CLIMBING TO THE SUMMIT
CONFERENCE PROGRAM
BRIDGING RESEARCH AND PRACTICE IN ORTHOPAEDIC NURSING
11-13 NOVEMBER 2015
HILTON SYDNEY
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INVITATION TO ATTEND

The Orthopaedic Nurses Association of New South Wales warmly invites you to attend the 7th ANZONA Conference at Hilton Sydney, New South Wales, Australia.

Conference Theme:
Climbing to the Summit: Bridging Research and Practice in Orthopaedic Nursing.

Orthopaedic nursing is a nursing specialty focused on the prevention and treatment of musculoskeletal disorders. Orthopaedic nursing requires specialised skills, incorporates various subspecialties (e.g. trauma, rheumatology & paediatrics) and ranges from conservative to operative management of acute injuries to chronic systemic disorders in a variety of settings.

This conference aims to provide nurses interested in musculoskeletal nursing with an opportunity to collaborate, expand their knowledge with the latest information and most effective forms of treatment and exchange research and projects to influence and promote the highest standards of innovative evidence supported Orthopaedic nursing practice.

Conference Sub-themes:
• Professional expertise
• Outcome based clinical practice
• Professional Development

The Conference aims to:
Provide a platform for communication between researchers, young and established, and between researchers and practitioners.

Who Should Attend?
The Conference brings 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

Why Attend?
• Build connections and take advantage of the networking opportunities
• Collaborative Learning
• Continuing Professional Development
• Validate your practice
Professor Di Brown has a national and international reputation in nursing leadership and nursing education. She has extensive experience as both a clinician and academic. She has held senior clinical roles and as well, undertaken consultancies with organisations such as WHO, the World Bank, AusAID and various universities within and outside of Australia.

She is a Professorial Fellow at Charles Darwin University and a Visiting Professor of the University of Indonesia.

Di currently manages a large healthcare development project in Indonesia. Di’s passion is working with clinicians and health care leaders to assist them in managing changes to practice.

Abstract:
Nursing can be challenging, trying and tough. It is easy to complain about the difficulties that face us every day. However, if we’re serious about improving health care and improving our work-life then we need to resist simply looking for the faults in the system and to start to look for solutions. This talk aims to challenge thinking and to provide a framework for thinking about practice in a different way. What we need in today’s fast moving world is to become unorthodox, to look at problems in a different way, to give things a go... to be willing to try.

Ian Whiteley has worked at Concord Repatriation General Hospital in NSW since 1998. He has worked as a RN, CNE and NUM. He has been in his current role as the Clinical Nurse Consultant Stomal Therapy & Wound Management since 2005. Ian is an advocate for lifelong learning and has a Graduate Certificate in Stomal Therapy Nursing, Graduate Certificate in Nursing Education & Masters in Clinical Nursing and is published both nationally and internationally.

Abstract:
The aim of this presentation is to inspire nurses to engage in research. This is an introduction to how I got involved in research, the benefits of collaboration, putting research into practice and improving patient outcomes.
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<tr>
<td>Wed 11 Nov</td>
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<td>5.00PM - 6.00PM ANZONA Biennial General Meeting</td>
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<td>Thu 12 Nov</td>
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<td>8.45AM - 9.45AM Keynote Address: Climbing to the Summit: The Willingness to Try</td>
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<td>9.45AM - 10.30AM Advancing Orthopaedic Nursing Through International Collaboration</td>
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<td></td>
<td>Ann Butler-Maher, Anita Meehan and Ami Hommel</td>
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<td>10.30AM - 11.00AM Morning Tea with Trade Exhibitors</td>
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<td>11.00AM - 12.00PM Incidence, Diagnosis and Treatment of Bone and Soft Tissue Tumours with an Insight to Future Changes in Management</td>
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<td>12.00PM - 12.40PM So You Think You Can’t Write</td>
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<td>Julie Santy Tomlinson and Paul McLeish</td>
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<td>12.40PM - 1.00PM My Patient is Non Weight Bearing, Discharge Planning Issues and Concerns with Respect to the Non Weight Bearing Orthopaedic Patient: An Orthopaedic Case Manager’s Perspective</td>
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FRIDAY 13 NOVEMBER 2015

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<td>9.20AM - 9.40AM</td>
<td>Metal on Metal Hip Replacements: What Nurses Need to Know</td>
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<td>Sandra Kline</td>
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<td>9.40AM - 10.40AM</td>
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<td>Dr Sol Qurashi</td>
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<td>10.40AM - 11.10AM</td>
<td>Morning Tea with Trade Exhibitors</td>
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<td>11.10AM - 12.10PM</td>
<td>How Battle Field Experience Leads to Improvement in Orthopaedic Care</td>
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<td>Dr Brett Courtenay</td>
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<td>12.10PM - 1.00PM</td>
<td>Pain Management Advances in Orthopaedics - “Pass me the winch and pulley”</td>
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<td>Dr Charlotte Johnstone</td>
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<td>1.00PM - 2.00PM</td>
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PARALLEL SESSIONS

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<td>Justine Naylor</td>
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<td>The Introduction of the Role of Metastatic Spinal Cord Compression Co-ordinator</td>
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<td>R6 - Joint Awareness - Patient Reported Outcomes after Total Knee Replacement (TKR)</td>
<td>Henriette Appel Holm</td>
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<td>P6 - Recognising Pin Site Infection: The Devil’s in the Detail</td>
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<td>S6 - Orthopaedic Nursing in Malaysia: Where We Are Now and Where We Are Heading</td>
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<td>Conference Summary</td>
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Advancing Orthopaedic Nursing Through International Collaboration
Ann Butler-Maher, RN, MS, FNP-BC, ONC, ICON Ambassador, [retired]
Anita J Meehan, RN-BC, MSN, ONC, FNNGNA, Clinical Nurse Specialist/ICON Ambassador,
Akron General Medical Center, Akron, Ohio USA
Ami Hommel, RN, PhD, Associate Professor/Chair, ICON Advisory Committee, Lund University,
Lund, Sweden

International collaboration is an innovative way that nurses caring for orthopaedic patients can work together to promote the highest standards of orthopaedic nursing practice and care. The International Collaboration of Orthopaedic Nursing (ICON), of which ANZONA is a member, is a mostly virtual network of national and regional orthopaedic nursing organizations across four continents. Based on the recognition of similar patient problems and challenges for orthopaedic nurses globally, the Collaborative was formed in 2001 by leaders of three national orthopaedic nursing associations. ICON provides a range of activities and services including evidence-supported clinical practice initiatives, educational conferences and online programs, mentoring, specialty based research, and organizational development to a global network of orthopaedic nurses. Widely available, low cost internet-based technology such as email, SKYPE, Drop Box and others support this global networking. Despite geographic differences, technology provides the means for orthopaedic nurses to work together in real time. Such international partnerships enhance orthopaedic nursing practice and patient care in both advanced and developing health care systems.

Expected Learning Outcomes:
At the end of this presentation, the learner will:
1. Identify benefits of international collaboration.
2. Describe how technology can support international networking in real time.
3. Discuss products and services of ICON that can enhance orthopaedic nursing practice.

Incidence, Diagnosis and Treatment of Bone and Soft Tissue Tumours with an Insight to Future Changes in Management
Dr Paul Stalley, AM MBBS (HONS) FRACS FA Ortho A Orthopaedic Surgeon,
Program Director of Surgery Sydney Local Health District

Orthopaedic nurses often believe they can’t write for publication. They feel this way for a multitude of reasons.

The aim of this presentation is to encourage delegates to think about their own ability to write and consider how to channel their writing with an eye on their existing skills and ability to develop new ones.

Learning outcomes:
At the end of the presentation delegates will be able to:
1. Recognise their own ability to write material for others to read
2. Develop skills in writing for publication.
3. Develop a personal action plan to start writing on a regular basis and think about how this might be shared with others.
12.40pm – 1.00pm

My Patient is Non Weight Bearing:” Discharge Planning Issues and Concerns with Respect to the Non Weight Bearing Orthopaedic Patient: An Orthopaedic Case Manager’s Perspective
Fiona D’Costa-Box BA (HONS), RN, BScN, MSCN Cabrini Malvern Hospital

Fractures in the elderly are a major health care problem in the Western world, associated with significant morbidity, mortality and loss of function. Its incidence is expected to increase as the population ages. Of particular concern, is the added challenge when the Orthopaedic patient is Non Weight Bearing (NWB) for a significant period of time after surgery. NWB patients provide a challenge with regards to discharge planning, especially since they are usually not able to attend In Patient Rehabilitation during their NWB period. The presenter will discuss the role of the Orthopaedic Case Manager (OCM) when managing the NWB patient during their hospital stay, upon discharge and prior to rehabilitation. The author will discuss the challenges of discharge planning the NWB patient, the strategies that author has implemented in her private hospital setting, as well as ongoing concerns.

The learner will be able to identify issues/concerns relevant to discharging the NWB patient.
The learner will also be able to gain knowledge of the presenter’s discharge planning strategies.
The learner may be able to modify these strategies to assist them when discharging the NWB patient in their own hospital setting.

3.40pm – 4.20pm

On the Way to the Top: Fortunes of War
Lynley Papadopoulos, current President NZONA

In order to understand where we are and where we are going, we need to understand where we have come from.

In keeping with the centenary of the ANZAC landings at Gallipoli, this paper seeks to discuss the influence war has had on the development and ongoing growth of healthcare, including nursing, surgery and other care. I seek to look at developments that influence our practice today but whose birth was initiated by events related to conflict. This paper will touch on events from the Crimean War to the modern day.

The ascent of Mt Everest was done in stages with each stage a learning experience in preparation for the next. The same applies to most things, we learn from what has gone on before.

Learning outcomes:
Develop an understanding of historical developments that influence practice today
Develop an understanding of how developments today can influence practice in the future
Develop a realization that healthcare development is an ongoing process and we push on to the top
Understand that despite war and carnage that is in our world, it isn’t all doom and gloom.
Your Help is Needed - Do You Have a Minute or 2?
Paul McLiesh, Lecturer, University of Adelaide

Orthopaedic Nurses are working together as groups from around Australia & New Zealand as well as from around the world. An important question that we must ask is: How is that work being coordinated & who is doing the work?

Now is the time that all orthopaedic nurses, especially leaders of the group, must be working towards the long term future of the specialty. How this is achieved is one of the most important questions orthopaedic nursing has faced in the past decade. Leaders of groups such as ANZONA are working towards ensuring the long term future of orthopaedic nursing as a specialty but more is needed. A ground swell of support and effort is needed from the ground up. This means engaging orthopaedic nurses from all levels in this process. How we do this in a world where time is in short supply is a difficult question. Engaging each other, creating a sense of pride and passion is needed and this is where each person is needed. I ask each of you to make a commitment to promoting the specialty, talking about the specialty, get involved in working together to keep orthopaedic nursing strong.

Learning Outcomes:
• Develop a sense of ownership of promoting the orthopaedic nursing specialty.
• Develop an awareness of the needs of the specialty to ensure the future of the group
• Understand the need for every orthopaedic nurses engagement in this process & how they can be involved and even drive this.
• Be aware of the current work of ANZONA & how this relates to everyday practice as well as relating to work occurring internationally.

Metal on Metal Hip Replacements: What Nurses Need to Know
Sandra Kline, Clinical Nursing Faculty, Kaplan College School of Nursing, Kaplan College School of Nursing, Las Vegas Nevada Campus, USA

Having been a nurse for 39 years, I became bionic in the last seven years. I beep at the airports and am thankful when I walk through the security scanner instead of having the wand and the pat down! In February of 2014 I was notified by my surgeon’s office, that I was part of the study regarding my DePuy hip that has been recalled. This presentation is offered from the dual perspectives of scared patient and knowledgeable nurse.

Recently, I was functioning as clinical nursing faculty at a local hospital, when a woman visiting her daughter went out and used the ladies room. When she was finishing her business she leaned her body forward to clean herself and dislocated her hip. Just like that! This story is very distressing to me in the face of my own hip revision. The woman’s initial hip surgery was May of 2014, and this is her third dislocation in FOUR months! Concerns are worldwide about the recall and revisions occurring with the metal on metal hip replacements; they are real and compromise patient outcomes, thereby reducing quality of life.

The objectives of my presentation are:
1. Identify the complications of the recalled devices
   a. Elevated metal levels in the blood of chromium and cobalt
   b. Fluid collections containing metal shavings from the joint
   c. Avascular necrosis and damage in the surrounding tissue
2. Demonstrate re-educating patients to understand revision and rehabilitation
How Battlefield Experience Leads to Improvement in Orthopaedic Care
Dr. Brett Courtenay, Orthopaedic Surgeon, St Vincent’s Hospital, Sydney

It is said that the only victors of war are munitions technology and medical advances. Sadly this is probably correct. The modern battlefield in the Middle East has been no exception. A developed country spends significant money to support and treat its soldiers; the benefits of this when well-managed, can be transferred to civilian experiences.

From the original US invasion in Gulf War 1 until today all medical facilities in the Middle East have been keeping extensive medical notes, storing all results and now incorporating outcomes as well. This has led to evidence that once radical approaches to severe trauma management have been able to be validated. Today an injured person presenting to a Forward Surgical Team (FST) with a pulse has a 95% chance of going home; the previous 67% mortality of the most severe injuries has been reduced to 19%. This change has been effected by accurate data collection, analysis of progress and review of outcomes.

The author has deployed to a NATO FST Role 2E (a surgical facility with ICU capability) in 2009 in Tarin Kowt Afghanistan at the time of the National elections. Applications of general principles of Damage Control surgery, the aggressive use of blood products and proven protocols will be discussed with clinical case studies.

SuperPATH Hip Replacement
Dr. Sol Qurashi, Orthopaedic Surgeon, Nepean Hospital

Dr. Sol Qurashi is a Sydney trained and based Hip and Knee Surgeon specialising in Hip and Knee replacement and Knee reconstruction surgery. He pioneered the SuperPATH hip replacement technique in Australia in 2013. He practices in both the public and private sectors and has academic affiliations with the University of Sydney. He is a fellow of the Australian Orthopaedic Association and a member of the Asia Pacific Arthroplasty Society and a serving member of the Australian Defence Force.

Aim:
To assess patient outcomes and results of SuperPATH hip replacements in Australia. SuperPATH is a new hip replacement technique that was introduced in Australia in late 2013. It is the least invasive technique when considering the soft tissue envelope of the hip joint with implications on stability and functional recovery and rehabilitation times.

Design and Participants:
The first 100 SuperPATH hip replacements performed by the senior author were retrospectively assessed at a minimum of 6 weeks post operation.

Outcome Measures:
Results involve analysis of a functional and patient satisfaction questionnaire as well as reporting of all complications.

Results and Conclusion:
Current results are trending towards excellent functional recovery and patient satisfaction with minimal complications.
Pain Management Advances in Orthopaedics - “Pass me the winch and pulley”
Dr Charlotte Johnstone, Pain Specialist, Royal Prince Alfred and Prince of Wales Hospitals Sydney

Pre-operative considerations:
• Physical fitness - wait list delay, pain, overweight lend themselves to reduced physical stamina.
• Cardiovascular system - influences perioperative outcome especially for THJR Revision where major fluid shifts are likely.
• Respiratory - Obstructive sleep apnoea, obesity and renal dysfunction will have a significant impact on perioperative choices.
• Those patients who are already taking opiates, have an anxiety disorder and who catastrophise are likely to have more difficulty with pain management perioperatively.

Intraoperative issues:
• General anaesthesia vs regional anaesthesia
• Intrathecal morphine - what are the risks?
• Regional blockade - benefits vs risks
• Patient controlled analgesia in this group of patients

Postoperative issues:
• Fast track orthopaedics??
• Intravenous versus oral analgesia
• Intrathecal morphine - monitoring
• X rays - when is the optimum time?
• Mobilisation
• Oral analgesia
• Gabapentanoids

The long-term view
How to prevent chronic pain in this population?
**T1) Trauma 1 - Mind the Gap – Using Leadership Theory in Professional Practice - A Personal Journey**

Kathy Murphy, Orthopaedic Trauma Nurse Coordinator, Barts Health NHS Trust

The presenter is currently undertaking an audit of Major Trauma Centres (MTCs) in England to identify how each centre prioritises orthopaedic trauma patients when listing for surgery. The workshop would be a welcome opportunity to seek the knowledge and views of ANZONA members and provide an international perspective.

There are various guidelines and standards within orthopaedic trauma for particular injuries. Two main standards are the British Orthopaedic Association and British Association of Plastic, Reconstructive and Aesthetic Surgeons Standards for Trauma (BOAST 4) guidance for open fractures, and the best practice tariff for hip fractures from the National Hip Fracture Database (NHFD). BOAST 4 requires primary debridement of open fractures in a joint procedure with senior plastics and orthopaedic surgeons within 24 hours. Definitive skeletal and wound cover should be achieved in 72 hours and should not exceed one week. To achieve best practice tariff for hip fractures, surgery is required within 24 hours and there is a financial incentive attached to this. In the current economic climate of the National Health Service (NHS) however, the pressure to meet these time frames, given the resources available, can be difficult.

The results of a literature search will be presented to workshop members with the aim of then working within groups to explore common themes arising from this and the final results of the audit of English MTCs. The goal would be a review of current practice in Australia and New Zealand and allow this format to be repeated in England for comparison.

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**E1) Elective 1 - Is Satisfaction with the Acute-care Experience Higher Amongst Consumers Treated in the Private Sector? A Survey of Public and Private Sector Arthroplasty Recipients**

Associate Professor Justine Naylor, Senior Principal Research Fellow, South West Sydney Local Health District, NSW

**Aim:**

This study aimed to determine: 1) whether total knee or total hip arthroplasty (TKA, THA) recipients treated in the private sector are more satisfied with their acute-care experience and more likely to recommend the service than those treated in the public sector; 2) the predictors of satisfaction.

**Methods:**

TKA or THA recipients enrolled in an existing study involving high-volume arthroplasty centres, participated in a telephone survey 35 days post-surgery. 12 Likert-style questions were asked covering several healthcare experience domains. Likelihood of future recommendations of the service and overall satisfaction were also asked. Proportions of respondents stating ‘very satisfied’ for each question were compared. Multivariate regression modelling was used to identify the predictors of the latter outcomes.

**Results:**

410 respondents (n = 203, private sector) participated. High levels of satisfaction were noted in both sectors with > 80% reporting ‘satisfied’ or ‘very satisfied’ for most domains. The private sector had a significantly greater proportion responding ‘very satisfied’ for hospitality (food and cleanliness) and frequency of surgeon visitation. For all other questions, the private sector did not report significantly higher levels of satisfaction. The absence of a complication was associated with a 20% increase in the likelihood of reporting very high satisfaction (>90/100) (p = 0.02), and was associated with a 17% increase in the likelihood of recommending the hospital in the future (p = 0.007). ‘Sector’ was not a predictor of these outcomes in multivariate models.

**Conclusion:**

Satisfaction with the acute-care experience is generally high amongst arthroplasty recipients operated upon in specialty centres regardless of which sector provided the care. The presence of a complication is an important factor considered by consumers when evaluating their care, indicating consumer satisfaction may indeed be an indirect marker of quality in this population.
The field of Paediatric Limb Reconstruction surgery in Orthopaedics is a small one, and not widely understood outside its own circles. The role of the specialist nurse within this circle, can be even more invisible and this presents challenges to those in these roles. This presentation will discuss the issues of isolation and how two Limb Reconstruction nurses with thousands of kilometres between them remain connected and support each other with resultant benefits to their paediatric patients. There are many differences between the two roles, being in two different States, however with many similarities and with a sharing of resources and experiences, the support provided to each other can be surprising from guideline writing, to meeting at conferences. As the role expands, its profile is raised with the nurses becoming active participants in the annual medical ALLARS conference (Australian Limb Lengthening and Reconstruction Surgery). Each year as we meet, we plan to grow bigger and better, and hope to spread the interest in LR nursing. Come with us as we share with you our “Tale of Two Cities” and learn a little about the secret world of Paediatric Limb Reconstruction Nursing.

**Purpose:**
Complete and accurate diagnoses in trauma patients can be difficult to establish, sometimes resulting in delayed diagnosis. The impact of this recognized phenomenon on management and eventual patient outcome in the trauma setting remains unclear. The trauma services at our institution provide tertiary clinical surveys for all trauma patients admitted for longer than 24 hours, followed by routine re-review of all severely injured patients’ imaging with a senior radiologist. This study categorises delayed diagnosis of trauma patients, reviews their management consequences and evaluates final outcomes.

**Methods and Materials:**
A retrospective review was performed of all trauma patients who experienced a delayed diagnosis after presenting to a major tertiary hospital between December 2010 and December 2012. Cases were identified by the RBWH Trauma database and classified according to a modified Clavien system, as follows: I no change to management, II conservative management initiated, IIIa further imaging required, IIIb additional operative/interventional management necessary, IV major complication, V death as a result of delayed diagnosis.

**Results:**
Within a 24 month period a total of 3196 trauma patients were admitted and 1424 tertiary surveys performed. Delayed diagnoses were detected in 322 patients (10.1%); 98 were detected initially by clinical assessment and confirmed by imaging, and 224 were first detected after re-reviewing radiology. The majority of delayed diagnoses were category I (14.6%) or II (76.1%), requiring either no or only conservative subsequent management. Additional imaging was indicated in 78% of delayed diagnoses, with 1.6% necessitating surgical or interventional management. No cases of missed or prolonged diagnoses resulted in category IV or V outcomes. Overall, delayed diagnoses resulted in significant changes to management in less than 1% of patients.
Conclusion: In our institution one in ten trauma patients experience incomplete diagnosis upon initial presentation, although missed or delayed diagnoses that significantly alter management outcomes are very rare. These results are superior to other published rates of missed injuries in trauma patients. This study confirms the importance of tertiary surveys in providing complete evaluations for trauma patients. Understanding the patterns and processes that lead to these findings will lead to a better understanding of the associations between mechanisms of injury, presentation and injury types. This may subsequently allow for improved primary and secondary surveys, more effective use of medical imaging, better communication between the emergency department, medical imaging and trauma teams. Ultimately, audits such as these aim to improve patient care, optimize use of medical resources and reduce healthcare costs.


(E2) Elective 2 - Developing, Evaluating and Translating of a Joint Replacement DVD
Karen Punchard, Registered Nurse, Toronto Western Hospital, Canada
Tatiana Velasquez, Register Nurse, Toronto Western Hospital, Canada

In 2010 an educational DVD was produced to be shown to patients while attending a Pre Admission class for Total Joint Replacement Surgery. In our experience, we found that patients moving through the pre admission process were experiencing information overload, anxiety, and were having difficulty retaining all the information they were given. In addition, inconsistencies of content were occurring since different health care professionals, including nurses, and physiotherapists, were teaching the preadmission education class, so a DVD was developed to address the problem. Once the DVD was completed, an evaluation was conducted in order to study the effects of pre-operative instructional DVDs on patient knowledge, understanding of exercises, preparedness, perceived ability to participate in post-operative exercises/activities, post-operative compliance and participation. The outcome was very positive as patients stated they felt more prepared about what to expect with their upcoming surgery as well they enjoyed the visuals. After the evaluation, the DVD has been translated into Cantonese, Mandarin, Portuguese and Italian. By having the DVD being offered in several languages a greater number of patients will watch the DVD in their language of preference in the comfort of their home. Our presentation will include the development, evaluation and the translation of this DVD.
This study was carried out to determine if watching a computer multimedia education program improves what people understand about the operation they/their child is about to undergo. Before surgery all patients undergoing elective surgery must give consent indicating that they understand the procedure they are about to undergo. In paediatrics this responsibility falls to the parents, however it is known that many patients are unaware of the nature of surgery they had recently, and 10-29% cannot recall information given to them six months later. Startlingly, only 40% of patients read the informed consent before signing it which presents us with some issues and improvements must be made. It is acknowledged that people learn in different ways.

- Visual
- Auditory/verbal
- Written e.g. pamphlets and brochures
- Kinaesthetic

The LR Service at RCH Melbourne has developed a multi-media computer program to improve the informed consent process.

Presented in the style of animation, the module enables complex principles to be presented in a simple manner and it addresses the different learning styles of people. It also addresses different learning abilities.

The module uses a combination of words, pictures and voice to convey the relevant information. It was shown to all families who were to undergo lower limb reconstruction surgery. It included all elements of a true informed consent:

- Nature of the problem
- Aim of the operation
- What the operation can and cannot do
- What happens after the operation and the expected benefits of surgery along with consequences and a description of potential complications.

The project was multi-centred and included both private and public patients. It was a prospective, randomised, multi-centred controlled study.

Those included in the study were those with an interest in limb reconstruction surgery including patients over the age of 14, parents, guardians and all participants waiting to undergo limb lengthening surgery with an external fixator.

As has occurred in other centres using multimedia programs, it is expected that there will be improvement with a greater satisfaction of information, ease of decision making, retention of knowledge over time, compliance and a better experience of the hospital stay.
Hip fracture is associated with high rates of morbidity and mortality. Whilst hip fracture rates are decreasing, absolute numbers of presentations to emergency departments throughout Australia are increasing. In October 2011 a group of clinicians representing all Australian States and New Zealand gathered in Sydney with the shared goal of improving care of hip fracture patients. Anita Taylor is the ANZONA representative to the Steering group of the Australia New Zealand Hip Fracture Registry (ANZHFR).

A number of activities are currently underway to support the development of an Australian and New Zealand Hip Fracture Registry. These include:

- Development of Standards for Hip Fracture Care – development commenced October 2014 in collaboration with the Australian Commission for Safety and Quality in Health Care (ACSQHC). Due for completion late 2015.
- Piloting of a minimum dataset for patient information. Dataset now available to all hospitals.
- Development of an electronic data entry system for ongoing patient audit. Demonstration sites ‘live’ throughout NSW.
- Consultation with consumers and representatives from patient/older person organisations.

This presentation will provide a description and update on progress with the above issues and relate it to international trends in hip fracture care.

Region Zealand [Denmark] has launched the Health Profile “Helbredsprofilen.dk” - a portal aimed to be a supportive tool that hopefully will be able to provide knowledge to people with chronic diseases.

People with osteoarthritis need basic information about the disease and how it can affect their life. It is important to reduce uncertainty, increase motivation to exercise and improve self-perceived health and quality of life. Patient education is a good way to improve knowledge and confidence in own abilities.

Method:
A group of interdisciplinary health professionals have, by workshops and focus group interviews with former patients and their relatives, formulated targeted information on various topics before, under and after hip- and knee-replacement-surgery. Patients not offered surgery, with long lasting pain from arthrosis, are also offered information and tools on the website.

Topics:
- pain and pain treatment
- aids and equipment
- rehabilitation
- bandages
- visits in the outpatient clinic
- nutrition and weight loss/weight stability before and after surgery
- how to prepare your home - and coming home from the hospital

On the website short films [3-4 minutes] are shown with health professionals, former patients and relatives, giving useful information replacing lots of paper information. The patients can watch the films and read about the topics as often as needed at home and discuss topics with eg relatives.

The plan is to launch the osteoarthritis part of the website in autumn 2015 [October].

The Health Profile is a project that continuously evolves and strives to make the project nationwide.
Results:
148 TKA and 135 THA protocols from 11 public and 8 private hospitals across five states were included. Regardless of rating method applied, full compliance was 50% (95% CI 42-58) or less for TKA and THA protocols. Compliance with specific aspects of the recommendations varied.

Conclusions:
Low compliance with the recommended Australian guideline is apparent. Multiple factors contribute to this. Studies are needed to determine if better patient outcomes are associated with care that complies with guidelines that are more or less prescriptive.

(P4)
Practice 4 – The Introduction of the Role of Metastatic Spinal Cord Compression Co-ordinator
Sharon Budd, MSc, RGN, Derby Hospitals NHS Foundation Trust
The role of Metastatic Spinal Cord Compression (MSCC) Co-ordinator was introduced into the Royal Derby Hospital in April 2011. This was a result of the NICE guidance on the management of MSCC and the East Midlands Cancer Network’s ‘peer review’ process.

This session will discuss how the role was introduced and how it has progressed since 2011 with the following learning outcomes:-
- Awareness of the MSCC guidelines
- Explore the different approaches to the role
- Who to involve in the planning of the role and communication to the wider team
- The patient journey before and after the MSC Co-ordinator (case studies)
- Challenges
- Audit of the role/meeting of guidance targets
- Future plans/challenges

References
www.nice.org.uk/guidance/cg75
www.eastmidlandscancernetwork.nhs.uk

Table 1. Compliance ratings based on duration of prophylaxes
1 Chemoprophylaxis (right drug, right dose) from 1 to 15 (TKA) or 1 to 35 days (THA); Mechanoprophylaxis (any) until discharge from acute-care
2 Chemoprophylaxis (right drug, right dose) for a minimum of 10 (TKA) or 28 (THA) days; Mechanoprophylaxis (any) until discharge from acute-care
3 Chemoprophylaxis (right drug, right dose) for exactly 10 to 15 (TKA) or 28 to 35 days (THA); Mechanoprophylaxis (any) until discharge from acute-care
In 2012, pressure ulcer prevalence and incidence data collected at a mid-west hospital in the USA showed that 39% of all patients who developed hospital-acquired pressure ulcers (HAPUs) had a surgical procedure lasting greater than two hours. Of these patients, 70% were 60 years of age or older, 37% had diabetes, and 92.5% had a Braden Risk score of 18 or lower. The data provided the impetus to look further into enhanced assessment and prevention interventions before, during, and after surgery.

There are currently few surgical specific risk assessment tools and none that incorporate interventions. A PICO question was developed: *Will the rates of surgically related pressure ulcers decrease (O) with the utilization of a peri-operative specific pressure ulcer risk assessment tool and associated interventions (I) for patients (P) who are undergoing surgical procedures lasting 2 hours or longer?* A risk assessment tool was developed combining information from the literature and from the hospital’s clinical data repository. The tool was developed, validated and approved by the institutional review board for evaluation. At the conclusion of this session the attendee will be able to describe the process of developing a pressure ulcer risk assessment tool, identify peri-operative specific pressure ulcer prevention strategies and discuss outcome data.

In the presentation/workshop will we demonstrate and discuss teaching strategies in health care education, but also how we can change practice at our orthopedic wards. For example, patient centered care has changed to person/family centered care. The old way to work with this competency was to listen to the patient and demonstrate compassion and respect. However, today that is not enough. Now we recognize the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values and needs.

In 2003 the Institute of Medicine (IOM) identified five core competencies needed for Health care professionals: patient centered care, work in interdisciplinary team, employ evidence based practice, apply quality improvement and utilize informatics, later safety was added. The Quality and Safety Education for Nurses (QSEN) adapted these core competencies for nursing in 2007. The Swedish Society of Nursing, the professional society that brings registered nurses together on professional issues, has highlighted the core competencies and have made leaflets which have been distributed to all members. Furthermore, in collaboration with the Swedish Medical Association, a booklet of the core competencies teamwork and quality improvements was released in spring 2014. Now we have continued our collaboration and are working with the competencies safety and person centered care.

In the presentation/workshop will we demonstrate and discuss teaching strategies in health care education, but also how we can change practice at our orthopedic wards. For example, patient centered care has changed to person/family centered care. The old way to work with this competency was to listen to the patient and demonstrate compassion and respect. However, today that is not enough. Now we recognize the patient as the source of control and full partner in providing compassionate and coordinated care based on respect for patient’s preferences, values and needs.

Learning outcomes - after the session the nurses will be able to:

- recognize core competencies
- demonstrate how they can implement the core competencies at their work place
(P5) Practice 5 - Waitemata District Health Board - Surgical Site Infection Improvement (SSI) Programme - Leading the Way
Bev Hopper, RN, BHSc, PGCert, MHP, Waitemata District Health Board, New Zealand

Surgical Site Infection (SSI) is one of the leading causes of healthcare associated infections. It is associated with high morbidity and prolonged length of stay. A national SSI surveillance program was envisioned by Health Quality and Safety Commission with stepwise inclusion of selected procedures. WDHB, through a successful quality improvement project were chosen as a development site prior to National SSI rollout. Between March and July 2013 WDHB SSI team assisted in refining data collection and entry processes, engagement of stakeholders, resource utilisation, and future direction for effectively using surveillance to improve patient care. Continuous surveillance for knee and hip arthroplasties, and revisions at Northshore Hospital and the Elective Surgical Centre has been in place now for over two years. An automated email captures readmission of target patients within 120 days of surgery. Patients with suspected SSI prior to discharge, or readmitted within 90 days of admission, are reviewed by SSI team. A data collection form, revised for usability and capturing important DHB specific information about risk factors and practice, is submitted electronically to a national database server. Reports and improvement strategies are discussed with our Orthopaedic team. The improvements we have made, along with a summary of the data collected over the last 2 years, will be presented. Input from Waitemata DHB’s SSI improvement team has been substantial in the development of the National SSI programme.

(S5) Special Interest 5 - Bridging the Gap within Orthopaedic Nursing through ‘Observership’
Norsyahidah Binte Hassan, Senior Staff Nurse / Nurse Clinician Specialty Care (Orthopaedics), Singapore General Hospital
Anita Taylor, Orthopaedic Nurse Practitioner, Orthopaedic & Trauma Unit, Royal Adelaide Hospital, CALHN

This presentation will discuss the experience of a six week ‘Observership’ undertaken at the Royal Adelaide Hospital looking at the management of patients with hip fracture from Emergency Department presentation to post-operative care. Norsyahidah Binte Hassan from Singapore spent six weeks shadowing ONP Anita Taylor in early 2014. In this presentation Norsyahidah will share her experience of the observership including her aims, insights gained and practice change achieved as a result. Preparing for placement involves good planning. Anita will share her perspectives on hosting an ‘observer’ and the benefits such a model may bring to the orthopaedic nursing community.
Pin site infection is a frequent and distressing problem for patients undergoing skeletal external fixation. Using the results from two research studies this presentation aims to help delegates to understand the clinical features of pin site infection from the patient’s perspective. The paper will also include discussion of a proposed assessment schema for use by clinical staff and patients which delegates will be able to share with practice colleagues and consider for implementation in practice.

Learning outcomes:
At the end of the session delegates will be able to:
1. Recognise the symptoms of pin site infection and other inflammatory responses.
2. Discuss how such information might inform practice with patients with external fixation.
3.15pm – 3.35pm – Session 7

(R7) Research 7 - Vitamin D Deficiency and Progressive Osteoarthritis of the Knee... Is there a Link?
Christine Schutz, Medical Researcher in Orthopaedics, Wakefield Orthopaedic Clinic, Adelaide

Objective:
The objective of this study was to examine a consecutive cohort of subjects undergoing knee replacement for Osteoarthritis and to investigate whether serum concentrations of 25(OH)D of below < 30 ug/l had an increased risk of progressive OA as defined by X-ray and other joint surgery for OA.

Results:
At the time of writing this project is continuing but results will be available before this meeting next year.

Conclusion:
Early results suggest that individuals deficient in Vit D have an increased risk of Progressive OA in knee OA and other joints.
**Practice 7 – The Influence of Orthopaedics into Palliative Care**

Stephen Wright, RN BN, Grad Dip Nurse Sc Orthopaedics, SA Health

**Questions:**
- What has Orthopaedics got to do with Palliative Care?
- What impact does it have on the client and carer; and the medical, nursing and allied staff, and research?

The Objective of the presentation is to ‘look outside your square’. The challenge for Orthopaedic Nurses today are to look out and look up at the potential applications in other fields other than surgical where our skills can be applied.

Palliative Care is today providing more opportunities to apply recent innovations in supporting patients that would otherwise suffer with chronic pain as a result of bone cancer.

In July 2014 a 71 year old male diagnosed with cartilage cancer undertook an operation to replace the right calcaneus with a 3D-printed titanium heel implant.

It was also reported in August 2014 that a 12 year old boy with a soccer injury in China, revealed a malignant tumour on the spinal cord. Doctors inserted an implant created with a 3D printer. Research provides the Orthopaedic Nurse new knowledge to look and to see new opportunities.

Linking the two is a challenge.

**Expected learning outcomes:**
- to allow the delegates to look outside their own squares of normal practice to consider new opportunities not discovered yet. Palliative Care is one area of practice that is influenced by new orthopaedic practice.

**Special Interest 7 - The National Competency Standards: A Critical Evaluation of Their Use in Practice**

Sally Robertson, RN, BN, ICCert, MEd(Adult), Grad Cert Higher Education, Associate Dean School of Nursing, University of Notre Dame

The National Competency Standards for the Registered Nurse are the benchmark for registered nurse practice. They are designed as minimum practice standards and are used to assess the competence of all registered nurses entering the profession including university graduates, overseas qualified nurses and nurses who are subject to reassessment. They are also used as a benchmark for performance reviews and appraisals to make judgements about ongoing competence. Those who use the standards in the assessment of competence need to understand the application of the standards to practice.

More importantly, registered nurses must be able to self-regulate and judge their own performance using the standards as the professional benchmark and reflect on their own professional development needs. In order to do this, the registered nurse must understand the standards including the collection of data to make judgements about competence. To undertake this, registered nurses needs skills in critical self-reflection and self-evaluation.

This paper will address the critical issues in relation the use of the standards in practice and will explore self-assessment to build capacity in registered nurses as they strive to become self-regulated life-long learners.

**Learning outcomes:**
- Explore the use of the National Competency Standards for the Registered Nurses in practice
- Build capacity to critically reflect on practice and benchmark to the National Competency Standards for the Registered Nurses
The Conference has accommodation block bookings at the hotels listed below. 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.

**SYDNEY HILTON**
(Conference Hotel)
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- $319.00 Single/Double/Twin Share per room per night
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2 Bond Street, Sydney

- $320 Executive Studio Apartment per room night (1 x Queen Bed)
- $550 Two Bedroom Apartment per room night (2 x Queen Bed)
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SOCIAL FUNCTIONS

WELCOME RECEPTION – WEDNESDAY 11 NOVEMBER 2015
The Welcome Reception is included in the full registration price.
Extra tickets may be purchased

Venue: Ballroom foyer, Hilton Sydney Hotel
Date: Wednesday 11 November 2015
Time: 6:30pm – 8:30pm
Dress: Smart Casual
Cost: Included in full registration
Additional Tickets: $80.00
Provided: Canapés and beverages

CONFERENCE DINNER – THURSDAY 12 NOVEMBER 2015
The Conference Dinner is included in the full registration price.
Extra tickets may be purchased, depending on availability.

Venue: Ballroom Hilton Sydney Hotel
Date: Thursday 12 November 2015
Time: 7:00pm – 11:30pm
Dress: TBA
Cost: Included in Registration
Additional Tickets: $130.00
Provided: 3 course meal, with beer, wine and soft drink

HAPPY HOUR

Venue: Bar at the Hilton
Date: Friday 13 November 2015
Time: 5:00pm – 6:00pm
Dress: Smart Casual
Cost: Your own cost

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• http://www.sydney.com/ - What’s on in Sydney

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From Sydney Airport, taxis are available to take you directly to the Hilton Sydney hotel. The journey normally takes around 30 minutes and costs approximately $45-$50.

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As an environmentally friendly hotel with a focus on sustainability we recommend you take the Train for direct, convenient access to the hotel from the airport and most other locations. There is a Train Station located at both the Sydney Domestic and International Airports with a direct line to the city. Exit the train at Town Hall Station and the Hilton Sydney hotel is located adjacent to the Victoria Galleries, entry via Pitt Street or George Street. Travelling time is around 25 minutes and costs approximately $15 per person each way.

BY SHUTTLE BUS
From Sydney Domestic and International Airports a shuttle bus is available in front of the Arrivals Hall. The cost is approximately $16-$18 per person each way. Advance booking is not required; however for a shuttle bus transfer from Hilton Sydney to the airport pre-booking is required.

CAR PARKING
There is a secure underground car park located at Hilton Sydney. The carpark is owned and managed by Secure Parking. Self-parking is $51.20 for 24 hours from time of entry. Hilton Valet parking is available ($68 for 24 hours) or enter the carpark directly and Secure will park the car for you at casual parking rates. Other car Parks are available in the Domain and under St Andrew’s cathedral.

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 no allocated seating you may have to ask the hotel waiters for your specific meal or look for the Special Diets table.

SYDNEY WEATHER
In the month of November the average daytime temperatures in Sydney are generally around 23°C (68°F) whereas the night temperatures generally tend to hover around 16°C (61°F). Sydney also experiences on average 8 hours of sunshine per day during this month.

WHAT TO WEAR
Dress for the conference is smart casual. Due to varying temperatures in the Conference rooms it may be advisable to bring a light wrap or jumper Conference Dinner – Theme to be advised on Registration.

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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 12 October 2015 will be refunded less 25% of the Conference Registration fee, to cover administration costs. No registration refunds will be given after this date.

REGISTRATION AND ACCOMMODATION CHANGES POLICY
Registration and accommodation changes will not be accepted unless made in writing. Changes made within 14 days of the event may incur costs due to specific hotel and venue policies.

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