator, Addenbrooke’s Hospital, Cambridge University NHS Trust.
- Beverley Wellington, Clinical Nurse Specialist, Scottish National Brachial Plexus Injury Service, New Victoria Hospital, Glasgow and Lecturer, University of the West of Scotland
- Sonya Clarke, Senior Teaching Fellow, School of Nursing and Midwifery, Queen’s University Belfast

Acute compartment syndrome (ACS) is a well-documented potential complication of orthopaedic trauma and/or surgery. If left unrecognised and untreated it can result in necrosis leading to contractures and permanent nerve damage. At worst the patient may end up losing a limb or their life. Early detection and management is key. However there is no real consensus on key elements such as what to assess, how to assess and how frequently. Within the UK some individual hospitals have locally produced guidelines and assessment tools but they vary in detail, the degree of evidence base, and have not been tested on a large scale.

With this in mind The Royal College of Nursing’s Society of Orthopaedic and Trauma Nursing (SOTN), in conjunction with The British Orthopaedic Association have selected a working group to develop national guidelines consisting of orthopaedic nurses, surgeons and other members of the MDT. This will result in an early warning score to be used in the clinical setting. A substantial literature review has now taken place which has allowed us to recognise where the gaps in evidence lie and what we need to focus on. A consensus event is being held in autumn of this year and where gaps do exist expert opinion will be gained. Therefore, this presentation will focus on available evidence (which in some cases is surprising), evidence gaps (again, very interesting), discussion on the project including difficulties and positive outcomes from working with such a group, a basic overview of a national early warning score and assessment tool and finally the finished product.
3.30pm - 3.50pm
Skin Closure in Primary Total Hip Arthroplasty at the Northern Hospital
Dr Sam Bewsher Orthopaedic Registrar, Royal Melbourne Hospital, Victoria

Introduction & Aims: A recent meta-analysis suggested the risk of infection was four times greater using staples for skin closure in hip surgery compared to sub-cuticular sutures, but the rates of haemo-serous wound discharge was not statistically different.

The aim was to demonstrate that in THR, staples lead to not only an increase in infection rates, but also contributed to increased rates of wound ooze resulting in early dressing change and a high rate of temporary clexane cessation.

Methods: Retrospective audit of 188 consecutive primary THR recipients from a 3-year period (November 2009 to October 2012) was conducted. Data collected included: stapled or sutured closure, dressing change/reinforcement and temporary cessation of clexane. Adverse outcomes were defined as patients receiving oral Abx, or re-admission for IV antibiotics or washouts due to presumed wound infection.

Results: There were 188 primary THRs on 175 patients; 136 closed with staples and 52 with sutures. In the staples group, each patient had an average of 2.4 dressing changes until healed versus 0.9 for sutures (OR 5.6 [2.15-11.38] p<0.0001). Patients with staples had their clexane temporarily ceased more frequently for oozing wounds than those with sutures (OR 5.91 [1.35-25.87] p=0.018). Although a statistically higher rate of adverse outcomes could not be demonstrated for staples or sutures within the cohort, three or more dressing changes (OR 5.58 [1.57-19.77] p=0.008) and temporary clexane cessation (OR 5.58 [1.57-19.77] p=0.008) were identified as independent risk factors for adverse outcomes.

Conclusions: Using staples for closing the skin in Primary THR leads to a higher rate of wound ooze requiring more frequent dressing changes and more frequent temporary cessation of clexane, both of which are independent risk factors for adverse outcomes.

3.55pm - 4.45pm
VTE Prophylaxis in Orthopaedics - Panel Discussion
Yupin Crawford, BSc(Hons), MBA Business Development Manager Vascular Therapy, Covidien

Clinical practice guidelines are there to help improve screening, prevention, and treatment of Venous Thromboembolism based on the current best evidence. Current evidence-based medicine (EBM) standards demand that clinicians use the best available evidence in their clinical decision making.

Consensus, is this possible in Orthopaedics? How do we best work with variables to offer clinically practical and effective prevention strategies for patients?
9.20am - 9.40am
***Online Paediatric Fracture Guidelines***

Associate Professor Leo Donnan MMS, FRACS, FAOrthA., Director of Orthopaedic Surgery,
The Royal Children’s Hospital, Melbourne, Victoria

The Online Paediatric Fracture Education module was launched late in 2012, to assist in the understanding of fracture patterns and treatments in children. By use of a multi-media module, it is anticipated that those using the module will gain a greater understanding of the differences between fractures of the adult patient and the paediatric patient, and so be able to better treat these patients and therefore reduce the issue of complications. Information is presented in an e-learning format and uses animation for education of health professionals from various backgrounds.

9.45am - 10.05am
***FN – A Global Multidisciplinary Network to Improve Fragility Fracture Management and Prevention***

Ami Hommel, RN, CNS, Associate Professor, Lund University & Skane University Hospital, Sweden

**Background:**
Since nearly 9 million fractures occurs annually worldwide, fragility fracture and their care are a challenge to health care systems. Fragility fractures are strong predictors of future fracture since they reflect poor bone quality, therefore important to prevent the next fracture. A network has been formed to serve as a global mechanism for exchange of information and expertise of different topics. One of these networks is the fragility fracture network (FFN), a multidisciplinary network formed in August 2011. The network focus is on the patient who has had a fracture.

**Aims are to:**
1. Disseminate globally the best multidisciplinary practice in preventing and managing fragility fractures
2. Promote research aimed a better treatment of osteoporosis, sarcopenia and fracture
3. Drive change that will raise fragility fracture higher up on the healthcare agenda in all countries

**Results:**
The FFN held their first international conference in Berlin, Germany in September 2012 with more than 350 participants from all over the world. Clinical pathways for patients with a hip fracture were presented by nurses from USA, Sweden and UK resulting in many good discussions during the conference on how nurses can make differences in the care of these patients.

**Conclusion:**
Orthopaedic nurses encourage the development and implementation of clinical pathways from evidence-based guidelines. FFN will undertake global educational activities and scientific exchange to achieve education and support for people who have sustained fragility fractures. Although initially the FFN has limited its membership to relevant professionals the patient voice should be included.

10.10am - 10.30am
***Building Capability Across Countries: A Collaboration Between Nurses From 2 Hospitals in 2 Countries to Improve Orthopaedic Care***

Sihuh Nyoman Ali, Clinical Nurse Educator, BN, MN, Sanglah Hospital, Bali
I Gede Agung Rat Kresna Putra, Quality Coordinator, Dip Nsg, Sanglah Hospital, Bali
Ruth Jones, Clinical Nurse Manager, Orthopaedic Trauma Unit, Royal Darwin Hospital
I Made Artana, Clinical Nurse Educator, Orthopaedics, Skep, Sanglah Hospital, Bali
Di Brown, Project Coordinator, Sister Hospital Program. RN, PhD, Sanglah Hospital and Royal Darwin Hospital, Northern Territory

This paper describes a collaborative orthopaedic nursing professional development program between Royal Darwin Hospital (RDH) in the north of Australia and Sanglah Hospital in Bali, Indonesia.

Over 35 patients present each day to the Emergency Department at Sanglah Hospital following a motor vehicle injury (mostly from motor bikes). Debridement of open fractures and Open Reduction Internal Fixation (ORIF) are two of the top five surgical procedures, with fracture of long bones one of the top ten causes of admission. In Indonesia patients are cohorted according to their ability to pay which meant that prior to this program orthopaedic patients were scattered throughout the hospital and their care was less than optimal.

In 2011 three nurses from Sanglah went to The Royal Darwin Hospital for a 4 week clinical skills development program, including participation in their Orthopaedic Nursing Course. On return they conducted a local Introduction to Orthopaedic Nursing Program at Sanglah for 20 local nurses.

This was the first time that doctors and nurses had worked collaboratively to deliver professional education to nurses. It was also the first continuing professional education that many of the nurses had ever had. As a result of the program, the quality of care has improved, length of stay has reduced, patients are more satisfied, and medical and nursing staff are more satisfied with their capacity to provide care.

**Conclusions:** This program improved clinical care as well as providing a model of cross cultural professional development that may be helpful for other nurses who would be interested in working in developing countries.
## PLENARY SESSIONS

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<td>The Utilisation of Orthopaedic Nurses’ Assessment Skills - Do They Improve Patient Outcomes?</td>
<td>Sue Stewart, PhD Candidate University of Ballarat, MN (Orthopaedics), RN, Lecturer Holmesglen Institute, Moorabbin, Victoria</td>
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<td>Acute to Rehab Spinal Cord Injuries</td>
<td>Anna Brown, Clinical Nurse Consultant (CNC), VSCS Specialist Clinic, Austin Health, Melbourne, Victoria</td>
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<tr>
<td>12.10pm</td>
<td>Acute to Rehab Spinal Cord Injuries</td>
<td>Anna Brown, Clinical Nurse Consultant (CNC), VSCS Specialist Clinic, Austin Health, Melbourne, Victoria</td>
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<tr>
<td>12.15pm</td>
<td>Acute to Rehab Spinal Cord Injuries</td>
<td>Anna Brown, Clinical Nurse Consultant (CNC), VSCS Specialist Clinic, Austin Health, Melbourne, Victoria</td>
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<tr>
<td>12.35pm</td>
<td>Latest Development in VTE Management in USA</td>
<td>Beverly A Morris, RN, CNP, MBA, Nurse Practitioner; Director of National Association of Orthopaedic Nursing, University of California, San Diego Medical Center, USA</td>
</tr>
</tbody>
</table>
Are We Fit Enough to Run a Good Race?
Peter Davis, Associate Professor (Retired), University Nottingham, UK

This paper explores whether orthopaedic nurses are fit enough to join and run the race in response to current orthopaedic health care challenges. The essence of orthopaedic care relates to the mobility and mobilising patients. In relation to their professional life orthopaedic nurses need to be physically fit, mentally and socially fit, as well as environmentally. We are not immune to the effects of poor lifestyle choices in areas such as reduced physical activity, poor diet, increased alcohol consumption and inability to reduce the effects of stressful working environments. For example, the rate of increase in obesity, diabetes, hypertension, and depression in nurses is increasing in the developed world. Unfortunately, this is true for many health care professionals who reflect the society they are in rather than lead as healthy examples.

Learning outcomes are related to the increased ability in orthopaedic nursing practice to:
• Understand why nurses struggle to keep race fit
• Recognise how to get to the start line when racing to meet the challenge
• Run a good race consistently over long periods of time
• Pursue principals of training for life-long health

PARALLEL SESSION D (Please indicate your session preferences on your registration form)

Clinical  D1. Atypical Femoral Fractures
Anita Taylor, Orthopaedic Nurse Practitioners, Orthopaedic and Trauma Unit, Royal Adelaide Hospital, and Cheryl Kimber, Orthopaedic Nurse Practitioner, Flinders Medical Centre, South Australia

This presentation will report on a multi-centre, case series of atypical femoral fractures. Information regarding atypical femoral fracture associated in particular with bisphosphonate use is gathering. It appears these fractures behave like ‘stress fractures’. This presentation will report on the emerging evidence surrounding this phenomenon, the aetiology and review the management of several clinical examples sourced via ‘case finding’ within two tertiary referral centres in Adelaide. This presentation aims to elucidate upon this relatively rare clinical incidence and draw implications for clinical practice, particularly in the area of patient education.

Clinical  D2. The Orthopaedic Surgical Journey of the Paediatric Patient and Family with Sarcoma
Noelle Coleman, Clinical Nurse Coordinator, Paediatric Limb Reconstruction Service, Royal Children’s Hospital, Brisbane, Queensland

Learning outcomes:
• Types of Sarcoma
• Diagnosis of sarcoma
• Medical management
• Surgical planning/management
• Rational for ongoing follow up to skeletal maturity

The Queensland Paediatric Reconstruction Service (QPLRS) at the Royal Children’s Hospital Brisbane has expanded their service to incorporate the surgical management of the paediatric patient & family with a diagnosis of Sarcoma. The surgical journey of this specialist patient group requires a multidisciplinary team approach across the specialist teams coordinated by the Limb Reconstruction Service Clinical Nurse (CNLRS) to ensure a lean thinking approach to their care and management. The learning curve for the CNLRS expansion into this specialist area has been vertical and is ongoing in terms of holistic management of the sarcoma patient and family. Parental and professional feedback has been positive and therefore encouraging in terms of the surgical journey of the patient’s treatment providing a more streamlines and coordinated approach.

Research and Quality  D3. Improving Communication with Trauma Patients
Melissa Bantick, RN, Grad Dip Crit Care, Grad Cert Ed, Trauma Program Manager, Royal Melbourne Hospital, Victoria

In 120 in-depth interviews the perceptions of the care received by Trauma Patients with blunt trauma in the Victorian State Trauma System, have been identified. Of these 56.7% of participants reported negative perceptions regarding communication related to prognosis, ward rounds, decision making, timing and conflicting information.

Aim: To identify the perceptions of patients regarding Trauma Care at one Major Trauma Service.

Method: We surveyed 169 inpatient trauma admissions at the Royal Melbourne Hospital over a period of 12 weeks. The survey addressed the themes of General Satisfaction, Decision Making, Information and Wards Rounds. Patient responses were then correlated with demographics of Age, Sex, Mechanism of Injury (MOI), Injury Severity Score (ISS) and Length of Stay (LOS). Exclusion criteria included GCS was <15, they were not cleared of Post Traumatic Amnesia (PTA), non English speaking, or sectioned under the Mental Health Act. Patients under the age of 18 were included if a guardian was present.

Result: Data collection for this project is in progress and will be available at the time of presentation. Early data analysis demonstrates that while >94% of patients are generally satisfied with care and ward rounds, they have poor perceptions of their involvement in decision making, felt they often received conflicting information and did not have a good understanding of injuries or how these might impact on their life beyond hospital.

### PARALLEL SESSION E

#### Clinical E1. Dementia Friendly Orthopaedic and Trauma Nursing

**Julie Santy-Tomlinson, Senior Lecturer, The University of Hull, UK, and Co-Editor International Journal of Orthopaedic and Trauma Nursing**

Dementia is arguably the most significant health issue affecting modern society. It currently affects many millions of older people across the world, so the likelihood of a dementia sufferer being an orthopaedic patient is high. Patients with dementia present a significant challenge due to the catalogue of difficulties they experience because of their impaired memory and cognition, making them more vulnerable to receiving poor care. For example, patients with dementia who suffer a hip fracture have been shown to receive less effective pain assessment and pain management (Morrison & Siu 2000). There are a number of challenges of providing acute hospital care to patients with dementia and there is strong evidence that we invariably get it wrong.

“In this day and age, how could anyone disagree that treating people struggling to live with dementia as whole human beings is the right and civilized way to respond? However, a cursory look around service provision […] people with dementia are not valued by society and the care they receive is not based on trust, respect and dignity” (Brooker 2007 p 31) However, much is an offer in the way of improving the care of dementia sufferers and their families in hospital settings. The aim of this presentation is to inspire delegates to examine and improve the care of patients with dementia in their unit through education and change in practice. The presentation aims to be of interest to all orthopaedic nurses working with patients who have dementia.

At the end of this session delegates will be able to:

1. Identify the fundamental needs of orthopaedic patients with dementia
2. Identify the things that can go wrong for the orthopaedic patient with dementia
3. Understand how to make orthopaedic care dementia friendly

**References**


#### Clinical E2. Take a Chance on Me

**Helen Jowett, RN, Trauma Services Manager, The Royal Children’s Hospital, Victoria**

Chance fractures are most commonly seen in the mid lumbar region in the paediatric population as compared with the adult population whose injury tends to occur more commonly in the thoraco-lumbar junction (T12-L2). The fracture usually results from a high speed motor vehicle crash when the passenger has been wearing the more traditional style lap belt. The lap belt transsects the passenger’s abdomen and is therefore referred to as the ‘seat belt injury’.

In the paediatric population they can be especially challenging to manage when there are competing surgical co-morbidities. This is due to 50% of Chance fractures being associated intra-abdominal injuries. Whilst the majority of children today are conservatively managed for surgical injuries, for the children who do require operative management, this may pose issues. When this patient cohort presents and their injuries are so significant that they require an urgent, time critical laparotomy, the ability to appropriately assess the patient can be compromised. Other factors such as developmental age, no parents/carers available at time of admission, fatalities at the scene and non-English speaking background are all contributing factors to decreased assessment of the child. Once the patient has received their urgent surgery it is very challenging for the clinicians involved to accurately assess the spine. The child is often unable, to accurately locate their source of pain or to differentiate if in they have spinal pain or pain related to their surgical incision.

The following case presentation will highlight all of the issues discussed above. It will look at the whole patient journey from a pre-hospital perspective right through to discharge from the definitive care setting.

#### Research and Quality E3. Fractured Neck of Femur: How We Reduced the Length of Stay!

**Megan Yeoman, Clinical Nurse Consultant, Austin Hospital, Victoria**

Health Round Table revealed that the Fracture Neck of Femur group at our organisation had a significantly longer length of stay than similar organisations.

Led by executive and senior clinicians, a multidisciplinary team was created who looked at what the current practice was in managing these patients, and could we move toward a patient centred approach as opposed to a system oriented approach in a bid to reduce length of stay. Time to theatre, prolonged fasting, inadequate analgesia and delirium were just a few areas flagged for improvement. Pain services were asked to assist in optimising pain management in this group who were previously identified as having little peri operative pain.

This talk will discuss how collaboration between departments and multidisciplinary team members led us to become an exemplar hospital when managing these patients.
Neurovascular observations are fundamental core clinical skills that nurses undertake to monitor the neurovascular status of a patient. This essential knowledge of a patient’s clinical status, provides an early warning sign of developing orthopaedic complications such as nerve injury and compartment syndrome.

Expert orthopaedic nurses in a major Australian metropolitan trauma hospital identified a deficit in nursing knowledge, an understanding, of the significance of observation results with a lack of useful documentation of neurovascular observations required action to improvement this situation.

An audit was performed in numerous clinical areas throughout the hospital to ascertain and verify the presence and extent of this skill deficit. Knowledge and documentation tools used varied amongst clinical areas. Extensive consultation with clinicians, policy makers and clinical governance was sought resulting in the development of specific neurovascular charts for upper and lower limbs. The introduction of this tool in conjunction with education programmes has resulted in a clinician driven practical tool being implemented throughout the whole hospital.

This paper will provide an overview of the Bone & Soft Tissue Sarcoma Service for the West of Scotland based in Glasgow Royal Infirmary.

The main aim of this paper is to highlight the role and responsibility of the Clinical Nurse Specialist (CNS) caring for patients with a diagnosis of giant cell tumour of bone (GCT).

This follow up service, previously consultant led, has developed over the last 3 years, not only providing continuity of care but a rigorous assessment process. GCT of bone is a relatively rare tumour of the skeleton. Although classified as benign, GCT’s can be aggressive and recur locally in up to 50% of cases with a small incidence of lung metastases or spontaneous transformation to a high grade malignancy.

The preferred surgery is curettage, high speed burring of the tumour cavity, cementoplasty and plating.

The benign although aggressive condition can prove to be a significant cognitive challenge for patients and their carers as they face a diagnosis, surgery and long term follow up, with the additional burden of recurrence and or malignant change. The CNS role offers a pivotal role in offering a patient centred approach to care.
**Clinical G1.** Post-discharge Pain Experience Following Primary Total Hip and Total Knee Arthroplasty in Patients Whose Primary Language is Not English
Yvonne Ramlall, RPN, LCP Fellow, Holland Orthopaedic & Arthritic Centre/ Sunnybrook Health Sciences Centre

**Abstract:** The objective of this study is to review how communication barrier impact the understanding of and reporting of pain levels and management options, rather than whether non-English speaking patients actually experience different pain levels.

**Purpose:** The purpose of the study was: (1) To determine pain scores of the patients upon discharge from Acute Care; (2) Assess what level of pain scores are found to be satisfactory by patients; (3) Assess the number of prescribed pain tablets taken; (4) Assess the association between pain score and the number of tablets controlling for age and gender and (5) To determine whether the patients are satisfied with their ability to communicate their pain control needs; to describe their satisfaction and to say how to improve pain control.

**Method:** Consent was obtained in the presence of a substitute decision maker and a copy was kept on record. Ethics approval was obtained. Patients were presented with a Study Instruction Sheet which provided directions surrounding the completion of the Pain Self-Assessment Form (PSAF). Pain Scores were measured 3 times/day for 5 days.

**Sample/Response Rate:** Of the 22/143 patients who qualified, 20 consented; 2 declined; 13 went to Internal Rehab; 1 to External Rehab and 6 were discharged to home. Overall response was 94.7%.

**Satisfaction:** Fifty-six per cent of patients were satisfied with pain control; 50% reported nausea; 28% reported dizziness and sweating; 22% reported constipation and 39% needed an interpreter.

**Clinical G2.** Person Centred Care
Beverley Wellington, Clinical Nurse Specialist, Lecturer, Scottish Brachial Plexus Injury Service, Glasgow, Scotland

The paper will open by providing an overview of the Scottish National Brachial Plexus Injury Service 9 year activity including mechanisms of injury and treatment patterns.

The main aim of the paper is to showcase the responsive role of the Clinical Nurse Specialist within the service multidisciplinary team and demonstrates the delivery of a patient focused approach to care. The CNS has increased her activity within the service and has developed a key pivotal role in supporting the patient and their carers with various activities including a cognitive behavioural therapy approach to counselling, motivational interviewing, non-pharmacological pain management, sexual counselling, assertiveness training, leisure & sporting activity advice and goal centred action planning.

The patient’s perspective is paramount to the individualised care that is provided and the uniqueness of the patient is embraced and responded to. This is a challenging and rewarding part of the Clinical Nurse Specialist role that enables a holistic pathway of care for every individual patient. There has recently been a patient held record introduced to the service to improve complex communication issues. This patient centred approach to care is echoed in our mission statement – which will be discussed.

**Research and Quality G3.** How Do The Elderly Cope With Ilizarov Frames?
Maria Vincent, Clinical Nurse Specialist RGN ONC, Northern General Hospital, Sheffield, UK

The aim of the study was to evaluate how patients over 65 years of age cope with the Ilizarov method of treatment, for tibial fractures and deformity correction, compared with patients a decade younger. Two age groups were selected, 50-65 years versus 65 years and over. 20 consecutive patients were recruited for each group. SF36 scores were completed pre-operatively, at 6 weeks post op and 6 weeks post frame removal. 41 patients were recruited in total. Seven patients were lost to follow up – 2 died, 2 became too ill to continue with treatment, 3 did not complete the SF36. This left 34 patients. T test was used to analyse the results. Both age groups showed an equal and statistically significant drop in SF36 scores whilst the ilizarov frame was on (p<0.01 for each group). After frame removal, SF36 in the >65 group was not significantly different to pre-operative values. In the younger group, SF36 after frame removal was still significantly lower than pre-operative values (p<0.01). Age makes no difference in how patients cope with the ilizarov frame during treatment. Older patients have low pre-injury function levels, but appear to return to this level quickly after frame removal. Younger patients do not recover pre-injury function in 6 weeks after completion of treatment.
# PROGRAM

## WEDNESDAY 30 OCTOBER 2013

<table>
<thead>
<tr>
<th>Time</th>
<th>Event Description</th>
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<tbody>
<tr>
<td>4.00pm - 5.00pm</td>
<td>ANZONA Annual General Meeting</td>
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<tr>
<td>3.30pm - 6.30pm</td>
<td>Registration</td>
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<tr>
<td>6.30pm - 8.30pm</td>
<td>ANZONA Welcome Reception at Hilton on the Park Hotel</td>
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<td>Acknowledgement of International Orthopaedic Nurses Day and brief presentation</td>
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## THURSDAY 31 OCTOBER 2013

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>7.30am - 8.30am</td>
<td>Registration continues</td>
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<tr>
<td>8.30am - 8.45am</td>
<td>Conference Opening</td>
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<td>Address by ANZONA President</td>
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<td>Address by Conference Chair</td>
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<tr>
<td>8.45am - 9.45am</td>
<td>Keynote Address: Sharpening the Image of Nursing</td>
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<td></td>
<td>Beverly A Morris, RN, CNP, MBA, Nurse Practitioner, University of California, San Diego Medical Center, USA</td>
</tr>
<tr>
<td>9.45am - 10.05am</td>
<td>Orthopaedic Nursing in 2010s</td>
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<td>Paul McLiesh, Lecturer, BN, GDip Orth, MNSc, University of Adelaide, South Australia</td>
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<tr>
<td>10.10am - 10.30am</td>
<td>Professional Practice</td>
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<td></td>
<td>The Experience and Effectiveness of Nurse Practitioners in Orthopaedic Settings</td>
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<tr>
<td></td>
<td>Anita Taylor, Orthopaedic Nurse Practitioner, Royal Adelaide Hospital, South Australia</td>
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<tr>
<td>10.30am - 11.00am</td>
<td>Morning Tea with Trade Exhibitors</td>
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<tr>
<td>11.05am - 11.25am</td>
<td>Journey to the Finish Line: Fast Track Joint Replacements in The Queen Elizabeth Hospital</td>
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<td>Lesley Thomas, Orthopaedic Nurse Practitioner, The Queen Elizabeth Hospital, South Australia</td>
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<tr>
<td>11.30am - 11.55am</td>
<td>Local Infiltration Analgesia Reduces Length of Stay and Complications</td>
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<td>David Mitchell, Director of Orthopaedics, Ballarat Base Hospital, Victoria</td>
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<tr>
<td>12.00pm - 1.00pm</td>
<td>Getting Published - Writing for Publication for Orthopaedic and Trauma Nurses</td>
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<td></td>
<td>Peter Davis, Emeritus Editor, International Journal of Orthopaedic and Trauma Nursing, and Julie Santy-Tomlinson, Co-Editor, International Journal of Orthopaedic and Trauma Nursing</td>
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<tr>
<td>1.00pm - 2.00pm</td>
<td>Lunch with Trade Exhibitors</td>
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<tr>
<td>Parallel Sessions</td>
<td>Professional</td>
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<tr>
<td><strong>WEDNESDAY 30 OCTOBER - FRIDAY 1 NOVEMBER 2013</strong></td>
<td><strong>HILTON ON THE PARK HOTEL, MELBOURNE, AUSTRALIA</strong></td>
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<tr>
<td><strong>3.00pm - 3.30pm</strong></td>
<td><strong>Afternoon Tea with Trade Exhibitors</strong></td>
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<td>Dr Sam Bewsher, Orthopaedic Registrar, Royal Melbourne Hospital, Victoria</td>
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<td></td>
<td>Yupin Crawford, BSc (Hons), MBA Business Development Manager – Vascular Therapy, Covidien</td>
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<tr>
<td><strong>2.05pm - 2.20pm</strong></td>
<td><strong>A1. Orthopaedic Nurse Practitioner in the Acute Care Environment, A Western Australian Perspective</strong></td>
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<td>Sharon Pickles, Nurse Practitioner, Sir Charles Gairdner Hospital Perth</td>
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<td><strong>2.25pm - 2.40pm</strong></td>
<td><strong>B1. Protocols, Their Role in Changing Practice</strong></td>
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<td>Cheryl Kimber, Orthopaedic Nurse Practitioner, Flinders Medical Centre, South Australia</td>
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<tr>
<td><strong>2.45pm - 3.00pm</strong></td>
<td><strong>C1. So you Thought Developing a Procedure was Going to be Easy! My Journey</strong></td>
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<td>Larissa Bailey, Clinical Nurse, RN, Grad. Dip. Ortho, Flinders Medical Centre, South Australia</td>
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<tr>
<td>3.00pm - 3.30pm</td>
<td><strong>Skin Closure in Primary Total Hip Arthroplasty at the Northern Hospital</strong></td>
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<tr>
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<tr>
<td>3.55pm - 4.45pm</td>
<td><strong>VTE Prophylaxis in Orthopaedics - Panel Discussion</strong></td>
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<tr>
<td>4.50pm - 5.00pm</td>
<td><strong>Summary and Conclusion of Day 1</strong></td>
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<tr>
<td>7.00pm - 7.30pm</td>
<td><strong>Pre-dinner Drinks at Hilton on the Park Hotel</strong></td>
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<tr>
<td>7.30pm - 11.30pm</td>
<td><strong>Conference Dinner at Hilton on the Park Hotel</strong></td>
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**FRIDAY 1 NOVEMBER 2013**

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<tr>
<td>8.30am - 9.15am</td>
<td><strong>Keynote Address: Preparing for the Changing Landscape of Specialty Orthopaedic Nursing Practice</strong> Emeritus Professor Judith M Parker AM</td>
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<tr>
<td>9.20am - 9.40am</td>
<td><strong>Online Paediatric Fracture Guidelines</strong> Associate Professor Leo Donnan MMS, FRACS, FAOrthA – Director of Orthopaedic Surgery, The Royal Children’s Hospital, Melbourne, Victoria</td>
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<tr>
<td>9.45am - 10.05am</td>
<td><strong>FN – A Global Multidisciplinary Network to Improve Fragility Fracture Management and Prevention</strong> Ami Hommel, RN, CNS, Associate Professor, Lund University &amp; Skane University Hospital, Sweden</td>
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<tr>
<td>10.10am -10.30am</td>
<td><strong>Building Capability Across Countries: A Collaboration Between Nurses From 2 Hospitals in 2 Countries to Improve Orthopaedic Care</strong> Siluh Nyoman Alit, BN. MN., Clinical Nurse Educator, Sanglah Hospital, Bali I Gede Agung Rat Kresna Putra, Dip. Nsg., Quality Coordinator, Sanglah Hospital, Bali Ruth Jones, Clinical Nurse Manager Orthopaedic Trauma Unit, Royal Darwin Hospital I Made Artana, Clinical Nurse Educator, Orthopaedics, Skep, Sanglah Hospital, Bali Di Brown, RN. PhD, Project Coordinator, Sister Hospital Program, Sanglah Hospital and Royal Darwin Hospital, Northern Territory</td>
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**FRIDAY 1 NOVEMBER 2013 - CONTINUED**

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<tbody>
<tr>
<td>10.30am - 11.00am</td>
<td>Morning Tea with Trade Exhibitors</td>
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</tbody>
</table>
| 11.00am - 11.20am | The Utilisation of Orthopaedic Nurses’ Assessment Skills - Do They Improve Patient Outcomes?  
Sue Stewart, PhD Candidate University of Ballarat, MN (Orthopaedics), RN,  
Lecturer Holmesglen Institute, Moorabbin, Victoria |
| 11.25am - 11.45am | Management of Spinal Cord Injury Outside of a Specialist Spinal Injuries Unit – The Derby Experience  
Sharon Budd, Trauma Nurse Coordinator, Royal Derby Hospital, England |
| 11.50am - 12.10pm | Acute to Rehab Spinal Cord Injuries  
Anna Brown, RN, Clinical Nurse Consultant, Austin Hospital, Victoria |
| 12.15pm - 12.35pm | Latest Development in VTE Management in USA  
Beverly A Morris, RN, CNP, MBA, Nurse Practitioner; Director of National Association of Orthopaedic Nursing,  
University of California, San Diego Medical Center, USA |
| 12.40pm - 1.00pm | Are We Fit Enough to Run a Good Race? Peter Davis  
Associate Professor (Retired) MBE, MA, BNEd, University Nottingham, UK |
| 1.00pm - 2.00pm | Lunch with Trade Exhibitors + Poster Judging                         |

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<tr>
<th>Parallel Sessions</th>
<th>Clinical</th>
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</table>
| 2.05pm - 2.25pm   | D1. Atypical Femoral Fractures  
Anita Taylor, Orthopaedic Nurse Practitioners Orthopaedic and Trauma Unit, Royal Adelaide Hospital, and  
Cheryl Kimber, Orthopaedic Nurse Practitioner, Flinders Medical Centre, South Australia |
|                   | D2. The Orthopaedic Surgical Journey of the Paediatric Patient and Family with Sarcoma  
Noelle Coleman, Clinical Nurse Coordinator, Paediatric Limb Reconstruction Service, Royal  
Children’s Hospital, Queensland |
|                   | D3. Improving Communication with Trauma Patients  
Melissa Bantick, RN, Grad Dip Crit Care, Grad Cert Ed, Trauma Program Manager, Royal  
Melbourne Hospital, Victoria |
| 2.30pm - 2.45pm   | E1. Dementia Friendly Orthopaedic and Trauma Nursing  
Julie Santy-Tomlinson, Senior Lecturer, The University of Hull, UK and  
Co-Editor International Journal of Orthopaedic and Trauma Nursing |
|                   | E2. Take a Chance on Me  
Helen Jawett, RN, Trauma Services Manager, The Royal  
Children’s Hospital, Victoria |
|                   | E3. Fractured Neck of Femur: How we Reduced the Length of Stay!  
Megan Yeoman, Clinical Nurse Consultant, Austin Hospital, Victoria |
| 2.50pm - 3.05pm   | F1. Neurovascular Observations – Are They More Than Just a Tick?  
Cheryl Kimber RN ONC. MNP, MRCNA, Orthopaedic Nurse Practitioner, Flinders Medical Centre,  
South Australia, and Larissa Bailey, RN, Grad Dip. Ortho., Clinical Nurse,  
Flinders Medical Centre, South Australia |
|                   | F2. Giant Cell Tumour of Bone - Surgical treatment  
Helen Findlay, Clinical Nurse Specialist Orthopaedic Surgical Oncology, Glasgow Royal Infirmary, Scotland |
|                   | F3. Building Capability to Achieve Best Patient Outcomes  
Michelle Wagner, RN, St Vincent’s Hospital, Toowoomba, Queensland |
| 3.10pm - 3.25pm   | G1. Post-discharge Pain Experience Following Primary Total Hip and Total Knee Arthroplasty in Patients Whose Primary Language is Not English  
Yvonne Ramill, RPN, LCP Fellow, Holland Orthopaedic & Arthritis Centre/ Sunnybrook Health Sciences Centre(HC/SHSC) |
|                   | G2. Person Centred Care  
Beverley Wellington, Clinical Nurse Specialist,  
Lecturer, Scottish Brachial Plexus Injury Service, Glasgow, Scotland |
|                   | G3. How Do The Elderly Cope With Ilizarov Frames?  
Maria Vincent, Clinical Nurse Specialist RGN ONC, Northern General Hospital, Sheffield, UK |
| 3.30pm - 4.00pm   | Afternoon Tea with Trade Exhibitors |
| 4.00pm - 5.00pm   | Conference Summary  
Acknowledgement of Sponsors and Raffle Draw |
|                   | ANZONA 2015 Conference  
Close of Conference |
| 5.00pm - 6.00pm   | Happy Hour |

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*ANZONA 2015 Conference*
ACCOMMODATION

The Conference has accommodation block bookings at the hotels listed below. We highly recommend you register early, especially if you require accommodation, as it is the Melbourne Cup Carnival week and all hotels are heavily booked. You will need to book and pay for your full accommodation cost when you register. A confirmation letter, together with a Tax Invoice will be sent to you.

**Hilton on The Park, (Conference Hotel)**
190 Wellington Parade, East Melbourne

- **$274.00** Hilton King Room per room per night (includes breakfast for one person)
- **$289.00** Hilton King Room per room per night (includes breakfast for 2 people)

http://www.hiltonmelbourne.com.au

**Mercure Hotel**
13 Spring Street, Melbourne
(Located across from Treasury Gardens and a 5 - 10 minute walk to the Hilton)

- **$225.00** City View Room per room per night
- **$25.00** Full buffet breakfast per person per day


**Quest Jolimont**
153-155 Wellington Parade South, East Melbourne
(5 - minute walk to the Hilton)

- **$165.00** 1 Bedroom Apartment per room per night (1 x Q bed) (Max 2 Guests)
- **$235.00** 2 Bedroom Apartment per room per night (1 x Q bed & 2 x singles/ 2 x Q beds) (Max 4 Guests)
- **$12.00** Cold Breakfast per day, per person

*Must be booked prior to arrival **Hot Breakfast available at Café Olive*


**Mantra on Jolimont**
133 Jolimont Road, East Melbourne
(5 - minute walk to the Hilton)

- **$159.00** Studio Apartment per room per night (1 x Q bed OR 2 x singles)
- **$189.00** 2 Bedroom Apartment per room per night (2 x Q Bed OR 1 x Q bed or 2 x singles) (Max 4 Guests)
- **$25.00** Full buffet breakfast per person per day

SOCIAL FUNCTIONS

Welcome Reception
Venue: Ballroom Foyer, Hilton on the Park Hotel
Date: Wednesday 30 October
Time: 6:30pm - 8:30pm
Dress: Smart Casual
Cost: Included in full registration
Additional Tickets: $80.00
Provided: Canapés and beverages

Conference Dinner
The Conference Dinner is included in the full registration price. Extra tickets may be purchased, depending on availability.
Venue: Grand Ballroom, Hilton on the Park Hotel
Date: Thursday 31 October
Time: 7:00pm - 11:30pm
Dress: Details to be provided in the Conference Newsletter
Cost: Included in Registration
Additional Tickets: $130.00 subject to availability
Provided: 3 course meal, with beer, wine and soft drink

Happy Hour
Venue: Parkview Bar – Hilton on the Park
Date: Friday 1 November 2013
Time: 5:00pm – 6:00pm
Dress: Smart Casual
Cost: Your own cost

What’s on in Melbourne?
There is so much to do in Melbourne therefore to assist you with planning your trip we suggest you investigate the following websites:
http://www.visitmelbourne.com
http://www.tourstogo.com.au
http://www.penguinislandtour.com.au
http://www.visityarravalley.com.au
http://www.racingvictoria.net.au/springracingcarnival
http://melbournecup.com
GENERAL INFORMATION

HILTON ON THE PARK,
192 WELLINGTON PARADE,
MELBOURNE

Located in elegant East Melbourne, the Hilton Melbourne on the Park hotel is set in the heart of the city's sporting and entertainment district and overlooks the beautiful Fitzroy Gardens.

Train and tram links are available from the hotel's doorstep and the city center is just a short walk from this central Melbourne hotel.

Situated directly opposite the Melbourne Cricket Ground (MCG), Rod Laver Arena and Melbourne Park, this Melbourne hotel is close to all the action.

MELBOURNE TRANSPORT – MYKI CARDS

Melbourne’s public transport system now runs on Myki Cards and you are no longer able to purchase a ticket on board any public transport; you will need a Myki card. If you are planning to stay in Melbourne and use the public transport system, you can purchase your Myki Card before arriving in Melbourne, and have it topped up and ready to go. A full fare Myki costs $6.00. When you buy a Myki it has no value on it, so you need to top up before you travel. Please go to www.myki.com.au for further information.

Myki visitors packs are also available. These can be purchased at the Skybus terminal at Melbourne Airport, and various outlets throughout the city. Please refer to the Myki website for the most up to date information. The pack contains a Myki smart card loaded with enough value for one day’s travel. An information pack is also included. You will also find discounts to many attractions throughout the city in the pack. The Myki pack is currently $14.00, which includes $8.00 travel credit.

MELBOURNE WEATHER

The month of October is characterized by gradually rising temperatures, with daily highs increasing from 18°C to 20°C over the course of the month, occasionally exceeding 27°C or dropping below 13°C only one day in ten.

WHAT TO WEAR

Dress for the conference is smart casual – look for details of the dinner theme in the Conference Newsletters.

CONFERENCE PARTNERS’ POLICY

We respectfully remind you that partners accompanying delegates are not eligible to attend conference sessions and do not qualify for refreshments and lunches during the day. Any partner wishing to attend events not previously selected and paid for in his or her registration may do so at the Conference Registration desk. We would be pleased to accommodate any requests where possible.

CANCELLATION POLICY

Registration cancellations will not be accepted unless made in writing. Cancellations made before Monday 30 September 2013 will be refunded less 25% of the Conference Registration fee, to cover administration costs. No registration refunds will be given after this date.

Substitute delegate is acceptable.

CAR PARKING

Self parking will be charged at a special conference rate of $22 per car, per day

TRANSPORT

SkyBus offers an express bus service from Melbourne airport to the city centre. This service operates 24/7, including all public holidays. Buses run from every 10 minutes throughout the day. Tickets can be purchased on arrival at the bus stop or purchased online at www.skybus.com.au. SkyBus also provides a complimentary city hotel transfer service, subject to availability.

For further information visit www.skybus.com.au or email info@skybus.com.au

For bookings/enquires telephone 03 9335 2811 or fax 03 9338 5075

CAR HIRE

Avis http://www.avis.com.au
Budget http://www.budget.com.au
Europcar http://www.eurpocar.com.au
Hertz http://www.hertz.com.au
Thrifty http://www.thrifty.com.au

DIETARY REQUIREMENTS

All dietary requirements can be catered for. Please include any special requests you may have on your registration form or online submission. If there is not allocated seating you may have to ask the hotel waiters for your specific meal or look for the Special Diets table.

CONFERENCE MANAGER

Please refer any registration queries to: Ros Christie or Katrina Daymond BCC Management, Level 1, 370 Bay Street, Port Melbourne, Vic. 3207 Ph: 03 8679 5460 Mob: 0400 964 696 Fax: 03 8679 5469 Email: info@bccm.com.au Website: www.bccm.com.au

REGISTER ONLINE

https://www.secureregistrations.com/ANZONA2013/ [Credit Card payments only]

WEBSITE: http://www.anzona.net or www.onavic.com.au
Effective Reduction in Hospital Acquired Conditions

7% of all deaths in hospitals are due to Venous Thromboembolism¹


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