A devil of a time
25 – 28 May 2016
Grand Chancellor Hotel
Hobart

Conference handbook
including program

Thank you to our proud platinum sponsor and major sponsors

MÖLNLYCKE HEALTH CARE
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As ACORN President it is my pleasure to welcome you to Hobart and our 17th National Conference.

The biennial ACORN Conference is the highlight of the Australian perioperative nursing professional calendar; offering you the perfect combination of education, industry access, networking, and a touch of frivolity.

Our organising committee has worked tirelessly to develop a world class scientific and social program to top the success of our last conference in Melbourne which attracted over 1,000 delegates and 80 trade partners.

The conference theme – a devil of a time – is open to your interpretation but we intend for it to evoke images of the feisty native carnivorous marsupial, the Tasmanian devil.

The conference program includes over 60 oral presentations, 17 poster presentations and 4 workshops. Masterclasses will also be available to delegates during the Conference program.

The International Federation of Perioperative Nursing’s biennial board meeting is being held in conjunction with our conference. I welcome the IFPN board members and all of our international delegates joining us from around the world.

I hope that you have all set aside extra time to explore Tasmania and its rugged wilderness areas, historic towns, national parks, and world heritage sites.

Have a devil of a time!

Dr Jed Duff
ACORN President
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## ACORN

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## General information

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ACORN 2016 Sponsors

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3M

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Hospitals around the country are mitigating risk and reducing costly adverse events by implementing ACORN’s Standards for Perioperative Nursing in Australia. Is yours?

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**Print edition**
Easy hands-on access to ACORN’s evidence-based standards in a traditional print format. Available only in a bundle.

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“The latest edition of the ACORN Standards for Perioperative Nursing in Australia offer evidence-based and peer-reviewed guidelines for perioperative staff and other members of the team, to standardise perioperative practice and promote patient and worker safety. The 14th edition is available in a variety of formats to suit you and your facility’s needs.”

Dr Jed Duff, President, ACORN
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About ACORN

The Australian College of Operating Room Nurses (ACORN) is a registered, member-based, health promotion charity that serves the patient, community and the perioperative profession to promote the prevention and control of disease.

Vision
ACORN’s vision is for Australian patients to receive the safest and highest quality perioperative care in the world.

Purpose
ACORN’s purpose is to:
1. set, promote and continually review national ‘best practice’ standards for perioperative services or nursing
2. provide a central reference point for, and consultancy service on, perioperative policy, procedures and practice, to assist other organisations and industry stakeholders to advance the health and welfare of the community
3. encourage and promote research projects relating to perioperative nursing to assist industry participants in the prevention and control of disease in the community and to increase knowledge and learning in the perioperative nursing field
4. promote educational opportunities for perioperative nurses
5. hold biennial national conferences to promote best practice and discuss and address current challenges in perioperative nursing practice.

Priorities between now and 2018 ACORN will focus on:
1. developing the organisation through good governance and investment developing people, structures and resources
2. consolidating and expanding services through building strength and unity, facilitating the efforts of our local associations and promoting best-practice standards, education and services to further the prevention or control of disease
3. leading and advocating on behalf of our members and the profession as the peak body for perioperative nursing
4. strengthening partnerships and collaboration through formalising arrangements with our existing partners and forging new ones with key stakeholders in Australia and abroad
5. increasing and diversifying financial support, in order to achieve our purpose, through raising awareness of perioperative nurses’ life-saving practices.
ACORN Governance

Executive Committee
Dr Jed Duff » President
Allanah Hazelgrove » Honorary Secretary
Joy Jensen » Honorary Treasurer
Wendy Rowland » Executive Officer

Board
Dr Jed Duff » President
Allanah Hazelgrove » NSW Director
Karen Hay » NSW Representative
Wendy Rogers » NT Director
Lesley Stewart » NT Representative
Joy Jensen » QLD Director
Michelle Reardon » QLD Representative
Cathie Hashemi » SA Director
Diana Hutt » WA Representative
Sarah Bird » TAS Director
Rachel Foster » TAS Representative
Pauline Moore » VIC Director
Rebecca East » VIC Representative
Caroline Dufton » WA Director
Grace Loh » WA Representative

Officers
Wendy Rowland » Executive Officer
Kylee Carmody » Secretariat and Administration Officer
Eleanor Tan » Journal Officer
Dr Sonya Osborne » Standards Editor
Dr Paula Foran » Education Officer

Committees
Standards Committee
Allanah Hazelgrove, Dr Brigid Gillespie, Lesley Stewart, Michelle Reardon, Mary Middleton, Catherine Steel, Dr Jed Duff, Joy Jensen, Dr Sonya Osborne

Standards Faculty
Dr Sonya Osborne » Standards Editor

Lead reviewers
Amanda Gore, Julie Johnson, Lilliana Levada, Dr Pat Nicholson, Sue Ireland

Reviewers
Angela Hand, Carolyn Rose, Catherine Smith, Deb Burrows, Emma Babao, Gail Staines, Jenny Cubitt, Judith Zach, Kathryn Clark, Louise Grant, Mandy Akamarmoi, Mary Middleton, Robyn Williams, Ruth Melville, Sandy Leathwick, Scott Landall, Tina Sayce, Tracy Kerle, Vicky Warwick

Education, Research and Journal Committee
Wendy Rogers » Chair
Sarah Bird » Journal Editor
Dr Brigid Gillespie, Judy Romit, Karen Hay, Karolin King, Lauren Goudas, Dr Paula Foran, Rebecca East, Tracey Kerle

Journal Faculty
Sarah Bird » Journal Editor
Jennifer Austin, Rebecca East, Dr Paula Foran, Theofanis Fotis, Leanne Glennie, Kenneth Hancock, Dr Rene Michael, Ralph Nicholas, Pat Nicholson, Dr Sonya Osborne, Dr Marilyn Richardson-Tench, Sally Savage, Kathryn Taaffe, Robyn Williams, Judy Zach

Conference Committee
Cathie Hashemi » Chair
Allanah Hazelgrove, Deborah Burrows, Di Hutt, Dr Jed Duff, Grace Loh, Joy Jensen, Karen Hay, Kylee Carmody, Pauline Moore, Sharon Harding, Sharon Mewett, Tracey Nicholls, Wendy Rogers, Wendy Rowland

Membership, Marketing and Website Committee
Pauline Moore » Chair
Janet Perry-Watson, Rachel Foster
Judith Cornell AM (1940 - 2014), after whom this award is named, is one such nurse. Judith was one of two NSW Operating Theatre Association (OTA) representatives to attend the inaugural planning meeting held in Melbourne in 1975 that led to the 1977 Australasian Conference of Operating Room Nurses being held in Canberra. Judith chaired this conference, at which it was decided to form the Australian Confederation of Operating Room Nurses, ACORN. The inaugural meeting of ACORN was held the following year, with each of the six Australian states, as member bodies of this national body, sending two representatives. Judith was the first chair of ACORN and served on council for many years. The purpose of the national body was to look into all aspects of nursing practice in the operating room and to that end ACORN produced its first Standards, Guidelines and Policy Statements in 1980.

Following her retirement from perioperative nursing in 1986, to take on other challenges, Judith was made a life member of the NSW OTA. ACORN salutes the achievements of Judith Cornell, AM and the outstanding contribution she made to perioperative nursing in Australia.

Orators

2002 Judith Cornell (NSW)
2004 Narelle Hines (NSW)
2006 Bernadette Brennan OAM (Vic)
2008 Dr Lois Hamlin (NSW)
2010 Judith Berry (SA)
2012 Menna Davies (NSW)
2014 Dr Patricia Nicholson (Vic)

The oration will be held at the opening session of the ACORN National Conference.
Local Associations

<table>
<thead>
<tr>
<th>Local Association</th>
<th>Address</th>
<th>President</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales Operating Theatre Association (NSWOTA)</td>
<td>PO Box 212</td>
<td>Hayley McIntosh</td>
</tr>
<tr>
<td></td>
<td>CROYDON NSW 2132</td>
<td></td>
</tr>
<tr>
<td>Northern Territory Perioperative Nurses Association (NTPNA)</td>
<td>PO Box 43203</td>
<td>Sharon Harding</td>
</tr>
<tr>
<td></td>
<td>CASUARINA NT 0811</td>
<td></td>
</tr>
<tr>
<td>Perioperative Nurses Association of Queensland (PNAQ)</td>
<td>GPO Box 2518</td>
<td>Emma Babao</td>
</tr>
<tr>
<td></td>
<td>BRISBANE QLD 4001</td>
<td></td>
</tr>
<tr>
<td>South Australian Perioperative Nurses Association (SAPNA)</td>
<td>PO Box 149</td>
<td>Di Hutt</td>
</tr>
<tr>
<td></td>
<td>O’HALLORAN HILL SA 5000</td>
<td></td>
</tr>
<tr>
<td>Tasmania Operating Room Nurses (TORN)</td>
<td>PO Box 513</td>
<td>Rachel Foster</td>
</tr>
<tr>
<td></td>
<td>KINGSMEADOWS TAS 7249</td>
<td></td>
</tr>
<tr>
<td>Victorian Perioperative Nurses Group (VPNG)</td>
<td>PO Box 593</td>
<td>Pat Nicholson</td>
</tr>
<tr>
<td></td>
<td>EAST MELBOURNE VIC 8002</td>
<td></td>
</tr>
<tr>
<td>Operating Room Nurses’ Association of WA (ORNA)</td>
<td>PO Box 8342</td>
<td>Caroline Dufton</td>
</tr>
<tr>
<td></td>
<td>WARNBORO FAIR WA 6169</td>
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</tbody>
</table>
The International Federation of Perioperative Nurses (IFPN) is a global organization dedicated to actively promoting perioperative nursing. IFPN’s mission is to support perioperative nurses working towards globally improving patient care by promoting safe surgery and evidence-based best practice standards, through research and education in collaboration with member organizations and other relevant collaborators. IFPN is not a political organization to deliver personal or individual country agendas; it is a collaborative, united network to deliver shared ambitions for our specialty through recognition by the international strategic leaders (ICN) and the impact on patient care. This achieved by education and best practice so that we can grow our global perioperative network. The IFPN network is the engagement of like-minded professionals and the liaison between the organizations that they represent.

IFPN Membership world-wide represents over 100,000 perioperative nurses
IFPN currently has 11 financial member associations –
ACORN – Australia
AfPP – UK
AORN – USA
SOBECC – Brazil
EORNA – 27 European countries
Gorna – Greece
JONA – Japan
KAORN – Korea
ORNAC – Canada
PNCNZ – New Zealand
PNG PNS – Papua New Guinea

IFPN is the only international speciality organization representing perioperative nursing at an international Level though the International Council of Nursing – ICN. IFPN is the link though ICN on international activities and nursing issues forming policy and influencing World Health Organisation (WHO) agendas.

Other affiliate speciality groups within ICN are:
→ Council of International Neonatal Nurses (COINN)
→ European Federation of Nurses Associations (EFN)
→ International Federation of Nurse Anaesthetists (IFNA)
→ International Skin Care Nursing Group (ISNG)
→ International Society of Nurses in Cancer Care (ISNCC)
→ NANDA International
→ Sigma Theta Tau International (STTI)
→ World Federation of Critical Care Nurses (WFCCN)

I would like to introduce myself as the President of ASIORNA 2015-2016.
ASIORNA serves as a platform for overseas colleagues for communication and sharing experiences. I would like to take this opportunity to invite the Asian Peri Operative Nurses in each country come together to be members of ASIORNA. As a result, we will work together to provide a platform for healthcare professionals to share experience, advancing practice, information and networking. Ensure continuous quality improvement and enhance standard of patient care through the education and standard of practice.

I am looking forward to meeting you in Hobart.
2018 International ACORN & ASIORNA Conference

23–26 May 2018
Adelaide Convention Centre
South Australia

www.acorn.org.au/conference2018
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Floorplan
Exhibition precinct
Catering & dietary requirements

Refreshment breaks and Lunches are included in the full registration and day registrations. All refreshments will be served in the Partners in Health & Education Precinct. If you have advised the Conference Secretariat of special dietary requirements, please speak to a member of catering staff at the commencement of each meal break / social function.

Conference satchel

All ACORN 2016 delegates will receive a Conference satchel. ACORN would like to thank and acknowledge Multigate for their support in providing these satchels.

Conference venue and accommodation

Hotel Grand Chancellor Hobart
1 Davey Street
Hobart, Tasmania
Accommodation Reservations: 1800 753 379

Conference Secretariat

ICMS Australasia Pty Ltd
GPO Box 3270
Sydney NSW 2000
Telephone: +61 2 9254 5000
Facsimile: +61 9251 3552
E: info@acorn2016conference.org.au

Dress code

Smart casual is suggested for all Conference sessions. Our conference dinner is always a highlight of the ACORN Conference. Join with us in celebrating with the theme ‘winter wonderland the place to have a devil of a time’.

Duplication / recording

Unauthorised photography, audio taping, video recording, digital taping or any other form of duplication is prohibited in the conference sessions.
Emergency details

In an emergency telephone 000 for Ambulance, Fire Service or Police.

Exhibition opening times

The exhibition will be held in the Federation Ballroom and Mezzanine level foyer and will be open at the following times.

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<thead>
<tr>
<th>Date</th>
<th>Time</th>
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<tbody>
<tr>
<td>Thursday 26 May</td>
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<tr>
<td>Friday 27 May</td>
<td>10:00 – 17:00</td>
</tr>
<tr>
<td>Saturday 28 May</td>
<td>10:00 – 14:30</td>
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First time at ACORN?

We invite you to join us at our ‘newcomer’s session’. Join the ACORN team and meet the local state and territory association Presidents. You can also look forward to meeting Jed Duff, ACORN President, who will introduce you to ACORN and provide information about:

- the trade exhibition
- competitions
- workshops
- masterclasses
- the different education streams
- the Conference dinner.

Date – Wednesday 25 May 2016
Time – 15:45 to 16:15
Room – Grand Ballroom Section 1

Internet and Wi-Fi access

Wireless internet (Wi-Fi) will be available free of charge for delegates at ACORN 2016. Join the network below and enter the password.

Network Name (SSID): ACORN_Wireless
Password: acorn2016

Lanyards

Lanyards must be worn at all times during ACORN 2016 for security purposes and to assist the organisers with identifying participants.
Liaisons

**VIP guest liaison**

Sarah Bird, ACORN President Elect has been allocated as liaison person to assist VIP guests.
Sarah’s contact details are as follows:
Sarah Bird
sarah.bird@acorn.org.au
0400 641 431

**International delegate liaison**

Di Hutt, ACORN Representative (South Australia) has been allocated as liaison person to assist International delegates.
Di’s contact details are as follows:
diana.hutt@sa.gov.au
0418 894 235

**International delegate liaison – assistant**

Tracey Nicholls, ACORN Committee member has been allocated to assist also.
Tracey’s contact details are as follows:
tracey.nicholls@sa.gov.au
0411 771 976

International and VIP guest lounge

An International and VIP guest lounge will be available for your use from 8.00 am on Thursday 26 May and during conference hours. The lounge is located in Chancellor Room 6 on the Ground floor. The lounge will provide a place for you to relax and network with other delegates. Light refreshments will be available.

Unfortunately, the International Lounge is unable to be locked; we urge you not to leave any valuables in the lounge and can take no responsibility for any lost goods or items.

Lost property

If you find an item or if you have lost an item, please see the staff at the registration desk.

Mobile phones and electronic devices

As a courtesy to speakers and your fellow delegates, please switch off your phones and electronic devices during presentations and whilst in session. Power for charging will be available at the ACORN stand in the case of emergencies.
Parking

Car parking is available for hotel guests and is located under the hotel. An additional cost is payable if non hotel guests wish to use the carpark. Access to the car park is from the rear of the building on Macquarie Street. From the hotels main entrance drive along Davey Street which is one way and then turn right on Argyle Street and immediately right again onto Macquarie Street. Valet parking; $18 per vehicle overnight. Undercover self parking; $9 per vehicle overnight (limited space).

Photo schedule

The state and international group photo schedule is detailed below. The meeting place for the photos will be the Ground floor staircase, located adjacent to the Federation Concert Hall entrance.

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<td>VIP’s and International Delegates</td>
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<tr>
<td>Tasmania</td>
<td>13:45</td>
</tr>
<tr>
<td>New South Wales/Australian Capital Territory</td>
<td>14:00</td>
</tr>
<tr>
<td>Western Australia</td>
<td>14:15</td>
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<table>
<thead>
<tr>
<th>Friday 27 May</th>
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<tbody>
<tr>
<td>Queensland</td>
<td>12:10</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>12:25</td>
</tr>
<tr>
<td>South Australia</td>
<td>13:30</td>
</tr>
<tr>
<td>Victoria State</td>
<td>13:45</td>
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</tbody>
</table>

Advisory of photograph recordings

A Photographer has been engaged to make and record a pictorial history of the 2016 Bi-Annual Conference of the Australian College of Operating Room Nurses. ACORN respects the rights of its members and guests not to be included in the pictorial history collected at the conference. Should you wish not to be included in any photographs or consent to those photographs being published, including but not limited to the ACORN Website, the ACORN Journal or used in digital media platforms such as Twitter and Facebook, then we advise that you stand clear (ideally behind) until the area is clear of the Photographer. Consent for the inclusion of, and reproduction of images will be considered implied unless otherwise indicated.
Poster presentations

Posters will be displayed on the Mezzanine Foyer of the Hotel Grand Chancellor. Posters will be arranged in streams and can be identified by their unique poster number. The abstracts for these poster presentations can be found at the end of this handbook.

All poster presenters are to be at their posters during lunch on Thursday 26 May from 12:40 – 14:30 as well as during the Welcome Reception from 18:00 – 19:30 to respond to questions. Judging will be co-ordinated by the ACORN Education, Research & Journal Committee and will take place on the Friday lunch break. The best poster presentation will take place during the closing ceremony on the Saturday 28 May 2016.

Registration desk

The registration desk is located in the foyer of the Mezzanine Level Ground Floor at the Hotel Grand Chancellor and will be open at the following times.

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Wednesday 25 May</td>
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<td>8:00 – 17:30</td>
</tr>
<tr>
<td>Saturday 28 May</td>
<td>8:00 – 14:30</td>
</tr>
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</table>

Speaker preparation

Speakers are required to check in with the technical staff prior to their presentation in the speakers preparation room. This room is located adjacent to Ballroom 3 on the first floor.

Smoking

Smoking is not permitted indoors at the Hotel Grand Chancellor. Smokers must always remain at least 4m from any doorway when smoking. Fines can be imposed for smoking in prohibited places.

Taxis

Taxis are available from the reception of the Hotel Grand Chancellor.

Text book signings

The authors of the Perioperative Textbook 2e will be available at the ACORN stand to sign copies. Come and meet the authors who have written this valuable resource.

Times for book signing will be updated regularly in the conference APP and announced each morning prior to lunch.
The app provides convenient access to details on:

→ the program
→ sessions
→ speakers
→ venue
→ other delegates
→ sponsors and trade
→ and will provide up to date information in the weeks leading up to the conference and during the conference.

If you have never used an app before, don’t worry, ACORN have a team, led by Joy Jensen (QLD) to assist you. Please visit us at the ACORN stand in the Partners in Health & Education Precinct.
Hospitals and perioperative nurses around the country are mitigating risk by being involved with ACORN

Subscribe to our quarterly Journal

Journal of Perioperative Nursing in Australia

“The Journal for Perioperative Nursing in Australia provides the latest evidence-based and peer reviewed articles, written by experienced perioperative nurses in Australia and around the world. Subscribe and stay current, get involved in your professional community and provide your patients with quality care.”

Dr Jed Duff
ACORN President

ACORN represents the professional interests of all nurses working in perioperative settings in Australia.

anaesthetic nurses  circulating nurses
instrument nurses  post-anaesthesia recovery nurses
day of surgery admission nurses  pre-admission clinic nurses
unit managers  perioperative nurse surgeon assistant
day surgery nurses  acute pain nurses  perioperative educators
perioperative researchers  endoscopy nurses
Master of Ceremonies

Brian Nankervis (Conference MC)
Performer and Writer
Australia

Australian comedian, a performer, writer and producer Brian Nankervis is a sharp, versatile and experienced MC working in the corporate space, performing poetry shows in schools and offers a RocKwiz-inspired music quiz for corporate events. Brian taught primary school children at Wesley College, Glen Waverley and Kingswood College, Box Hill, for six years before fleeing the classroom in 1985 to become a waiter at Melbourne’s legendary theatre restaurant The Last Laugh. He was a writer/performer on the Channel 10 hospital soap opera “Let the Blood Run Free” and made regular appearances on “Hey Hey It’s Saturday” from 1986 as the tortured street poet Raymond J Bartholomeuz. He is currently writing, producing and co-hosting for the A.F.I Award winning SBS music trivia show, ‘RocKwiz’. RocKwiz is a dream come true for this lifelong music fan!

Keynote Speakers

Nadine Champion
Motivational Speaker
Australia

The Warrior Code
12:25 – 13:25, Saturday 28 May 2016, Concert Hall

Nadine Champion is a fighter, inside the ring and out. As a martial artist with almost 30 years’ experience and an undefeated full contact fighter, Nadine has learnt a lot about inner strength. She has translated the lessons learnt in the ring to academic and professional success: she has even used them to WIN her fight against cancer. Boasting a gold medal from the World Cup of Martial Arts, Nadine passes on 20 years’ worth of unique lessons learnt from her Sensei: world champion fighter Benny “the Jet” Urquidez. Her passion and profession is teaching Internal Training, which focuses on strengthening the mind. These lessons have changed her life and seen her positively transform the lives of many others. Nadine believes that success in any area often comes from learning to believe in yourself and trusting your ability to deliver under pressure. As a woman in a male-dominated field, Nadine has valuable insights into bringing out the unique strengths of men and women, allowing them to be their best and reach their goals.
Ramona Conner
Association of perioperative Registered Nurses (AORN)
United States of America

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UNIVERSITY of
TASMANIA

Translating Evidence into Practice, Parts 1 & 2
11:30 – 13:00 Thursday 26 May 2016, Chancellor Room 4
15:30 – 17:00 Thursday 26 May 2016, Chancellor Room 4

The above workshop is by invitation only.

Ramona Conner, MSN, RN, CNOR is Editor-in-Chief of the AORN Guidelines for Perioperative Practice. Her responsibilities include providing professional expertise regarding perioperative nursing practice to the AORN Board of Directors, national committees, staff, members, specialty assemblies, and standard setting/regulatory bodies, accreditation agencies, and professional associations. Ramona represents AORN as a member of the AAMI Sterilization Standards Committee, serving as a co-chair of ST-79. She received the AAMI 2015 Standards Developer Award. Ramona has been appointed as a US expert attending the ISO TC 198/WG 7 meeting in Berlin, December 2015. Ramona is also a member of the Facility Guidelines Institute’s Health Care Guidelines Revision Committee (HGRC) for the Guidelines for Design and Construction of Health Care Facilities, 2006, 2010, and 2014 editions. She was a member HGRC Steering Committee for the 2014 edition and continues to serve on the 2018 committee. Ramona has authored “Clinical Issues” columns and other articles published in AORN Journal and other professional publications.

Bronte Martin
National Critical Care Trauma Response Centre, Royal Darwin Hospital, Australia

Better the devil you know - Global EMT classification & standards
09:00 – 10:00, Friday 27 May 2016, Concert Hall

Bronte is currently Director of Nursing (Trauma & Disaster) at the National Critical Care Trauma Response Centre, providing clinical governance and oversight for in-reach Trauma Services at Royal Darwin Hospital, NCCTRC Education & Training program, and the Australian Medical Assistance Team deployable Field Hospital capability. As founding member of the NCCTRC team, Bronte has been active in the establishment of key clinical, acute healthcare partnerships in Emergency and Disaster Management response within the Asian-Pacific region. Recent deployments include Tropical Cyclone Pam, Vanuatu in March 2015 as AusMAT Rapid Needs Assessment Team Leader and International Emergency Medical Teams Coordinator, and Philippines super-Typhoon Haiyan in November 2013 as clinical co-lead for Team Alpha of the AusMAT Field Hospital. Bronte has also been a member of the Australian Defence Force for the past 15 years in the Royal Australian Air Force Specialist Reserve with numerous Operational experiences, including previous deployments to Solomon Islands in 2004 and Afghanistan with
NATO Coalition partners in 2010. Most recently, Bronte has just returned from undertaking a 6-month secondment in 2015 with the World Health Organisation Global Emergency Medical Teams Secretariat in Geneva to develop and establish a Global Classification, Mentorship & Verification program; ensuring validated, quality international Emergency medical care is delivered in response to Sudden Onset Disasters.

Professor Jane Reid
Bournemouth University and Clinical Lead Wessex Patient Safety Collaborative, United Kingdom

Sponsored by

Any ‘devil’ can tempt us: Understanding violation and migration in the perioperative setting
10:30 – 11:30, Saturday 28 May 2016, Concert Hall

Professor Jane Reid has enjoyed a career of nursing posts in acute care and Higher Education. Roles within the past six years have included President of the Association for Perioperative Practice (AfPP), Nurse Advisor WHO 2nd Global Challenge Safe Surgery Saves Lives (Geneva), Associate Dean (Nursing and Allied Health Professions) Bournemouth University and Nurse Advisor to the National Patient Safety Agency (NPSA). Jane has also served as a former President of the International Federation of Perioperative Nursing (IFPN) Jane’s current portfolio includes, Co-Chair of the Learning to be Safer Expert Group, Health Education England (HEE), Clinical Lead Wessex Patient Safety Collaborative, Regional Lead (South of England) for Sign up to Safety, and Non-Executive Director Dorset County Hospital NHS Foundation Trust. Special interests include professionalism, human factors, patient safety, continuous quality improvement, healthcare ethics and law. In 2013 Jane was recognised by the Health Service Journal (UK) in association with Barclays and the NHS Leadership Academy, as one of the most inspirational women leaders, in healthcare.
Amy Scott
Motivational Speaker
New Zealand

Connecting the dots: How to rub people up the RIGHT way
09:00 – 10:00, Saturday 28 May 2016, Concert Hall

Passionate about improving communication of people, families, businesses, organisations, teams, workplaces and communities everywhere, Amy Scott (former lawyer) says “It’s not rocket science - it is simply learning how not to rub people up the wrong way!” Living in beautiful Alexandra, she is a proud born and bred rural Central Otago girl. Whilst she’s represented NZ in ice hockey she’s still not allowed to drive tractors! Following a career as a practicing lawyer Amy changed direction. Amy has since had over 10 years experience as a communication consultant, trainer, speaker, mentor and author. She is a recognised “thought leader” and one of Australasia’s most sought after speakers. Amy is also an accredited “Dots!” facilitator (currently NZ’s best professional development) who “engages and energises” audiences with her down to earth style.

Dr Lisa Spruce
Association of perioperative Registered Nurses (AORN)
United States of America

Sponsored by

Translating Evidence into Practice, Parts 1 & 2
11:30 – 13:00 Thursday 26 May 2016, Chancellor Room 4
15:30 – 17:00 Thursday 26 May 2016, Chancellor Room 4

The above workshop is by invitation only.

Dr Lisa Spruce is the Director of Evidence Based Perioperative Practice for the Association of Perioperative Registered Nurses. She is responsible for the overall leadership, development, evaluation and maintenance of the products, services, and guidelines for perioperative practice developed by AORNs Nursing Practice Team and AORNs Research and Information Centre. Dr Spruce led the process for producing the AORN evidence appraisal tools and model, which helps translate literature-based interventions into systematic, evidence based guidelines, thus raising the bar for perioperative standards. Dr Spruce has authored two of AORNs national guidelines which are used throughout the U.S. and many other countries to inform perioperative nursing practice. Dr Spruce is a board certified Acute Care Nurse Practitioner, Adult Clinical Nurse Specialist, Perioperative Clinical Nurse Specialist and as a CNOR. Dr Spruce is currently the author of the AORN Journal’s Back to Basics Series which is co-published in Australia and China. Dr Spruce serves as the AORN representative to the American Academy of Nursing’s Choosing Wisely campaign and was inducted as a fellow in the American Academy of Nursing in October.
Dr Victoria Steelman
University of Iowa
United States of America

Sponsored by
Medtronic

10 top patient safety issues
14:30 – 15:15, Thursday 26 May 2016, Concert Hall

Dr Steelman has been a perioperative nurse for over 25 years. As a perioperative advanced practice nurse at the University of Iowa Hospitals and Clinics, she focused on implementing evidence-based practice changes for 20 years. She is currently Associate Professor in the College of Nursing at the University of Iowa, teaching graduate students’ evidence-based practice. Dr Steelman’s program of research focuses on perioperative safety and quality. She has extensively published and presented about issues related safe patient care in the operating room, including five research studies focusing on prevention of retained surgical sponges. She is well recognized for her contributions and received AORN’s Outstanding Achievement awards for Research and Evidence-based Practice. In 2008, Dr Steelman received the AORN’s highest award, the Award for Excellence in recognition of her contributions to perioperative nursing. In 2007, she was inducted into the American Academy of Nursing in recognition of the national and global impact of her work. She is past-president of AORN.
ACORN CONFERENCE 2016

Elsevier Australia and ACORN present the launch of

Perioperative nursing
AN INTRODUCTION, 2e

By Lois Hamlin, Menna Davies, Marilyn Richardson-Tench and Sally Sutherland-Fraser

Written in collaboration with ACORN, this edition aligns with the ACORN Standards, 14th Edition and PNC NZNO Standards.

It also reflects the latest national and international standards, including the:

- NSQHS Standards
- The new NMBA Standards for Practice for Registered and Enrolled Nurses
- The WHO Surgical Safety Checklist.

Publication date: 18 April 2016
RRP: $89.95
Exclusive launch price: $71.95

Order your copy of this valuable perioperative nursing resource at an exclusive discounted rate from the ACORN stand.
**PROGRAM**

**WEDNESDAY MAY 25**

### SESSION OVERVIEW

<table>
<thead>
<tr>
<th>Concert Hall</th>
<th>Grand Ballroom - Section 1</th>
<th>Grand Ballroom - Section 2</th>
<th>Grand Ballroom - Section 3</th>
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<tbody>
<tr>
<td>11:00 – 17:00</td>
<td><strong>Registration opens</strong> - Ground floor foyer, Hotel Grand Chancellor Hobart</td>
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<table>
<thead>
<tr>
<th>Time</th>
<th>Workshop 1</th>
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<tbody>
<tr>
<td>12:30 – 13:00</td>
<td>Organ Procurement</td>
<td>Loan Equipment</td>
<td>Anaesthetic Nurse Role</td>
<td>ASEPSIS+</td>
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<td><em>Facilitator: Amanda Gore</em></td>
<td><em>Facilitator: Pat Nicholson</em></td>
<td><em>Facilitator: Sue Ireland</em></td>
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<td>13:00 – 13:30</td>
<td>Post Anaesthesia Nurse Role</td>
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<td>Fatigue</td>
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<td><em>Facilitator: Sue Ireland</em></td>
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<tr>
<td>13:30 – 14:00</td>
<td>Organ Procurement (repeat)</td>
<td>Loan Equipment (repeat)</td>
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<tr>
<td>15:30 – 15:45</td>
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<td>Comfort Break</td>
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<tr>
<td>15:45 – 16:15</td>
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<td>ACORN Newcomers Session - (Information Session) - Grand Ballroom Section 1</td>
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*This workshop includes: Asepsis; Infection Prevention; Perioperative Attire; Surgical Hand Antisepsis and Gowning and Gloving.*

Please note the program is subject to change at any time at the discretion of the Organising Committee.
Workshop overviews

In healthcare, standards provide a common language and set of expectations that enable healthcare professionals, systems and organisations to work together for best patient outcomes. For the individual perioperative nurse, the language of standards provides an important vocabulary for thinking about the things you do in your everyday professional practice; a sort of aide-mémoire to remind us of our responsibility to uphold principles for the delivery of quality care and to hold others accountable for their adherence to those same standards of practice. ACORN has been developing and publishing standards and other guidance documents, such as guidelines, position statements and nursing roles for some time. But, standards and guidelines for practice are not static. They are dynamic and need to be continually reviewed and updated in response to changes in healthcare practice, policy and legislation, and the emergence of new research, new technologies and new trends in surgery.

In these interactive workshops, you will learn about some of the recently revised standards – hear about the key changes and practice recommendations, discuss new evidence and emerging evidence that informed the revisions, and exchange some useful strategies for implementing the changes in your workplace.

Facilitator: Sonya Osborne, RN GCert (PeriopNurs)
G Cert (HigherEdu) MN (Research) PhD
Senior Research Fellow, Australian Centre for Health Service Innovation (AusHSI), School of Public Health and Social Work, Queensland University of Technology

Like you, Sonya Osborne, perioperative expert, academic and researcher, is passionate about perioperative nursing. With over two decades of experience in a range of perioperative environments, internationally and in Australia, her commitment to standards for practice is unwavering. Sonya appreciates, and shares with colleagues and students, that standards provide minimum requirements for best practice and provide a common language and set of expectations that enable perioperative nurses, health services and professional bodies to work together for best patient outcomes. Her favourite quote of the day is “The standard you walk past is the standard you accept.” Dr Osborne’s perioperative research program has included such topics as standard precautions and occupational exposure reporting, pain management, aspiration risk in elderly postoperative patients, infection prevention strategies, optimising patients for better postoperative outcomes, and most recently retained surgical items. Her complementary research passion is evidence-based practice and implementation science and her doctoral study, explored the relationship between practice culture and barriers to implementation of evidence-based practice. Sonya has a consistent record in research and dissemination at conferences and international refereed journal articles. As the inaugural ACORN Standards Editor, Sonya is in the best of both worlds, working with a committed team of perioperative nurses to ensure that the ACORN Standards are based on the best available evidence, aligned with contemporary changes impacting on practice, and remind us of our responsibility to uphold principles for the delivery of quality patient care.
Workshop overviews

Organ procurement

Facilitator: Amanda Gore, RN G Dip NursEd M HlthSci(Nurs) PhD candidate
Perioperative Nurse Educator, Lingard Private Hospital

Since commencing as a scrub/scout nurse at the Royal Alexandra Hospital for Children, Camperdown in 1989 Amanda has enjoyed a perioperative career which has extended to many areas - public hospitals, private hospitals, the defence force, project work, education and curriculum development. Since 2013 she has been the Unit Coordinator for the Graduate Certificate in Perioperative Nursing at the University of Tasmania. Amanda is currently a PhD candidate at UTAS and her research is focusing on how nurses enter the perioperative nursing specialty. Over the past three years, in her spare time, she has worked on the ACORN Standards Review Team and was the Team Leader for Perioperative Attire and Nursing Management of Posthumous Organ Procurement.

Nursing management of posthumous organ procurement

Posthumous organ procurement is a critical procedure that occurs infrequently and can give rise to perioperative nursing concerns on a number of levels. The workshop examines the new ACORN Guideline for Posthumous Organ Procurement in an interactive session. An overview of how the Guideline was proposed and developed will be followed by presentation of scenarios and an open forum. The goal of the workshop is to promote discussion and you are encouraged to share your experiences and bring your questions for the panel. You will leave the session with increased understanding of this challenging subject.

Loan equipment

Facilitator: Pat Nicholson, RN MEd PhD FACORN
Senior Lecturer, Perioperative Course Coordinator, Deakin University, School of Nursing and Midwifery, Faculty of Health

After completing her General Nursing and Midwifery Diploma Pat Nicholson completed a Diploma in Operating Nursing Science in South Africa. Her involvement in providing clinical support to the students while completing their placement in the operating suite led to her completing a Bachelor Degree, majoring in education. Shortly after immigrating to Australia Pat was appointed to coordinate the Anaesthetic and Perioperative course at the University of Melbourne, where she completed a Master of Education degree. She went on to complete her PhD focusing her research on instrument design and measurement of nursing competencies using Item Response Modeling, publishing and presenting her work both nationally and internationally. Pat is a senior lecturer at Deakin University and Director of the Perioperative Course. She holds an
honorary Senior Lecturer position at the University of Melbourne and honorary research position at Peter MacCallum Cancer Centre. Her current research includes education, nursing competencies, pressure injuries in the operating suite and medication safety in patients presenting for surgery. Pat represented Victoria on the ACORN Board for four years, which included Chair of the ACORN Standards. She was admitted as a Fellow of the College in 2010 and remains involved as a member of the censor panel for ACORN Fellows and team leader for the development of a new Guideline for the ACORN Standards for Perioperative Nursing. Pat has been a member of the Victorian Perioperative Nurses Group committee since 2001 and currently holds the position of President.

**Getting a handle on instrument loan sets and reusable medical devices**

With further technological innovations and continued advances in surgical technique, healthcare organisations will continue to rely on loan equipment. Therefore, attendance at this workshop will assist participants in developing a loan equipment management program that will ensure safe, quality care for patients presenting to the operating suite.

**Post Anaesthesia Nurse Role**

**Liliiana Levada, RN MN**

*Nurse Manager, Sydney, NSW Health*

Liliiana has over 30 years of experience in clinical and management aspects of perioperative nursing; with expertise in clinical practice, management, education, evidence-based practice and research. Liliiana likes to work in the area of interface between nursing science and clinical practice, and has particular interests in legal and policy issues in perioperative nursing. Whilst Liliiana is a subject matter expert in perioperative nursing; as a self-driven nursing professional she has also gained a substantial management experience in diverse arenas including patient safety management, after-hours hospital management, staffing management, quality improvement management, patient liaison management; and has a strong interest in healthcare standards. Liliiana is a member of the newly founded ACORN Standards Review Faculty and has presented at national and international professional forums.

**Wake up to PACU Nursing!**

PACU nurses recover patients from anaesthesia – supporting patients as they transition from oblivion to awareness; and ensuring the safe journey back to their physiological normality and stability. This presentation is designed to familiarise you with changes in the newly revised PACU Nurse nursing role statement and Management of the PACU Environment guideline. Participants will also engage in interactive discussions on some of the challenges facing today’s PACU nurses.
Anaesthetic nurse role

Facilitator: Sue Ireland, RN BNurs(Hons) GCertHE GCert Hlth Sci(Ed) GDip Nurs(Periop) MHSc(Nurs)

Lecturer in Nursing, Deakin University, School of Nursing and Midwifery, Faculty of Health

Sue is a nursing academic at Deakin University in the Western District of Victoria. Completing a Graduate Diploma of Nursing (Perioperative) and then a Master’s degree instilled Sue with a renewed passion for perioperative nursing. Sue also completed her Honour’s degree with her thesis entitled “A systematic review of the effectiveness and meaningfulness of telephone preoperative assessment for adults.” Which was published by the Joanna Briggs Institute and ACORN. Sue has been the lead reviewer of the “Fatigue in the Perioperative Environment”, and the “Role of the Anaesthetic Nurse” ACORN Standards and has recently been involved with the role of the PACU nurse and Management of the PACU. Sue’s goal is to be involved in further research into perioperative nursing and contributing to the dynamic and evolving practice that is operating room nursing.

The role of the anaesthetic nurse

Are you an anaesthetic nurse? What are your roles and responsibilities within this specialty of perioperative nursing? This session will provide information regarding the changes to the role statement and provide a forum for discussion regarding this important nursing role.

Fatigue

Facilitator: Sue Ireland, RN BNurs(Hons) GCertHE GCert Hlth Sci(Ed) GDip Nurs(Periop) MHSc(Nurs)

Lecturer in Nursing, Deakin University, School of Nursing and Midwifery, Faculty of Health

Fatigue and the perioperative nurse

Are you fatigued? Are your colleagues fatigued? Fatigue has been implicated as a factor in patient and staff safety in the workplace. Attendance at this workshop will enable discussion of strategies that can be implemented for the identification and management of fatigue in the perioperative environment.
Asepsis

Facilitators: Lilianna Levada, RN MN
Nurse Manager, Sydney, NSW Health

Julie Johnson, RN BAppSc (Adv Nsg) Education PGDip OH MHM
Associate Nurse Unit Manager, CSSD/Theatre, Northeast Health Wangaratta

Perioperative nursing is my passion. I have over 30 years’ experience in this advanced practice area, at times working as a clinician, manager or educator across many diverse geographic areas from tertiary campuses to regional and remote rural areas - it has been an eclectic mix of experiences and opportunities. Underpinning this is a commitment to best practice and quality patient outcomes. It is this rationale which has seen me volunteer to be an ACORN faculty member contributing to advancing preoperative practice in Australia over the last three years.

My qualifications, knowledge and skill mix have supported me to assist in the revision of the Infection Prevention and Surgical Hand Antisepsis, & Gowning and Gloving Standards as Team Leader, and provide support in the revision of the PACU suite of guidelines.

All things asepsis

"Information is not knowledge. The only source of knowledge is experience." – Albert Einstein

When you attend the Asepsis workshop you will receive information on evidence-based recommendations for management of asepsis as it relates to a range of perioperative practices, and will learn how to integrate these into your own work practice; in due course, you can become the source of knowledge related to best management of asepsis in the perioperative environment. This workshop will focus on the recently revised standards for Asepsis, Infection Prevention, Perioperative Attire and Surgical Hand Antisepsis, Gloving and Gowning.
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- Challenges facing Organ Transplantation practice
- Advances in Surgical technology in perioperative care
- Orthopaedic Robotic Surgery
- Perioperative Pain Management
- Operating Room Crisis Management
- Advances in Perioperative Monitoring
- Principle of Infection Control in Perioperative care environment

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Private Hospital Theatre Organization of Hong Kong

www.ASIORNA.org www.HKPHOTO.org.hk
# PROGRAM

**THURSDAY MAY 26**

## SESSION OVERVIEW

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<td>08:00 – 18:00</td>
<td>Registration opens - Ground floor foyer, Hotel Grand Chancellor Hobart</td>
</tr>
<tr>
<td>09:00 – 11:00</td>
<td>Welcome and Opening Ceremony - Judith Cornell Oration, Excellence Awards and Investiture of Fellows</td>
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<tr>
<td>11:00 – 11:30</td>
<td>Morning Tea &amp; Official Opening of Trade</td>
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<tr>
<td>11:00 – 11:30</td>
<td>Stryker pop up showcase - Chancellor Room 5</td>
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### Sessions

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<th>Session 2: Education</th>
<th>Session 3: Management</th>
<th>Session 4: Research</th>
<th>Session 5: Combined</th>
<th>Chancellor Room 4</th>
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<tr>
<td>Concert Hall</td>
<td>Grand Ballroom - Section 1</td>
<td>Grand Ballroom - Section 2</td>
<td>Grand Ballroom - Section 3</td>
<td>Harbour View Room One</td>
<td>Workshop</td>
</tr>
<tr>
<td>Clean air smells good <em>Therese McDowell &amp; Karen Boyd</em></td>
<td>Having a devil of a time with social media and culture change in healthcare <em>Pete Smith &amp; John Gibbs</em></td>
<td>Managerial and clinical perioperative nurses: Friends or foe? <em>Fiona Unac</em></td>
<td>Discharge decision making to detect clinical deterioration: Outcomes from the PACT study <em>Maryann Street</em></td>
<td>Manual handling challenges in the perioperative unit - reversing the satanic curse <em>Diane Greening &amp; Patricia Keating</em></td>
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### Changeover Times

<table>
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<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>11:50 – 11:55</td>
<td>Changeover Time</td>
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<tr>
<td>12:15 – 12:20</td>
<td>Changeover Time</td>
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### Further Sessions

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<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>11:30 – 11:50</td>
<td><em>Wrong side block-root cause analysis and subsequent practice changes</em> <em>Cheryl Whelan</em></td>
</tr>
<tr>
<td>11:55 – 12:15</td>
<td>Professionalism in the Operating Suite <em>Paula Foran</em></td>
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<tr>
<td>12:15 – 12:20</td>
<td><em>Specimen errors don’t cut it in the operating room</em> <em>Tracy Lee</em></td>
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<tr>
<td>12:20 – 14:30</td>
<td>Lunch &amp; Poster Presentations</td>
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Please note the program is subject to change at any time at the discretion of the Organising Committee.
### Program - Thursday May 26

<table>
<thead>
<tr>
<th>Time</th>
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<tbody>
<tr>
<td>13:10 – 14:15</td>
<td>Molnlycke Masterclass - Grand Ballroom - Section 1</td>
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<td></td>
<td>3M Masterclass - Partners in Health &amp; Education Precinct (Exhibition)</td>
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<td></td>
<td>Medline pop up showcase - Grand Ballroom - Section 3</td>
</tr>
<tr>
<td>14:30 – 15:15</td>
<td>Plenary Session: 10 Top Patient Safety Issues, Professor Victoria Steelman (Sponsored by ANZ/MEDTRONIC)</td>
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<tr>
<td>15:15 – 15:20</td>
<td>Changeover Time</td>
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</tbody>
</table>
| 15:20 – 15:40| Simulating arrests in theatre to empower BLS trained staff involvement  
Vicky Warwick |
| 15:40 – 15:45| Changeover Time                                                       |
| 15:45 – 16:05| The evolution of a rumour                                            
Tony Zuino |
| 16:05 – 16:15| Comfort Break                                                        |
| 16:15 – 16:35| How to make clinical teaching and learning more fun in our unit?       
Sean Rawani |
| 16:35 – 16:40| Changeover Time                                                       |
| 16:40 – 17:00| Perioperative & Sterilisation Services - The forgotten partnership?  
Deborah Burrows |
| 17:00 – 17:05| Changeover Time                                                       |
| 17:05 – 18:00| ACORN AGM and IFPN (International Federation of Perioperative Nurses) Welcome, including Standards Launch - Concert Hall |
| 18:00 – 19:30| Welcome Reception - Partners in Health & Education Precinct (Exhibition) |

Please note the program is subject to change at any time at the discretion of the Organising Committee.
11:00 – 11:30
Chancellor Room 5
Hazardous Exposure Prevention in the Operating Theatre
- Overview of the hazardous exposure risk to staff working in the operating theatre
- Presentation of study results: Traditional canisters versus a closed system
- Future research: Plans for a global health economics study
Presenter: Martlie Horn, Nurse Unit Manager, Kareena Private Hospital
Enquiries: Karen Nasuta - karen.nasuta@stryker.com

13:10 – 14:15
Grand Ballroom section 1
Surgical
Title: Your Personal Protection in the O.R.
Subtext: Double Gloving: Myth vs Fact – What is the true cost of double gloving, can you afford not to do it?
Speaker: Ros Byrnes, Senior Territory Manager Qld Surgical
About: In this interactive session we will explore and discuss many of the myths associated with double gloving and the associated risk to your own personal protection. What is the true cost associated with double gloving? We will explore the associated health economics and also the emotional cost associated with percutaneous needle stick injury.
Time: 30 - 40 minutes
Enquiries: Karen Fox - Karen.Fox@molnlycke.com

13:10 – 14:15
Grand Ballroom section 3
Subject: Change Management
Speaker: Garry Stratton Theatre Clinical Nurse Manager, Calvary St Lukes Hospital
Content: Change is the reality of an evolving day to day workforce. Change is evitable and can have positive and negative impacts. Understanding and responding to change is a necessary process that is often overlooked. Garry will be discussing the aspects of change management which have assisted him in his current role as Theatre Manager, as well as discussion of contemporary thinking in the field of change management.
Enquiries: Denis Cantin - denis.cantin@medline.com

13:10 – 14:15
Partners in Health & Education Precinct (Exhibition)
3M Australia, Discover your inner creative with SoluPrep™
Session 1: Clinical
11:30 – 12:40

Clean air smells good

Therese McDowell*¹, Karen Boyd*¹
1 Flinders Medical Centre

We began the long road to becoming smoke free at Flinders Medical Centre (FMC) back in May 2012. ACORN standard 20 was revised and authorized in November 2012. ‘All surgical smoke in the operating theatre must be evacuated to prevent exposure to the risks of the surgical plume to patients and personnel’ There is very strong evidence in the literature that surgical smoke contains carcinogens, chemical toxins and viral matter and is a health hazard for all exposed. (IFPN Guideline for Smoke Plume 2012) Despite this strong evidence, introducing smoke evacuation into our theatre suite was a very long process and came with many challenges including resistance to and implementing the change of current practices, choosing the right product for all users that would promote compliance, and justification of the cost implications. In our presentation we will share with you FMC’s journey to finally achieving the goal of 100% compliance to smoke evacuation in our theatre suite.

Wrong side block-root cause analysis and subsequent practice changes

Cheryl Whelan*¹
1 Nursing Council of New Zealand, Wellington, New Zealand

Topic overview
In December 2014 an orthopaedic patient having left shoulder surgery under a general anaesthetic was inadvertently given a supraclavicular block on the incorrect side. A root cause analysis was conducted to investigate the contributing factors and to determine what could be put in place to prevent the occurrence of further wrong side blocks.

Presentation objectives
This presentation will;
provide an insight into the factors contributing to the wrong side block
show the root cause analysis conducted following the event
share the lessons learnt and the subsequent changes made to practice.
Specimen errors don’t cut it in the operating room

Tracey Lee*¹

1 Auckland District Health Board, Auckland, New Zealand

Introduction

A local investigation into the significance of specimen labelling errors occurring in the Operating Room (OR) revealed a rise in errors. This rise was consistent with research however it was also a preventable error which research suggested could be corrected with standardisation in the specimen collection process.

Method

A focus group was made up of a convenient sample of OR nurses during their in-service time, within a department which processed large numbers of specimens per day. This group established a standardised process utilising action research principles allowing them to create the specimen collection process, put it into practice and re-evaluate until the process required no more changes. This process was introduced across five OR departments to ensure validity. It was then compared against incidents reported using Reasons Swiss cheese model to see where organisational systems and processes outside of the nurses’ control contributed to the errors and could support the new process.

Results

A standardised process was developed with a definitive checking point at Sign Out and put into practice across the ORs followed by an update in policy. A recent local audit comparing 6 months prior to the intervention with 6 months after has indicated specimen labelling error reductions have almost halved.

Conclusion

Utilising the principles of action research allowed nurses to be fully involved in exploring the issues and the solutions for specimen labelling errors in the OR and provided the empowerment necessary to make the changes successful in practice.

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Session 2: Education

11:30 – 12:40

Having a devil of a time with social media and culture change in healthcare

Pete Smith*¹, John Gibbs*¹

1 NSW OTA, Australia

Topic overview

Sometimes you have to sell a concept to the world in order to sell it to your own colleagues. Social Media is fast becoming a new millennium vehicle for education and reform in healthcare. The effort required and the level of sustained
engagement demanded are high if such efforts are to be successful, and success is by no means guaranteed. Here I describe the path undertook to implement clinical reform in terms of a safety and quality culture change relating to situational awareness and team performance in the operating theatres, and we discuss some of the expected, as well as some of the quite unexpected obstacles placed in our path. For anyone involved in, interested in, or thinking of becoming engaged in, the hottest new trend in healthcare, this talk is a must see. Hidden dangers; unanticipated surprises; discovering new friends; laughs, lows and twists and turns on a journey through the mysteries of the psychosocial universe, this talk has it all.

Presentation objectives

In this presentation, you will learn about:
- the growing trend of using social media for clinical education purposes
- transcending the inter-disciplinary divide
- growing networks and connectivity among health care professionals
- delivering low-cost high-impact solutions to front-line clinicians
- engagement: Forget the survey.

This is what it looks like Opportunities stemming from our experience with copyright Positivity: Together towards the future Introducing ‘Very Australian non-technical models of care’ as a social media philanthropic (ad)venture for the betterment of nursing.

Professionalism in the operating suite

Paula Foran*¹,²

¹ Australian College Operating Room Nurses. Adelaide Australia
² Honorary Senior Lecturer School of Nursing and Midwifery - Deakin University, Australia

Topic overview

Teamwork is an integral part of perioperative nurses, however several factors can impede this process having negative effects of patient safety. The aim of this presentation is to openly discuss the difficult issues that can prevent the smooth running of an operating suite, disrupt communication and promote poor staff morale.

Presentation objectives

The presentation will provide a definition of professionalism, discuss language, confidentiality (phone, internet and social media), bitching, white anting, and setting people up to fail. Each issue will be followed by an appropriate solution to the problem. The presentation will then move to an evidenced base discussion on teamwork and safety, linking poor staff behaviours with a decrease in patient safety. Discussion will continue on how to care for students, each other, ourselves and our patients.
Managerial and clinical perioperative nurses: Friends or foe?

Fiona Unac*, Jennifer Sexton*

1 Perioperative Nurses College of the New Zealand Nurses Organisation

**Topic overview**

Professional power struggles between nursing middle management and senior clinical nurses have been described as a major barrier for progressing advanced perioperative nursing practice. This paper explores the experiences of a charge nurse manager and an acute care nurse practitioner as they have adjusted to changes in roles and responsibilities within a small radiology nursing team. They share their experiences from different perspectives, with different challenges and different rewards. However, through mutual regard and respect they have been able to work collaboratively to significantly improve patient access and clinical outcomes.

**Presentation objectives**

At the end of the presentation conference delegates will:

- identify the known and hidden challenges in progressing advanced clinical nursing roles
- identify workplace cultures that promote and hinder advance nursing practice
- reflect on whether advanced perioperative nursing practice is celebrated or rejected in their workplace and the reasons for this
- reflect on how advanced perioperative nursing practice could improve patient outcomes in their workplace.

Helping your manager lead with passion and resilience

Anna Hinz*, Matthew Bell*

1 Cabrini Health, Australia
2 Multigate, Australia

**Topic overview**

In the current high-pressure working environment of the Perioperative Unit, increased responsibility and higher demands are ‘more so than ever before’ being placed on the Nurse Manager of the Operating Suite. They are expected to display unending resilience and be able to lead through challenging and constantly-changing circumstances without fail. So how can their staff play an integral part in the manager’s and therefore the team’s success? Much is written about how leaders need to be innovative, dynamic and available for staff to create high-performing departments, yet rarely does the conversation turn to how staff can work to support effective leaders and thus be an active agent themselves in creating positive outcomes that benefit all stakeholders, from nurses and administration staff through surgeons and, most importantly, the benefactors—the patients. Led by highly regarded and experienced nursing professionals, Anna Hinz and
Matt Bell, this session explores how staff can best support their unit leader(s) to help execute workflow and procedural change needed to take nursing into the next decade. The session will look at the processes and strategies required to support dynamic change in large departments and how all team members have a critical role to play in supporting their manager leaders as advocates for progress. How do we create the best teams to create the best outcomes? How can we better listen to each other to better establish positive and cohesive working environments and therefore departments that meet the financial and safety needs of an organisation? Having been leaders of large departments, Matt and Anna have extensive experience enacting progressive change in environments of adversity and challenge. Both have previously presented on innovation and change and how to get the most from variable team dynamics in difficult and stressful working environments. During many years working in parallel, the pair have long observed and advised on each other’s styles and professional approaches while leading through adversity. In conversation between them many times have they discussed how an ideal team may be developed and managed and what they would need to achieve the best results for patients, staff and the organisation and a whole.

Basic life support education in the operating suite- Back to basics

Sue Butcher*¹

¹ Central Gippsland Health Service, Sale, Victoria, Australia

Topic overview

Survival rates following cardiac arrest vary greatly and range from 3-27%, with a poorer prognosis for patients suffering cardiac arrest out of a hospital setting. Basic Life Support training is a mandatory requirement for hospital staff and recertification in CPR skills should be conducted annually (ARC Guideline 10.1). Education programs conducted in the Operating Suite should include training in resuscitation procedures. There is also a strong emphasis on education involving early recognition and response to the deteriorating patient. As perioperative nurse educators, what do we teach, how do we teach it and how do we engage staff to undertake their annual competency?

Presentation objectives

Education programs involving simulation and scenario based training in specific critical illness is often provided. In the Perioperative Unit such relevant scenarios may include management of anaphylaxis, malignant hyperthermia, airway obstruction or hypovolaemia. There are many issues to consider when providing such training including - planning, time allocation, equipment required, venue, costs and ensuring all staff are able to attend. Basic Life Support training requires minimal adjunctive equipment and education and practice opportunities can be achieved relatively easily. In the perioperative environment there is immediate access to resuscitation equipment for advanced airway management, drug therapy and defibrillation as well as a team of highly skilled staff. But what do we do when we don’t have such equipment within reach and support readily available? Vicki’s Story - how life changed forever for one of our own Operating Room Nurses.
Discharge decision making to detect clinical deterioration: Outcomes from the PACT study

Maryann Street*,1,2,5, Nicole M Phillips1,5, Mohammadreza Mohebbi3,5, Bridie Kent1

1 Deakin University, School of Nursing and Midwifery, Geelong, Australia
2 Eastern Health - Deakin University Nursing & Midwifery Research Centre, Box Hill, Australia
3 Deakin University, Faculty of Health Biostatistics Unit, Geelong, Australia
4 University of Plymouth, School of Nursing and Midwifery, Plymouth, UK
5 Deakin University, Centre for Quality and Patient Safety, Geelong, Australia

Introduction

Intensive observation of patients by nurses in PACU may lead to early recognition and response to clinical deterioration, reducing post-operative complications and length of hospital stay. This study aimed to evaluate whether use of the Post-Anaesthetic Care Tool (PACT) would enhance nurses’ recognition of and response to patients at-risk of deterioration and improve patient outcomes.

Method

A non-randomised prospective study at three hospitals of nursing management in PACU for adults undergoing elective surgery before and after the introduction of criteria to aid recognition and response to clinical deterioration. Patient outcomes were determined from the medical record following hospital discharge.

Results

Nursing response to patients at-risk of deterioration was higher using PACT, with more medical consultations initiated by PACU nurses (19% vs 30%; p<0.001) and more patients with Medical Emergency Team (MET) activation criteria modified by an anaesthetist while in PACU (6.5% vs 13.8%, p<0.001). There were higher rates of analgesic administration (37.3% vs 54.2%, p=0.001), nursing assessment of pain and documentation that ongoing pain relief had been ordered prior to discharge (55% vs 85%, p<0.001). Fewer adverse events were recorded in PACU before PACT (4.3% vs 12.3%, p<0.001). However, the rate of adverse events after discharge from PACU remained constant (16.5%), and the rate of cardiac events (5.1% vs 2.6%, p=0.021) and clinical deterioration (8.7% vs 4.3%, p=0.001) following PACU discharge significantly decreased.

Conclusion

The PACT study has demonstrated that using this PACU discharge tool enhanced nurses’ recognition and response to patients who experienced clinical deterioration following surgery.
Handover between anaesthetists and post anaesthetic care unit nursing staff using ISBAR principles: a quality improvement study

Patricia Kitney*, Dianne Buttigieg¹, Paul Bennett¹, David Bramley¹, Raymond Tam¹

1 Western Health, Melbourne, Australia

Introduction

ISBAR is a structured approach to communication between healthcare professionals. The acronym stands for: introduction/identification; situation; background; assessment and request/recommendation. ISBAR was introduced into the post-anaesthetic care unit (PACU) of a large Victorian health service in 2013. The aim of this study was to measure the effect of an education program on ISBAR compliance.

Method

A pre/post-test cohort design using a 13 item audit tool to measure compliance before and after a quality improvement intervention in two acute hospitals in Melbourne, Victoria. The intervention consisted of two hour in-service education session to anaesthetists and PACU nurses combined with visual cues using ISBAR wall posters.

Results

In Hospital A, significant improvement from pre to post audit was found in the items of cardiovascular assessment ($\chi^2 (1) = 4.06, p < .05$), respiratory assessment ($\chi^2 (1) = 12.85, p < .01$), analgesia assessment and actions (Fisher’s exact test $p < .05$) and responsibility + referral ($\chi^2 (1) = 4.44, p < .05$). For Hospital B significant improvement was found in communication difficulties ($\chi^2 (2) = 13.55, p < .01$) and significant decreased performance was found in respiratory assessment ($\chi^2 (1) = 8.98, p < .01$) and responsibility + referral ($\chi^2 (1) = 13.26, p < .01$).

Conclusion

An augmented education program can be associated with a significant improvement in ISBAR compliance, but can also be associated with decreased compliance. The mixed results are potentially consistent with previous evidence suggesting a sustained multimodal intervention may be required to produce uniformly positive change demonstrated on repeat assessment.

Factors associated with the development of pressure injuries in surgical patients. A retrospective study

Patricia Nicholson*, Christine Hunter*, Nick Santamaria, Tara Handke

1 School of Nursing and Midwifery, Deakin University, Melbourne, Australia
2 Peter MacCallum Cancer Centre, Melbourne Australia
3 School of Health Sciences, University of Melbourne, Melbourne Australia

Introduction

Pressure injuries (PI) cause significant pain, require extensive treatment and result in longer hospital stays with considerable expense to the patient and the organisation. The incidence of PIs is reportedly between 0.4% and 38% in the acute setting (Chen et al., 2012) with a high incidence reported in surgical patients (Primiano et al., 2011; Schultz et al., 1999; Stewart et al., 2007). While it has been accepted that PIs are caused by various forces other contributing factors include immobility, use of anaesthetic agents and repositioning the patient on the operating table, resulting in PIs that exhibit different epidemiological characteristics when compared to non-surgical patients (Chen et al., 2012).
Method
This multicentre project involved a retrospective, exploratory review of medical records to identify variables predictive of PI development postoperatively in patients undergoing a surgical procedure.

Results
Fifty per cent of the patients were classed as pre-obese or obese with a Braden score for the majority of patients rated as moderate to severe risk. More than 50% of the patients developed a Stage II pressure injury with the sacrum and heels the most common site, findings similar to the Victorian Pressure Ulcer Point Prevalence Survey (PUPPS) (2006).

Conclusion
With evidence to support the development of PIs in patients who are immobile and unable to change their position, patients undergoing surgery are at a higher risk than non-surgical patients (Schoonhoven, et al., 2002). This presentation will include an overview of the results of this study which was funded by a research grant from ACORN.

Session 5: Combined
11:30 – 12:40

Manual handling challenges in the perioperative unit - Reversing the satanic curse

Diane Greening*¹, Patricia Keating*¹

1 St George Public Hospital, Kogarah, Australia

All Perioperative Units have Manual Handling challenges and sometimes it takes a fresh pair of eyes to initiate the energy and enthusiasm required to recognise and bring about a change in practice. The consequences of Workplace Health and Safety (WHS) injuries imposes a personal, psychological and financial burden on the facility and staff member. St. George Hospital functions as a level one trauma centre, with an annual caseload of 16,500 procedures. The Perioperative Unit has over 177 staff (not including Medical Staff) with provision for most surgical specialties. For our contemporary workforce this presents numerous Manual Handling challenges. This presentation focuses on two potentially hazardous tasks which are regularly performed as part of our daily routine.

The Manual Handling manoeuvres in question involve:
1. moving Anaesthetic Machines for remote anaesthetic procedures
2. transferring anaesthetised supine patients into a prone/lateral position for surgery.

These manoeuvres have been undertaken for several years and it was only during a review, together with the hospital Manual Handling Co-ordinator that concerns were raised regarding our current practice. Using these examples, the process employed to resolve our Manual Handling issues will be explained.

The process involves:
- forming a focus group
- assess the risk
- simulation and brainstorming

Speaker abstracts
Thursday May 26
trial of new equipment/practice
review risk assessment
developing a Safe Work Practice
training and establishing a yearly competency.

Endeavouring to carry out processes within the constraints of working in the peri-operative environment is in itself a challenge. An established system still requires continuation of practice to ensure consistency is maintained.

Parachutes of tuberculosis - (the devil is in the detail) when extra pulmonary tuberculosis becomes aerosolised

Sally Lockhart*¹, Michelle Skrivanic¹
1 Concord Repatriation Hospital, NSW, Australia

Topic overview

This presentation arises from an incident where a clinician is suspected of contracting Mycobacterium Tuberculosis (TB) from a patient with positive wound TB in our Local Health District. The staff member was young and healthy and symptoms were late to present and so it is unclear how or when the transmission may have occurred. This led us to look closely into our procedural guideline for TB to ensure staff information was relevant and clear and to guide our management of future presentations to the OR. The more we explored this topic, the more we realized its importance for the safety of perioperative nurses and others; globalization and an aging population, may see more TB cases presenting to the operating theatre. The management of patients with TB has been well documented in the literature with guidelines on required controls being readily available. Over time our department has seen an increase in patients with suspected or confirmed extra pulmonary TB (EPTB) requiring surgery. Advice can be conflicting and ambiguous when it comes to the management of these patients in the operating suite. After consultation with infection control and engineering services, a best practice process was implemented. Additional risk-reduction precautions are required for EPTB, particularly during the treatment of aerosol-generating procedures such as hip washout using high-pressure irrigating devices.

Presentation objectives

This presentation will describe the history and epidemiology of tuberculosis in Australia, the management of operating room air-conditioning pre and post-surgery and the personal protective equipment requirements for staff.

Fatigue and intoxication: The pilgrimage to policy

Pete Smith*¹, John Gibbs*¹
1 NSW OTA, Australia

Introduction

The ACORN Standards now bear a guideline for the management of fatigue in the operating theatres. Whilst a guideline is advisory, the researchers discovered a correlation between the performance boundaries of fatigue intoxication and the Drug and Alcohol Policy already existent and enforceable within our organisation’s Code of Conduct Policy. Here they examine in detail what such a correlation may mean for the advancement of fatigue mitigation in the context of improved safety culture.
Methods

The researchers used mind-mapping techniques and a literature search for a possible range of answers to the question: ‘Can the ACORN Fatigue Guideline advance fatigue mitigation at a policy level?’

Results

We find that the ACORN Fatigue Guideline does in fact present an opportunity to increase the safety and reliability of the performance fabric of the Operating Theatre team in terms of an already existent organisational policy. We also find that the simple solution we discuss has precedence and is a robust and pertinent addition to our current fatigue guideline.

Conclusion

Fatigue intoxication bears the same performance equivalent as drug and alcohol intoxication. Marrying the two is an inevitable sequitur. The only question is: do we have the courage of our convictions to ‘first, do no harm’?

Plenary Session

14:30 – 15:15

Sponsored by Medtronic

10 top patient safety issues

Victoria Steelman*¹

¹ The University of Iowa, Iowa City, Iowa, USA

Topic overview

Perioperative nurses are in a unique position to understand the errors and the unreported near misses that occur in the operating room every day. Yet, issues are often unreported and the voices of these clinicians are often not heard. We surveyed perioperative registered nurses working in hospitals and ambulatory surgery centers to learn more about perioperative patient safety issues. This presentation will discuss each of the top 10 safety issues identified, the evidence of risk, and contributing factors. Pragmatic recommendations targeting each of these safety issues will be presented to promote our goal of enhancing perioperative safety, mitigating risk, and improving patient outcomes

Presentation objectives

This presentation will;

• list 10 priority patient safety issues identified by perioperative nurses
• identify clinical practice changes to improve the safety of patient care
• discuss the application of these recommendations in the practice setting.
Session 6: Clinical
15:20 – 17:00

Simulating arrests in theatre to empower BLS trained staff involvement

Ben Lockwood*¹

¹ Flinders Medical Centre, Adelaide, Australia

Introduction

Arrests in the perioperative environment require a team approach to ensure optimal patient outcomes. Often self-supported during an arrest, the perioperative team usually comprises a mixture of clinical expertise and both Basic Life Support (BLS) and Advanced Life support (ALS) trained staff members. An ALS simulation training program designed to support the annual development needs of anaesthetists highlighted gaps in the abilities or willingness of BLS trained staff members to actively engage in an arrest situation. An education program was established, using a combination of simulation and workshop training, to empower BLS trained perioperative staff to engage more readily in an arrest situation in order to better support the team, and improve patient outcomes.

Methods

Perioperative staff, both ALS and BLS trained, are provided an hour workshop on perioperative arrests, defibrillation, and the ALS algorithm. The workshop includes an interactive lecture/demonstration, as well as a reflective thinking discussion and question session. Feedback is sought following the session to determine if staff found the session useful and enjoyable, and if they met their learning objectives. Staff are then rostered to participate in perioperative arrest simulations, which are held once per fortnight with a variety of scenarios. The simulations, held in theatre, are aimed to be high-fidelity with maximum realism, and are run by a trained faculty of Anaesthetists and perioperative nurses. A debrief is held after each session for staff to reflect on practices and techniques, and to consolidate learning and experiences. A formal survey to follow the program will seek to explore staff perceptions of the initiative, new-skills acquisitions, team cohesion, and self-reported empowerment to participate actively in perioperative arrest situations.

Results

The project is ongoing (underway for 1 year) at the time of abstract submission. Initial results from feedback analysis have shown the interactive workshop to be highly valuable to de-mystify the ALS algorithm from a BLS trained staff member’s perspective. Furthermore, it has facilitated knowledge transfer into the activities that a BLS trained staff member can assist with in an arrest situation, such as preparation of drugs, scribing of events, placement of defibrillator pads, and cardiac compressions. Initial anecdotal feedback from participants in the simulation scenarios have suggested that the program has served to breakdown the fear barrier staff experience during arrest situations, enabling BLS trained staff members to ‘have a go’ in a safe and learning-based environment, with the ability to practice new skills. Further anecdotal feedback from ALS trained staff members has suggested an increase in team cohesion during arrest situations, and increased participation from the BLS trained staff members. Results from the survey will be explored in more detail.
Conclusion

The program, although still ongoing, has shown promising results with the education and empowerment of BLS trained perioperative staff members to actively engage and assist in arrest situations. As perioperative teams are often required to manage arrest situations without the support from external medical emergency teams, maximising team efficiency and activities is paramount. Furthermore, it is hoped that increased team cohesion and positive participation from all perioperative staff members will result in improved patient outcomes.

The evolution of a rumour

Tony Zuino*¹

1 QEII Hospital, Brisbane, Australia

Topic overview

There was a rumour that The Director of Surgery wished to hold a seminar with an interactive ‘real time’ operating component for a Video Assisted Anal Fistula Therapy (VAAFT) procedure which is a new treatment for pilonidal sinus and anal fistula. This procedure has been recently introduced at QEII Jubilee Hospital. I only heard about this workshop in a corridor conversation of my theatres and realised that I needed to be fully included. My immediate reaction was that we had not done anything like this before and I had no idea what this was all about and what was required. In addition to this it was a theatre procedure being performed in our stand alone Endoscopy Suite due to the technological capabilities within that unit. I knew that I needed to ensure that the nursing component met standards and was organised correctly. It soon became apparent that with only 6 weeks notice that the logistics were almost overwhelming and that considerable oversight was vital to ensure a successful day.

Presentation objectives

A contemporaneous review of aviva workshop and seminar with the collation of services, equipment, staffing, IT, logistics, credentialing and other issues that developed from the initial rumour to the workshop’s conclusion and the patients’ discharge. This presentation discusses the management, pitfalls and learnings that ensured a successful outcome for all including the patients.

How to make clinical teaching and learning more fun in our unit?

Sean Rawani*¹

1 Casey Hospital - Monash Health, Melbourne, Australia

Topic overview

The demands to ensure the quality and standards of patient care, the need for staff's professional development and the provision of unit-based inservice education for nursing staff in the perioperative environment may necessitate effective teaching and learning strategies that will require contributions from all team members for successful peer learning. What may be the best ways to approach a unit’s education needs? How to invite and involve all our colleagues? What can be the challenges? How can we make learning fun despite resource and time constraints? These are some of the questions that this presentation will attempt to address and the contents will provide practical and easy-to-replicate examples for all perioperative nurses regardless of level of practice and specialty. This session may prove of greater relevance to clinical nurse specialists, clinical education and management staff who envision influencing clinical practice by education strategies that are inspired and directed by organisational guidelines.
Presentation objectives

By attending this presentation and applying suggested strategies, the audience members will be able to:

- examine contemporary clinical education methods
- identify the barriers to teaching and learning as a team in the operating room environment
- specify the enablers of effective clinical teaching for the operating room nurses
- create staff education activities with minimal resources and positive outcomes
- enhance team learning by using organisational guidelines as an ongoing plan.

Perioperative & sterilisation services - The forgotten partnership?

Deborah Burrows*¹

¹ Southern NSW Local Health District, NSW, Australia

Topic overview

Operating Suites rely on efficient sterilisation services to achieve the required outcomes for surgery and operating room efficiency. So what happens in the sterilising unit and how can we enhance communication between perioperative and sterilising staff to develop strong relationships which will ensure better patient outcomes?

Presentation objectives

This presentation will discuss:

- expectations of perioperative staff and sterilising staff of each other
- develop a better understanding of the processes within a sterilising unit
- discuss the standards sterilising staff work under and
- discuss ideas for improving communication between the two units.

Session 7: Education
15:20 – 17:00

From concept to reality: A perioperative workforce initiative with a difference

Vicky Warwick*¹, Myra Book¹, Sheralee Tamaliunas³

¹ Nursing and Midwifery Office Department of Health Perth, WA, Australia

Topic overview

In Western Australia it has been identified that nurses choosing to enter the perioperative areas has declined. In 2015 major reconfiguration of the South Metro Health Service and the opening of a 600 bed tertiary hospital has proved problematic when trying to staff operating theatres adequately. Also at this time due to increased university enrolments and the inability for WA Health to accommodate all graduates into a program, approximately 400 graduate nurses
would not find employment in the acute sector on graduation. As a senior perioperative nurse I was contacted by the Nursing and Midwifery Office to discuss a strategy to increase the known and predicted shortages in the perioperative workforce. It was agreed that a fast track initiative to train graduates as perioperative nurses would be an ideal solution; and from there the Perioperative Intensive Transition (PIT) program was born.

Aim

The aim of this program was to recruit graduate nurses that want to work in the perioperative specialty and provide intensive training to enable them to ‘hit the ground’ running after 10 weeks.

Method

A 10 week intensive simulation program and curriculum was written and recruitment was commenced. Graduates would be offered a 26 week fixed term contract that was partially funded by the Nursing and Midwifery Office and the rest would be funded by the employing site.

Conclusion

This course is unique as it is a recruitment and workforce solution. The graduate nurses whom take part in the program should leave after 10 weeks having built the basic perioperative skills they require to operate at a novice beginner level on the clinical floor.

How does a specialty transition program influence the nurses learning and development?

Claudia Watson*, Dionne Johnston¹

¹ The Children's Hospital at Westmead, Sydney, Australia

Introduction

The Paediatric Perioperative Transition Program was developed and introduced into the Operating Suite of The Children's Hospital at Westmead, Sydney in 2009. The 12 month program encompasses: instrument, circulating, anaesthetics, recovery room and day surgery nursing. The program is in its 7th year and has been evaluated from a learner's perspective. Of the 39 nurses that have participated in the program, we have retained 87% in the Sydney Children's Hospitals Network. Of these, 82% of the nurses remain in employment at The Children's Hospital at Westmead, Operating Suite.

Method

A survey method was used to collect demographic data and an interview method was used to explore thoughts and feelings, with common themes emerging from this.

Results

The results demonstrated the limited experience in Operating Room nursing at the beginning of the program and the influence of the learning and development that followed.

Conclusion

This education program has demonstrated effectiveness in supporting new staff with limited experience and skills to transition into practice within the Operating Suite, achieve competency in practice and to be productive members of the team. In this presentation we will share with you the key findings of the evaluation and recommendations for future development of education transition programs.
Mentoring a perioperative nurse leader: Better the devil you know

Lois Hamlin*, Sally Sutherland-Fraser

1 Fellow Australian College of Nursing (FACN); Foundational Fellow, ACORN

Topic overview

Following the success of the first Australasian perioperative nursing book, ‘Perioperative nursing: An introductory text’ in 2009, a second edition was commissioned in 2014. A key aspect of early discussions with the publisher was the need to identify and develop another editor, to ‘future proof’ the text. This paper explores the use of mentorship to develop a perioperative nurse writer into the editorial role. The term mentoring eludes a precise or authoritative definition despite its long history and use in many walks of life. Minimally, it is a relationship between a person who is perceived to have greater relevant knowledge, wisdom or experience (the mentor) and a person who is perceived to have less. Informal communication, longevity of the relationship, and transmission of knowledge, social capital and psychosocial support also feature in most explications of mentoring.

Reference


Presentation objectives

This presentation will:
- explore the concept and various models of mentoring
- discuss the establishment of the mentoring relationship
- identify the mentor and protege’s approaches to their roles
- highlight the synergies and shortcomings of this approach to editorial development

Session 8: Management
15:20 – 17:00

Improving the delivery of healthcare in surgery through performance improvement, empowerment and accountability

Patrick Voight*

1 Deloitte Consulting, Detroit Michigan, USA

Topic overview

Performance Improvement, Empowerment, Accountability Across the world; inefficiencies, poor patient throughput, lack of coordination and poor quality care drive costs in our healthcare systems and hospitals. In many counties it is
estimated that 30% of spending on healthcare is related to these inefficiencies and lack or care coordination. With Nursing and other healthcare professionals at the front line caring for patients, we first-hand see the impacted related to broken processes in our daily work. As a result, in many situations, workarounds have been developed in order for us to carry out our daily patient care activities. Workarounds seem to become the ‘new normal’ in order for us to provide care to patients. In many cases, patients’ lives are at risk when this new normal becomes routine in providing care. There are numerous performance improvement methodologies capable of eliminating waste and poor care in our hospitals and operating rooms. These methodologies help us redesign patient care and nursing care processes in order to: improve efficiencies and throughput; coordinate care; improve quality and safe patient care. In order for processes to be redesigned and implemented, nursing and other healthcare professionals must have the understanding and skills to think, redesign and implement new processes. No matter what performance improvement methodology is utilized, a key aspect of sustaining the effects of the performance improvement is nursing empowerment and leadership accountability. Without these core skills and competencies, the improvement efforts realized will be short lived and quickly return to their prior, inefficient and unsafe state.

Presentation objectives

This presentation will:
- discuss drivers of inefficiencies in our Operating Rooms and their effect on patient care
- discuss the various performance improvement methodologies related to improving patient care, cost, quality and throughput
- discuss the roles, responsibilities and skills for Nurses and other healthcare professionals in leading performance improvement in our surgical departments
- discuss leadership and staff responsibilities in sustaining effective change in our work environments.

Review of perioperative services in country health SA

Sue Maksimovic*¹

¹ Gawler Health Service, SA, Australia

In May 2012 CHSALHN commissioned a review of peri-operative services. Thirty one health units participated in the desk top review against ACORN Standards, Australian/New Zealand Standard 4187, Gastroenterological Nurses College of Australia (GENCA) and Australian Council of Healthcare Standards (ACHS). Susan Maksimovic, Clinical Services Coordinator, Surgical Services, Gawler Health Service, was engaged as a project officer to address recommendations resulting from the audit. A risk management approach to prioritising the recommendations was taken. Information gained from the project was shared with CHSALHN perioperative managers and DONMs from units during a consultative forum. The CHSALHN Perioperative Managers Reference Group was established as a governance body for communication and consultation between perioperative managers throughout CHSALHN. Auditing against national standards was conducted in all units providing valuable information and opportunities for improvement. Standardised training and education across CHSALHN was established for all units across the rural regions. Auditing against South Australian and Country Health policies identified areas for increased resourcing to ensure best practice. Opportunities arose to identify clinical expertise in individual health units that CHSALHN was able to share across the broader rural area. Areas of clinical risk were identified and safe work practices introduced to address these. Information gained on equipment resourcing assisted South Australian Biomedical Engineering (SABME) to provide health units with equipment required to undertake safe surgery.
Topic overview

The Southern Adelaide Local Network (SALHN) is committed to continuous improvement and therefore regularly reviews services provided to ensure an efficient and effective use of resources for the three hospitals within the network, namely: Flinders Medical Centre (FMC), Repatriation General Hospital (RGH) and Noarlunga Hospital (NH). The purpose of the review was to establish one consistent, safe and effective model of care for patients requiring PACU care at RGH and to extend the available Day Surgery hours into the evening.

Presentation objectives

This presentation gives a background of the existing model of care which was complex and dependent on many variables and because of issues with team cohesiveness, inequality of work distribution produced significant inefficiencies. Using the principles of change management we strove to redesign and centralise patient care. The principle proposal was to establish the Main Recovery as the designated PACU Stage 1 site for all surgical patients who have had a procedure where an anaesthetic agent has been administered. The involvement with Human Resources was crucial in ensuring all staff were working within their contractual arrangements and to assist with team building. Risks were identified and a financial review took place followed by the implementation process. Evaluation occurred three months post implementation and a SALHN wide procedure, Clinical Pathway for Patients in the Immediate Post-Anaesthesia Phase was developed.

Session 9: Research
15:20 – 17:00

The devil is in the details - using Human Capital Theory to strategise transition to perioperative nursing

Amanda Gore¹

¹ University of Tasmania, Australia

In perioperative nursing, the role and power of the organisation is currently such that it is the gatekeeper of the perioperative nursing profession. The notion of human capital theory (Becker, 1962; Becker, 2009) has the potential to provide important insights about the relationship between perioperative nursing skills and employability in the specialty. This research investigates the applicability of human capital theory in transition to the perioperative nursing specialty. An empirical study is being conducted in Australia to determine if human capital theory explains the under-utilisation of
newly graduated nurses as employees in perioperative nursing; whether nurses would make different choices in their education if it increased their specific bargaining power; and whether strategic perioperative education initiatives would alter the recruitment practices of public and private operating theatres. Perioperative nursing skills are valuable asset in the marketplace. They are valuable to the owner (the individual nurse) who can use them to signal their capacity for work in the specialty and to exchange their skills for monetary reward. The skills are seen as valuable by employers seeking to recruit and retain ‘experienced’ nurses to enable a service to be delivered. They are valuable to patients and the community who rely their agency in helping produce a successful surgical outcome. Such skills are valuable and portable nationally and internationally for skilled migration. The means by which investment in such skills in perioperative nursing can be made underpins the shortage of perioperative nurses. The background to this research includes problems surrounding the investment in human capital that must occur in order for a nurse to become a perioperative nurse. A transition to practice occurs primarily because a unique and specific body of knowledge and skillset must be acquired in order to practice in this specialty, which takes time and investment to accrue. Furthermore, there is no longer perioperative nursing content in the undergraduate nursing curriculum (Allanson & Fulbrook, 2010; Rabach & Sutherland Fraser, 2009; Stobinski, 2008). Currently the employer is the gatekeeper of entry to perioperative practice, and so the onus lies with the organisation to develop or imbue their employees with the specific skills required to perform in the specialty (or to be productive). This research will develop evidence that demonstrates the limited employment opportunities available, even though there are many new graduate nurses who might wish to pursue this specialty. Despite this, the concept of a ‘skills shortage’ is reified, most notably in relation to skilled migration. Whether decoupling some of the learning associated with perioperative nursing from the employer is desirable and feasible will be a major focus of the study. The role of Australian College of Operating Room Nurses [ACORN] in relation to transition to the specialty will also be explored.

A devil of a time implementing evidence-based practice?

Sandra Leathwick*¹,²

1 ACORN, Australia
2 ACN, Australia

Evidence-based practice (EBP) is a global phenomenon due to its potential improvement of patient outcomes. EBP has been identified as a core competency of 21st century health care providers. It is a requirement of Nursing and Midwifery Board of Australia that a nurse must practice utilising evidence-based nursing care. But what exactly is EBP and why is it so important? There is a growing need for nurses to develop an understanding of EBP allowing them to improve efficiency and effectiveness. Whilst undergraduate nursing curricula are structured to include all steps of the EBP process there is research to indicate limited support when the students arrive in the clinical setting. EBP involves a specific skill set and a five-step process. With knowledge and practice this EBP skill set can be developed into an invaluable tool. Applying evidence into practice is a challenge in many settings for a multitude of reasons. It is important that nurses are familiar with barriers to implementation in order for them to be overcome. Consideration will be given to the strategies suggested in the literature to overcome some of these barriers. Online resources to support clinicians in developing the required skills and knowledge will be highlighted.

Presentation objectives

This presentation will;
- define and analyse the components of evidence based practice
- examination of the barriers to implementation of EBP
- review the strategies to overcome the barriers
- consideration of resources to help in the delivery of EBP in the clinical setting.
Session 10: Combined
15:20 – 17:00

Nursing and medical students learning together? A curly process, but it can happen!

Josephine Perry*¹

¹ University of Adelaide, Adelaide, Australia

Topic overview

The scrub competency has historically been part of the student orientation to their surgical placement. However, this has changed, with several major hospitals discontinuing this portion of the program. Reasons for this include increased student numbers and the subsequent time it takes to check off a scrub competency for each one, malaligned starting dates, variety of facilitators teaching variety of methods, and not being part of the core business of the clinical facilitators for the institution. There is a need for tertiary institutions to facilitate the scrub competency. Reasons for this include ability to pass large numbers through the competency, flexibility with offerings throughout a semester, homogeneity of teaching methods, and it is the core business of tertiary institutions to prepare students adequately for clinical placement. Since the scrub competency is identical for medical students and nursing students, it makes sense to teach it as an Intra Professional Learning (IPL) opportunity. As perioperative culture has moved into a team model of care, roles have evolved within theatres, and this is also vital to explore on an interdisciplinary level. The plan to combine medical and nursing students into a simulation exercise whilst doing their scrub competency serves to bring the two together in a common space and introduce the main aspects of an unfamiliar environment. Filming small vignettes and uploading them to the learning platform as required prerequisite viewing has helped to streamline the content portion, and make best use of the ‘hands on’ time as well as providing contextualisation.

Presentation objectives

This presentation will:

• introduce the decision flow for this activity, specifically why this activity was necessary to develop
• outline how the key stakeholders were identified
• examine processes for material sourcing
• describe the process of development
• discuss how the activity evolved, specifically through feedback mechanisms
• outline the activity itself, and present the base material for student reference
• discuss how this activity has become formalised
• describe how key stakeholders have been maintained for investment
• discuss how this activity can be ported to the new Adelaide Medical and Nursing School.
Bringing together:

✅ Quality
✅ Service
✅ Experience
✅ Knowledge

**OT Consumables Division**

- Sterile Single Use Bipolar & Monopolar Forceps with Pre-Attached Cable
  - Adson, Iris, McPherson, Jansen Bayonet, & more options available
- Smooth & Serrated Tips, Standard & Non-stick Tips

- Sterile Single Use Pelispec Vaginal Speculum with Smoke Extractor
  - 3 sizes available

- Sterile Single Use Hand Immobilisers
  - Large & Extra Large

- Sterile Single Use Spackman Uterine Cannula

**Re Redevelopment Division**

- Compactors - Wire Shelving Units - Mobile & Static
- Wire Baskets & Trolleys

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- Disposable Foam Face Cushions
- Reusable Elevation Pillow & Accessories
  - for difficult intubation & obese patients

**TROOP**

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- FAX: 08 9446 2637

**Office Address**

Suite 76, Ground Floor 50 St. Georges Terrace, Perth WA 6000
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<th>Time</th>
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<tbody>
<tr>
<td>07:30 – 08:45</td>
<td>Defence Force Recruiting Breakfast Session – Grand Ballroom Section 1</td>
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<tr>
<td>08:00 – 17:30</td>
<td>Registration opens - Ground floor foyer, Hotel Grand Chancellor Hobart</td>
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<tr>
<td>09:00 – 10:00</td>
<td>Keynote Address: Better the devil you know - Global EMT classification &amp; standards, Bronte Martin, Royal Darwin Hospital</td>
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<tr>
<td>10:00 – 10:30</td>
<td>Morning Tea</td>
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<tr>
<td>10:00 – 10:30</td>
<td>Stryker pop up showcase - Chancellor Room 5</td>
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**SESSION OVERVIEW**

**FRIDAY MAY 27**

### 10:30 – 10:50

- **Asepsis: Who holds the key to survival against bacteria**
  - **Lilliana Levada**

- **Why do nurses find it difficult to speak up?**
  - **Rhiannon Robinson**

- **Perioperative nurse’s perception and performance of protecting patient privacy**
  - **You Jin Kim**

- **Perioperative nurses’ attitudes toward organ procurement: A systematic review**
  - **Weili Gao**

- **Changeover Time**

### 10:55 – 11:15

- **Surgical hand antisepsis, gowning, gloving and subsequent practice changes**
  - **Julie Johnson**

- **Game of (perioperative) thrones**
  - **Sonya Osborne**

- **Should I stay or should I go?**
  - **Seri Wilson**

- **The impact of workflow on the utilization of the surgical safety checklist: A qualitative study**
  - **Brigid Gillespie**

- **Changeover Time**

### 11:15 – 11:40

- **The eMR - The changing face of the perioperative environment**
  - **Susan Taylor**

- **ACORN nursing role: The anaesthetic nurse**
  - **Sue Ireland**

- **Factors that predict the non-technical skills performance of scrub nurses**
  - **Evelyn Kang**

- **Changeover Time**

### 11:45 – 12:10

- **Surgical paediatric ambulatory care pathway development, Flinders Medical Centre**
  - **Lydia Belet**

- **A practice audit of the role of the non-medical surgical assistant in Australia**
  - **Tori Hains**

- **Rule breaking in perioperative nursing practice: Is this the new paradigm for getting the job done?**
  - **Sharon Bingham**

Please note the program is subject to change at any time at the discretion of the Organising Committee.
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<th>Time</th>
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<tbody>
<tr>
<td>12:05 – 14:00</td>
<td>Lunch</td>
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<tr>
<td>12:35 – 13:45</td>
<td>Mölnlycke Masterclass - Grand Ballroom - Section 1</td>
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<td>3M Masterclass - 3M Booth - Partners in Health &amp; Education Precinct (Exhibition)</td>
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<tr>
<td>12:15 – 12:35</td>
<td>Medline pop up showcase - Pink Glove Dance</td>
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<tr>
<td>12:15 – 12:35</td>
<td>Medline pop up showcase - Pink Glove Dance</td>
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<tr>
<td>13:45 – 14:00</td>
<td>Session 15: Clinical</td>
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<td>13:45 – 14:00</td>
<td>Grand Ballroom - Section 3</td>
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<td>13:45 – 14:00</td>
<td>Concert Hall</td>
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<td>Grand Ballroom - Section 1</td>
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<td>13:45 – 14:00</td>
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<td>13:45 – 14:00</td>
<td>Session 15: Clinical</td>
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<td>13:45 – 14:00</td>
<td>Session 16: Education</td>
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<td>13:45 – 14:00</td>
<td>Session 17: Management</td>
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<td>13:45 – 14:00</td>
<td>Session 18: Research</td>
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<td>14:00 – 14:20</td>
<td>Social media - The devil's in the detail Menna Davies</td>
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<td>14:00 – 14:20</td>
<td>Going digital: The force awakens Catherine Steel &amp; Sandy Sampson</td>
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<td>14:00 – 14:20</td>
<td>AUSMAT perioperative nursing; Exploration and challenge the boundaries of practise Amanda Gill</td>
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<td>14:00 – 14:20</td>
<td>Getting a handle on loan instrumentation Patrick Nicholson</td>
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<td>14:25 – 14:45</td>
<td>Surgery from a console: The devil vs Da Vinci Tracey Nicholls</td>
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<td>14:25 – 14:45</td>
<td>ANZAC Nurses: Following their steps to Gallipoli Sally Sutherland-Fraser</td>
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<td>Leadership and management: It's the little things Simone Ohlin</td>
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<td>14:25 – 14:45</td>
<td>Perioperative warming for caesarian section: A randomised, controlled trial Judy Munday</td>
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<td>14:50 – 15:10</td>
<td>St Vincents Thermal Care Project Rosie Lee</td>
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<td>Greening the OR - A devil of a time Rubie McIntosh</td>
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<td>14:50 – 15:10</td>
<td>Changeover Time</td>
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<tr>
<td>15:10 – 15:20</td>
<td>Changeover Time</td>
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<tr>
<td>15:20 – 17:50</td>
<td>Mock Trial: Tony Morris and Associates, Deloitte, NSW - Concert Hall</td>
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<tr>
<td>19:00 – 23:00</td>
<td>Conference Dinner - Macquarie Wharf No. 2 Cruise Terminal</td>
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07:30 – 08:45
Grand Ballroom section 1
Breakfast session title:
Head Start in Defence Health
Outline: Nursing Officer Roles within the Australian Defence Force are a far cry from civilian nurses jobs. They offer a great work variety, excellent opportunities for progression and promotion, and a very different patient demographic. Many of your nursing duties will be familiar but your workplace could be anywhere from a well-resourced military hospital to a temporary facility overseas, supporting a disaster-relief mission. Alternatively, a role in the Specialist Reserves gives you the opportunity to broaden your skills in exciting new environments, with a flexible part-time commitment.

Find out more and hear from current serving Health Professionals in the Australian Defence Force. Breakfast will be provided to the first 50 delegates who register.

Please forward your RSVP along with any dietary requirements to nmanning@dfr.com.au by no later than Friday, 20th May.

10:00 – 10:30
Chancellor Room 5
Hazardous Exposure Prevention in the Operating Theatre
• Overview of the hazardous exposure risk to staff working in the operating theatre
• Presentation of study results: Traditional canisters versus a closed system
• Future research: Plans for a global health economics study
Presenter: Martlie Horn, Nurse Unit Manager, Kareena Private Hospital
Enquiries:
Karen Nasuta
karen.nasuta@stryker.com
Pink Glove Dance
12:15

**Subject:** Pink Glove Dance

**Speaker:** Glenda Conejo – Medline Senior Product Manager

**Content:** Medline is focused on helping to improve lives. So it’s a natural extension of our corporate mission to help save lives through the early detection of breast cancer.

The Pink Glove Dance competition was launched because of the overwhelming response to the original Pink Glove Dance video in the US. Be part of the global phenomenon and help us build awareness, spread hope and help fulfil the vision that “A World without Breast Cancer is in Our Hands.”

**Enquiries:**
Denis Cantin
denis.cantin@medline.com

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**Sponsor sessions**

**Mölnlycke Masterclass**

**Title:** Surgical Site dressing to last the distance

**Speaker:** Lisa Pawlus R.N. Territory Manager, Mölnlycke Health Care

**About:** During this interactive session we will explore the principles for a dressing to last the distance. A dressing which is optimised for the challenges of surgical incisions, and how this dressing can support your post op blister reduction strategies.

**Time:** 30 – 40 minutes

**Enquiries:**
Karen Fox
Email: Karen.Fox@molnlycke.com

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12:35 – 13:45

**Partners in Health & Education Precinct (Exhibition)**

**Sponsor sessions**

**3M Masterclass**

**12:35 – 13:45**

**Partners in Health & Education Precinct (Exhibition)**

3M Australia, Discover your inner creative with SoluPrep™
Keynote address
9:00 – 10:00

Better the devil you know - Global EMT classification & standards

Bronte Martin*¹

¹ Royal Darwin Hospital, NT, Australia

The World Health Organization (WHO) Global Emergency Medical Team (EMT) Initiative aims to reduce the loss of lives and prevent long-term disabilities as a result of sudden onset disasters and outbreaks through the rapid deployment and coordination of quality assured Emergency Medical Teams; Preserving Health, Protecting Dignity and Saving Lives. The EMT Initiative supports member states, NGOs and international organizations by identifying best practice and minimum standards in clinical care, operational field logistics and coordination in austere environments.

The Australian Medical Assistance Team (AUSMAT) program is funded by Australia’s Department of Health to maintain a standby national and international EMT deployment capability to sudden onset disasters (SODs) and medical emergencies throughout the Asia-Pacific region. This includes a fully self-sufficient, Type 2 Surgical Field Hospital, most recently deployed for 21 days of operations in the wake of super-typhoon Haiyan.

There has been significant progress and transformative changes implemented in the quality and coordination of EMT responses to sudden onset disasters following the global lessons noted in Haiti Earthquake. International response operations in the Philippines, West Africa, Vanuatu and more recently Nepal have highlighted the need for flexible and effective coordination mechanisms that take into account the local context and operational environment. The Global EMT Classification, Verification and Mentoring program was introduced by WHO in 2015, ensuring a transparent, equitable and supportive process for validated, quality assured international Emergency medical care is delivered in response to Sudden Onset Disasters.
Asepsis: Who holds the key to survival against bacteria?

Lilliana Levada*1,5, Vicky Warwick2,5, Catherine Smith3,5, Robyn Williams4,5

1 Fairfield Hospital, Australia
2 Fremantle Hospital, Australia
3 Queensland Health, QLD, Australia
4 St Vincent’s Private Hospital, Australia
5 Australian College of Operating Room Nurses

Whilst our profession races to keep abreast with novel applications of the continuously evolving field of surgery, one thing remains the same in history of perioperative nursing: the race against infection within the perioperative environment continues. Despite current efforts there are still over 200,000 instances of surgical site infections (SSI) in Australia every year. With these reported incidents, SSI constitutes a significant amount of morbidity associated with surgery and sadly, it has a devastating effect on patients. The 2015 review of ACORN Standard - Aseptic Technique included active search, retrieval and appraisal of evidence related to the practical aspects of equipment and instrumentation management, surgical technique, environmental management, preparation of the patient for surgery and personnel skills - as a set of actions vital for establishment and maintenance of asepsis. This standard also mandates implementation of risk management in terms of asepsis and assists clinicians with practical safety measures for aseptic surgical practice. This presentation describes the process a dedicated team of ACORN Standard reviewers undertook; and whose resolve was to deliver a standard consistent with quality in surgical asepsis that is expected of us.

Surgical hand antisepsis, gowning & gloving - ACORN standard

Julie Johnson*¹, Mary Middleton¹,³, Sandy Leathwick¹,⁴, Carolyn Rose¹,⁵, Mary-Anne Renshaw¹,⁷, Mandy Akamarmoi¹,⁶

1 ACORN Standard Review Team
2 Northeast Health Wangaratta, Victoria, Australia
3 Caboolture Private Hospital, QLD, Australia
4 Australian Catholic University, QLD, Australia
5 Modbury Hospital, SA, Australia
6 Gosford Private Hospital, NSW, Australia
7 Adventist Healthcare, NSW, Australia

Introduction into the challenges of reviewing the recently released (will be by Conference) ACORN Standard ‘Surgical Hand Antisepsis, Gowning and Gloving’. Scrubbing Gowning and gloving is a fundamental practice in the operating room, and often we focus on the task involved without considering the consequences of our actions within the broader practice setting. The introduction of alternative products and the options available for the selection of gloves and gowns available place greater responsibility on preoperative staff to ensure they choose wisely to meet clinical considerations.
Utilising a risk management approach practitioners are encouraged to consider their requirements prior to selection of products to ensure they have been evaluated for safety, efficacy and cost. This ACORN Standard follows the previously established format of inclusion of key points from associated standards to provide continuity and cohesion within the standard. These Guidelines are supported by recent evidence based literature and extensive stakeholder consultation and have been developed to assist Health Service Organisations in policy review.

The eMR - The changing face of the perioperative environment

Susan Taylor*¹

1 PNAQ

Topic overview

St Stephen’s Hospital (SSH) in Hervey Bay opened on 13th October 2014 as the first fully integrated, digital hospital in Australia. Shortly after opening the hospital was awarded a Health Information and Management Systems Society (HIMMS) stage 6, with the aim to achieve the highest level of 7 after 12 months of data collection. The technical solution at SSH involves 29 Cerner Applications, 20 devices, 5 major clinical interfaces and 20 business interfaces. The end-to-end solution for SSH procedural areas include device integration with image capture, and vitals link; anaesthesia integration; medication management and procedure; and materials management.

Presentation objectives

The development of the electronic medical record (EMR) and integration of devices had a significant impact on the perioperative environment and workflows for SSH. There were many challenges faced by the eHealth team during the development and ongoing optimisation of the EMR. The presentation will share the identified benefits and lessons learnt during the journey to the electronic solution. Introducing a fully integrated digital eMR to the perioperative environment has a significant impact on the staff. Change management, training, support and adoption strategies utilised for the successful implementation at SSH will be shared.

Surgical paediatric ambulatory care pathway development

Flinders Medical Centre

Lydia Belet*¹,²

1 SAPNA South Australia, Australia
2 ACORN

Topic overview

The Surgical Paediatric Ambulatory Care Pathway at Flinders Medical Centre addressed the question: ‘Why have all the paediatric day surgery patients been cancelled due to bed availability when they do not require an inpatient bed?’

Presentation objectives

To establish a consistent, safe and effective ambulatory model of care for surgical paediatric patients. To reduce the potential for cancellation of elective surgical admissions in Paediatrics.
Session 12: Education
10:30 – 12:05

Why do nurses find it difficult to speak up?

Rhiannon Robinson*¹

1 Northern Territory Perioperative Nurses, Katherine, Australia

Topic overview

This topic has appealed to me since I conducted a presentation at the Northern Territory Perioperative Nurses (NTPN) study day in February 2015. A senior perioperative nurse in the audience made the comment ‘Do you know how difficult it is to speak up to some of the surgeons?’ It would be interesting to research the rationale for perioperative nurses not being able to speak up. Most of us realise the potential consequences of not saying something when there has been a breach in sterile technique, yet some of us are still apprehensive when there is a need to speak up. How are we being a good advocate for our patient and what are we doing to compromise patient safety when we do not say anything especially when most of the ramifications for remaining silent are quite obvious to all surgical and nursing theatre staff? I have seen first-hand that by speaking up the nurse patient relationship improves because there is more respect between the surgeon and the nurse.

Presentation objectives

This presentation will cover;
• various reasons why nurses find it challenging to speak up
• hierarchical structure of the perioperative environment
• fear of being ridiculed by either the surgeons or perioperative nursing staff
• recommendations for the nurse to be more assertive and have the courage to speak up when patient safety has been compromised.

Game of (perioperative) thrones

Sonya Osborne*¹, Lilliana Levada², Patricia Nicholson³, Julie Johnson⁴, Sue Ireland⁵, Amanda Gore⁶

1 Queensland University of Technology, QLD, Australia
2 Fairfield Hospital Sydney, NSW, Australia
3 Deakin University, VIC, Australia
4 Northeast Health Wangaratta, Australia
5 University of Tasmania, TAS, Australia

Speciality professional practice standards define perioperative nurses as a community of professionals - assisting perioperative nurses when advocating for consistency in quality patient care. It is an imperative for every professional perioperative nurse to model practice underpinned by the ACORN Standards throughout their workplace. ACORN’s mission is to promote excellence in perioperative nursing care and places great value on the Standards and the rigorous process of ensuring they are based on the best available evidence and aligned with contemporary changes impacting
on practice. In this interactive, audience participation session, teams of ACORN members will compete in a game-show type contest to determine who has the best knowledge of ACORN standards and the evidence underpinning The Standards. Everybody is welcome to test their knowledge in this fun, stimulating (and not so dangerous) challenge.

Presentation objectives

The objectives of this presentation are:

• provide a brief history of the ACORN Standards
• discuss the relationship between evidence, professional standards and practice behaviour
• provide the opportunity for perioperative nurses to ‘test’ their knowledge of ACORN Standards and the evidence behind the standard in a fun and collegial environment.

Session 13: Management
10:30 – 12:05

Perioperative nurse’s perception and performance of protecting patient privacy

In Ae Jung¹, You Jin Kim², Myoung Sook Kim³

¹ RN, Recovery Room, Department of nursing, Asan Medical Center, Seoul, Korea
² RN, Operating Room, Department of nursing, Asan Medical Center
³ Team manager, Operating Room Nursing Team, Asan Medical Center

This study was conducted to identify the level of perception and performance of patient privacy protection among perioperative nurses and the correlations between these factors. In terms of methodology, 301 nurses participated in a survey conducted from August 1 to August 9, 2015. Data were analyzed using t-test, ANOVA, Scheffe ? test, Pearson correlation, and Stepwise linear regression. The results of the analysis showed that the mean scores for the perception and performance of patient privacy protection among the nurses were 4.63 (±0.4) and 4.48 (±0.5) respectively. The level of perception of protecting patient privacy was significantly influenced by whether a respondent had completion relevant training (t=2.31, p=.022), awareness for the need for relevant training (F=14.86, p<.001). Performance was statistically relevant to the age (F=5.06, p=.007) of the respondents, their clinical experiences (F=5.45, p=.005), position (F=4.88, p=.002), awareness for the need for relevant training (F=7.36, p=.001), and experience of hospitalization and operation (t=2.86, p=.004). Perception had a positive relationship with performance (r=.476, p<.01). Factors influencing performance were perception (?=.462, p<.001) and clinical experience (?=.113, p=.027). Stepwise linear regression was significant (F=46.74, p<.001). From these results, we concluded that a relevant education project must be developed to improve the level of perception while policies and facilities must be established to enhance performance.
Should I stay or should I go?

Seri Wilson*¹

1 Seri Wilson, Royal Adelaide Hospital, Adelaide, Australia

Introduction

There is concern that the health industry may experience workforce issues with regards to a mass exodus of Baby Boomer Nurses (born between 1946 and 1965). The possibility of losing this large and important group from the Australian workforce, within a short period of time, has been flagged since the turn of the 21st Century. Of the 3440 currently employed nurses at the Royal Adelaide Hospital (RAH) 900 (26%) of those nurses are of the Baby Boomer generation, and will be planning retirement (RAH Human Resources 2015). This looming issue will have to be addressed by the RAH and Central Adelaide Local Health Network (CALHN) for workforce planning.

Aim

This study sought to examine the complex range of triggers that influence retirement intentions of baby-boomer nurses currently employed at the RAH as part of a Masters thesis. Baby-boomer nurses were asked to self-assess their ability and desire to remain employed by the RAH, to determine their retirement age intentions, and to discover the degree to which various triggers influence that decision.

The direction of the analysis was informed by three research questions:

1. How do demographics relate to individual baby boomer nurse retirement intention?
2. What are the triggers that are associated with retirement age intention of baby boomer nurses?
3. How are these triggers associated with nurses' intention to retire early or late?

This was achieved in a questionnaire format informed by a similar to a study conducted for the Queensland Police Service (Marcus 2007).

Method

A descriptive study was undertaken using inclusion/exclusion identified in the main write up. The goal of the study was to collect as many questionnaires as possible from the 900 nurses born between 1946 and 1965. Hard copy surveys were distributed throughout the RAH. 105 questionnaires (11% return rate) were returned to the researcher. A Statistical Package for Social Sciences (SPSS) database was used to analyze the results using crosstabs and factor analysis.

Results

The results are still in the process of being analysed to this date (2 October). Despite the low return rate, the researcher has taken into consideration that the results still represent the opinion of 105 nurses. The initial analysis suggested that the RAH boomer nurses were planning to postpone retirement. There were also trends within the data suggesting that nurses who worked part-time (flexible work arrangements) were more likely to delay their retirement. These trends are also reflective in the current literature.

Conclusion

The results will present a snapshot of the the opinion of the 105 baby boomer nurses of the Royal Adelaide hospital. The literature suggests that employers and older employees need to start talking about retirement intentions. Some identified barriers to this occurring include fear of the repercussions of anti-discrimination acts or threat to employment. Many studies recommend policies and incentives need to be developed to try and retain the baby boomer cohort. One avenue suggested was phased retirement which many nurses are already doing. The literature emphasizes the importance of future-proofing the workforce to ensure affordable and sustainable succession planning.
ACORN nursing role: The anaesthetic nurse

Sue Ireland*¹, Tina Sayce², Kathryn Clark³, Ruth Melville⁴, Jenny Cubitt⁵, Deborah Burrows⁶

1 Deakin University, Warrnambool, Australia
2 Northern Adelaide Local Health Network, Adelaide, Australia
3 Adelaide Community Healthcare Alliance Inc, Ashford Hospital, Adelaide Australia
4 Nambour Hospital, Sunshine Coast Hospital & Health Service, Australia
5 Canterbury Hospital Campsie, NSW, Australia
6 Southern NSW LHD, Bega, NSW, Australia

The anaesthetic nurse role is important in the continuum of safe, quality nursing care of the perioperative patient immediately prior to and during the intra-operative phase of surgery when the patient is at their most vulnerable. The anaesthetic nurse has the responsibility and accountability to have a certain level of skills, knowledge and attributes to ensure that they, as part of the team, provide high quality, person-centred care. The role of the anaesthetic nurse is two-fold, firstly as a competent, registered health professional regulated and bound by the standards of practice espoused by the Nursing and Midwifery Board of Australia and, secondly as the assistant for the anaesthetist that is expected to meet the requirements of the Australian and New Zealand College of Anaesthetists PS08 Statement on the Assistant for the Anaesthetist. As such the role is collaborative, working with anaesthetists, technicians, nurses and other members of the perioperative team. The aim of the role statement is to provide guidance for the development of policies and procedures relating to the role and responsibilities of the anaesthetic nurse. The statement has been informed by Standards from organisations such as ACSQHSC, especially the National Safety and Quality Health Service Standards, ANZCA, NMBA and ACORN; and evidence from the literature was sought in order to provide a broad, yet comprehensive understanding of this important role. This presentation will provide an overview of the revised role statement, and discuss the Standards and evidence from which it is derived.

A practice audit of the role of the non-medical surgical assistant in Australia

Toni Hains*¹, Haakan Strand¹, Catherine Turner¹

1 The University of Queensland, St Lucia, Australia

Introduction

The term Non-Medical Surgical Assistant (NMSA) encompasses all roles where healthcare clinicians without a medical degree provide clinical services during the perioperative phase of a patient’s journey. The role of NMSA is anecdotally gaining momentum within Australia. It is timely to ascertain who is preforming the role and quantify the practice setting, surgical specialty and scope of practice. This would enable establishment of a nationally recognised platform from which role evolution can occur.

Method

From 07 May to 07 July 2015 a NMSA Practice Audit was available online. Sampling was initially of a convenience modality with online links and invitations to participate via AANSA and ACORN. Respondents were asked to share the online link if they were aware of other clinicians performing the role.

Results

A total of 83 clinicians started the audit with a completion rate of 86%. Demographics of respondents captured included
age, gender, work experience and education. The majority of NMSAs were experienced RNs [>11yrs]; held post-graduate qualifications [80%], worked part-time, practiced predominantly in metropolitan areas [65%] and had been performing the role for 8 years or less. The specialty with the highest uptake of the NMSAs is orthopaedic surgery.

Conclusion
This presentation provides an overview of NMSAs practicing in Australia and provides cost effective evidence of the need for this service within the Australian healthcare system.

Session 14: Research
10:30 – 12:05

Perioperative nurses’ attitudes toward organ procurement: A systematic review

Weili (Lily) Gao*, Virginia Plummer§, Allison Williams§
1 Franston Hospital, Melbourne, Australia
2 Monash University and Peninsula Health, Melbourne, Australia
3 Monash University School of Nursing and Midwifery, Melbourne, Australia

Introduction
Organ donation is a life-saving treatment that improves the quality of life for patients with end stage organ failure. Organ procurement is part of the organ donation process, and is typically performed in a perioperative setting. Many perioperative nurses have participated in organ procurement procedures, and this experience may contribute to personal feelings of distress and negative attitudes toward organ donation.

Aim
This study explored the meaningfulness of perioperative nurses’ attitudes toward organ procurement. The aim of this systematic review was to investigate factors that influence nurses’ attitudes in order to enhance understanding of, and respect for perioperative nurses’ experiences and feelings. Another aim of this study was to implicate the findings to current practices to reduce perioperative nurses’ feelings of distress around their organ procurement experiences in future practice.

Method
A systematic review of primary research studies, published in the English language between 1990 -2014 was conducted. After identification, screening and then appraisal using JBI appraisal tools relevant quality research papers were reviewed for the meaningfulness of perioperative nurses’ attitudes towards organ procurement. Data extraction and analysis followed.

Results
The quality assessment resulted in seven qualitative and three quantitative research studies. A total of 29 findings derived from the qualitative papers were analysed and aggregated. The main findings were;
1. Perioperative nurses reported feeling emotionally distressed, challenged, lonely and physically drained throughout the entire organ procurement procedure.

2. Perioperative nurses reported finding their own unique self-coping strategies and ways of eliciting support.

3. Perioperative nurses’ had positive and negative attitudes toward organ donation.

A meta-synthesis was then undertaken to produce new insights and transform synthesized findings for evidence-based practice.

**Conclusion**

Perioperative nurses reported feelings of sadness, feeling challenged and physically drained through the entire organ procurement procedure, which were influenced by differing factors in the preoperative, intraoperative and postoperative stages. It is acknowledged that personal coping strategies and support are important to help perioperative nurses improve their psychological wellbeing, and their experiences and attitudes toward organ procurement and donation. The meaningfulness of these findings for practice policy and research is described.

**The impact of workflow on the utilization of the Surgical Safety Checklist: a qualitative study**

Brigid Gillespie*¹, Andrea Marshall¹,², Therese Gardiner², Joanne Lavin², Teresa Withers²

1 Griffith University, Brisbane, Australia
2 Gold Coast University Hospital, Gold Coast, Australia

**Introduction**

Regardless of the benefits associated of the Surgical Safety Checklist, adherence across its three phases remains inconsistent. The aim of this study was to systematically identify issues around workflow that impact on surgical teams’ consistent use of the Surgical Safety Checklist in a large tertiary facility in Queensland, Australia.

**Method**

Observational audit of 10 surgical teams and 33 semi-structured interviews with 70 participants from nursing, medicine and the community were conducted. Data were collected during 2014-15. Inductive and deductive approaches were used to analyse field observations and interview transcripts.

**Results**

The domain, impact of workflow on checklist utilization, was identified. Within this domain, seven categories illustrated the causal conditions which determined the ways in which workflow influenced consistency in checklist use. These categories included: busy doing the task; clashing task priorities; being pressured, running out of time; adapting processes to work patterns; doubling up on work; a domino effect leading to delays; and, reality of the workflow.

**Conclusions**

The greatest single challenge to consistency in checklist use in surgery is workflow. To fully realise the purpose of surgical checklists, structural changes to workflow may be required. Checklists are living documents and therefore checking processes need to be reviewed regularly and modifications need to respond to the local context.
Factors that predict the non-technical skills performance of scrub nurses

Evelyn Kang*¹, Brigid Gillespie², Debbie Massey³

1 R.N. MScHlth MHealthPrac, NCREN, Griffith University, Gold Coast, Australia
2 PhD FACORN RN, NCREN, Griffith University, Gold Coast, Australia
3 PhD RN, Princess Alexandra Hospital, Brisbane, Australia

Introduction

Factors contributing to adverse events in the operating room have been linked to failures in non-technical skills (NTS) of surgical care providers, rather than to a lack of technical training or expertise. Non-technical skills (NTS) have been recognized to enhance performance of all team members in surgery. Yet the evidence focusing on these specialist skills required by scrub nurses remain limited.

Method

An integrative review was first undertaken to identify the core NTS required by scrub nurses. The results of this review informed an observational study which aimed to identify the factors that potentially predict the NTS performance of scrub nurses. Two hundred procedures were observed at two tertiary hospitals in Queensland and the scrub nurses NTS were observed using a validated observational tool.

Results

The result of the observational study has found that a number of clinical (i.e. patient acuity as measured by ASA rating) and environmental factors (i.e. team familiarity, duration of surgery, change of scrub nurse and the number of occasion scrub nurse leaving room) were identified as potential factors that could disrupt the performance of scrub nurse and compromise safety of patients. Working with familiar team members in a core team was the most influential contributor to scrub nurse NTS performance.

Conclusion

Through the review, the core NTS required by scrub nurse to perform their role effectively are communication, teamwork, situation awareness, leadership and decision making. From the observational study, working in a stable team with familiar team members and patient’s acuity measured using ASA has been found to influence scrub nurse NTS performance during surgery.

Rule breaking in perioperative nursing practice - is this the new paradigm for getting the job done?

Sharon Bingham*¹

1 University of Tasmania, Hobart, Australia

Despite the focus on patient safety, patients undergoing surgery continue to suffer adverse events that may result in death, disability or increased length of stay. Procedures involving the wrong patient or body part; unintended retained instruments or other material; failures in instrument reprocessing; implanting of incorrect prostheses; surgical fires; burns from energy devices; pressure injuries and specimen management errors are adverse events recognized by
perioperative nurses as being amongst the top ten priorities for patient safety. Perioperative nurses perform a range of clinical activities pre, intra and post procedure to provide a safe environment for patients and minimize the risk of harm. These activities are guided by rules, standards, guidelines, policies, procedures and protocols that have been developed to support safe ways of working and limit the variability of human behavior. Perioperative nurses work in a dynamic, rapidly changing environment where there are often competing demands and pressures to get the job done. In this paper I advance the argument that perioperative nurses respond to pressures to get the job done by adopting ways of working other than following the rules. I contend that whilst these ways of working may potentially have unintended adverse consequences for patient safety, they can also be seen in positive light in that new and more effective ways of working are developed and assimilated into practice.

Session 15: Clinical
14:00 – 15:10

Social media - The devil’s in the detail

Menna Davies*¹

¹ NSW Operating Theatre Association, Sydney, Australia

Topic overview

Australians love internet technology, with social media still playing a significant role in many people’s lives. It is estimated that 68% of Australian internet users have a social media profile used mainly to catch up with friends and family (Sensis, 2015). The use of social media in healthcare has suffered from bad press over recent years due to its inappropriate use by some health professionals. Unprofessional behaviour, crossing of professional boundaries and violation of patient privacy via social media have made for unwanted headlines and in some cases has resulted in disciplinary action against health professionals. This has overshadowed the many positive uses of social media to connect and support patients; educate and share information amongst health professionals.

Presentation objectives

This presentation will:

• identify the common social media applications in general use
• briefly highlight the dangers and professional consequences of inappropriate use of social media by health professionals
• discuss, using actual examples, the positive impact of social media for both patients and health professionals
• describe ways in which social media can be used within the perioperative specialty.

Surgery from a console: The devil vs Da Vinci

Tracey Nicholls*¹

¹ Flinders Medical Centre, SA, Australia

Trans Oral Robotic Surgery (TORS). This talk will look at the revolutionary changes in treatment for cancer and non-
cancerous lesions of the throat. Current research is reported to confirm the use of minimally invasive surgery such as TORS, with the use of the DaVinci robot, may allow the consideration of de-intensification of adjuvant radiation and/or chemotherapy, (the devil). Successful surgeries particularly, here in Adelaide as well as other parts of the world are tending towards this amazing minimally invasive treatment in cancer patients. Early studies suggest better long-term recovery and morbidity reduction after TORS vs treatment with primary chemoradiation. The ability to preserve normal tissue and neurovascular supply using TORS contributes to rapid healing and a return to acceptable oropharyngeal function.

Objective 1
Discuss the treatment and treatment options for throat cancer

Objective 2
Review the oncologic and functional outcomes of TORS

Objective 3
Understand about the surgery and post-op care

Objective 4
Discuss common complications and symptom management after TORS.

Bibliography
The St Vincent’s thermal care project

Karen-Leigh Edward\textsuperscript{1,2,4}, Jo-Ann Giandinoto\textsuperscript{1,2}, Rosie Lee\textsuperscript{2}, Lauren Bell\textsuperscript{2}, Lea Natividad\textsuperscript{2}, Elyse Ladbrook\textsuperscript{3}, Daleeda Zoora\textsuperscript{2}, Jeff Reddy\textsuperscript{4}, Hoang Vien\textsuperscript{3}, Christine McShane\textsuperscript{2}

\textsuperscript{1} Australian Catholic University, Melbourne, Australia
\textsuperscript{2} St Vincent’s Private Hospital Melbourne, VIC, Australia
\textsuperscript{3} St Vincent’s Hospital Melbourne, Australia
\textsuperscript{4} University of Huddersfield, Queensgate, United Kingdom

Introduction

The St Vincent’s Perioperative Thermal Care Collaborative consists of a multidisciplinary team of clinicians located in the public and private sectors. The aim of the Thermal Care Collaborative was to maintain normothermia in the surgical patient throughout the entire perioperative journey. We sought to enable staff to use best practice guidelines for preventing inadvertent hypothermia - defined as core temperature less than 36°C. In Melbourne the participating sites included St Vincent’s Private Hospital - Fitzroy, Kew and East Melbourne and St Vincent’s Public Hospital.

Method

The team used a three-step care bundle to implement best practice guidelines for the prevention of inadvertent hypothermia. A panel of experts reviewed the NICE guidelines and prioritised three elements for inclusion in this bundle which comprised (1) assess risk (2) record temperature and (3) actively warm. To achieve implementation the following were instigated; staff and patient education, hypothermia risk alerts on Inpatient Management System, inclusion of hypothermia risk documentation on medical record forms, increasing the supply of thermometers and forced air warmers to key areas in theatres. Monthly tracking audits have been undertaken.

Results

Early data shows improvements in elements of thermal management, including; greater accuracy in documenting temperatures across the perioperative journey, a decrease in patients with inadvertent hypothermia during their surgical experience and a raised awareness among staff.

Conclusion

This collaborative has shown that the realities of translating evidence into practice can be achieved and has the potential for developing this approach to other clinical guidelines in the perioperative setting.
Session 16: Education
14:00 – 15:10

Going digital: The force awakens

Catherine Steel*¹, Sandra Sampson*¹
¹ Princess Alexandra Hospital, Brisbane, Australia

Digital Hospital* technology is anticipated to be the greatest patient safety and healthcare challenge many clinicians will experience in their career. Through a single site descriptive case study, this presentation will provide an overview of the planning and implementation processes employed in launching an integrated electronic medical record, transforming a Queensland hospital into Australia’s first tertiary digital hospital. Patient care is optimised through the accurate and efficient assimilation of pertinent information that informs the provision of care. In 2015, the Princess Alexandra Hospital in Brisbane introduced digital technology, which includes an integrated electronic medical record. In particular, this paper will describe the facility’s processes used throughout the developmental and change management engagement strategies in preparation for the launch. Also, lessons learnt during and following the launch will be described providing experiential learning for perioperative nurses. Now witness the power of this fully operational Digital Hospital.

ANZAC nurses: Following their steps to Gallipoli

Sally Sutherland-Fraser*¹
¹ Health Education & Learning Partnerships Pty Ltd, Sydney, Australia

Topic overview
In August 2015, I was a passenger aboard a small ship sailing north out of Athens on a commemorate voyage towards the Gallipoli peninsular. On route, was the Greek island of Lemnos, the site of the 3rd Australian General Hospital and the setting for many of the ANZAC nursing sisters diaries. How much can we learn by reading the published accounts of the ANZAC nurses’ work? If you are fortunate enough to access the diaries of those nurses who cared for the Gallipoli wounded, then you have heard their voices. From these voices, you may have begun to visualise the environment and conditions, the equipment and the casualties. There is a natural limit, however, to what you can learn solely by reading. Real experience is another thing entirely. Real experience is treading on the stony ground at Turk’s Head, without shelter under the hot sun in a heavy winter cape and uniform, stiff white collar, cuffs and veil. Real experience is the sound of a lone piper and the footfall of thirty nurses. Real experience is your sweat and thirst as you march through tall thistles and squint towards the treeless horizons of Lemnos. It’s a devil of a place for a hospital.

Presentation objectives
This paper will describe my real experiences following the nurses’ footsteps to Gallipoli, exactly one hundred years after these events. Shine light on a selection of WWI nurses’ stories as told by their families during interviews filmed aboard the ship. Ensure that the ANZAC nursing sisters’ stories are re-told to a wider audience so that their achievements are not forgotten.
AUSMAT perioperative nursing: Exploration and challenge the boundaries of practise

Amanda Gill¹, Katie Barry¹, Jessica Talimalie¹, Wendy Rogers¹, Bronte Martin¹, Peter Aitken¹, Annette Holian¹

¹ National Critical Care and Trauma Response Centre, NT, Australia

Introduction

Sudden onset disasters may cause surgical needs exceeding the capability of local health services. Foreign Medical Teams, including the Australian Medical Assistance Team (AUSMAT), provide surgical support to these countries. We explored the role of peri-operative nursing during deployment.

Methods

A case study approach was used linking epidemiological data and team narrative based on the AUSMAT deployment to the Philippines following Typhoon Haiyan (November 2013).

Results / Discussion

The AUSMAT was based in Tacloban City and provided regional surgical support. The AUSMAT was operational for 21 days and included a 26 bed Emergency Care outpatient facility, 34 bed inpatient surgical facility and 2 operating tables. There were 238 theatre cases performed by a surgical team of 2 surgeons, 2 anaesthetists and 2 peri-operative nurses embedded in a 37 person civilian medical team. Peri-operative nursing played important roles in not just sterilisation practices, theatre care, and surgical assistance but importantly supporting local health services. This included sterilisation of local hospital instruments / linen and local specialists working in AUSMAT theatres. This occurred in an environment with resource limitations (personnel, equipment), based in temporary facilities. Peri-operative nurses had to be flexible, adaptable, willing to work long hours under austere conditions and remain team players. Pre deployment preparation was essential including appropriate vaccinations and training (Major Incident and Medical Management Support (MiMMS), AUSMAT Team Member and Perioperative Nursing Courses).

Conclusion

The role of perioperative nursing is crucial in providing surgical care following disasters.

Key Clinical Points

Peri-operative nursing during AUSMAT deployment is a rewarding and challenging experience.
Leadership and management - It’s the little things

Simone Ohlin*¹
1 Metro North Hospital Health Service, QLD, Australia

Topic overview
Management and leadership are different. How the little things make a difference. It’s the small stuff that makes us sweet. Leadership is not just nurse manager.

Presentation objectives
This presentation will:
- define the difference between management and leadership
- leadership styles defined
- application of leadership in the every day Perioperative environment
- how to get back to basics and start to sweat about the small stuff (culture, counting, fingers under the table, Aseptic non-touch technique, hand hygiene etc).

Session 18: Research
14:00 – 15:10

Getting a handle on loan instrumentation

Patricia Nicholson*¹, Tracy Kerle, Louise Grant, Scott Landall², Angela Hand
1 School of Nursing and Midwifery, Deakin University, Melbourne, Australia
2 Sydney Adventist Hospital, Wahroonga, NSW, Australia

Due to improved surgical technology and the escalation in the complexity of surgical procedures the use of loan equipment has become common practice for many healthcare service organisations (HSO). The increased use of loan equipment creates a number of challenges for HSOs, for example loan equipment arriving too late for correct processing resulting in cancellations, or delays in surgical procedures, compromising patient safety. There are also a number of financial risks associated with the use of loan equipment therefore, a well-defined loan equipment management program on the management of loan equipment is required to minimize patient and personnel risks and ensure quality patient outcomes. A team of perioperative nurses were involved in the redevelopment of the ACORN Standard Use of Loan Equipment, which was guided by recent evidence based literature. This presentation will include an overview of the standard that has been developed to assist HSOs formulate and implement a loan instrument program taking into consideration patient safety issues and HSO’s ethical responsibilities regarding handling and sterilization of loan sets and reusable medical devices.
Perioperative warming for caesarean section: A randomized, controlled trial

Judy Munday*¹,², Sonya Osborne¹, Patsy Yates¹, David Sturgess²

¹ Queensland University of Technology, Brisbane, Australia
² Mater Health Services, Brisbane, Australia

Introduction
Rates of perioperative hypothermia amongst women undergoing caesarean section are unacceptably high. Intraoperative warming strategies have shown to be less effective in the population of women who receive intrathecal morphine for caesarean section. This study tests 20 minutes of preoperative warming versus usual care (no preoperative warming). The primary outcome of interest is maternal temperature decline from baseline to end of surgical procedure. Secondary outcomes include maternal thermal comfort, shivering and neonatal variables such as Apgar score and axillary temperature at birth.

Method
Full ethical approval was obtained for this randomized controlled study. Women giving informed consent and meeting the inclusion criteria were randomly assigned to either the control (usual care) or intervention (prewarming) group receiving 20 minutes of full body forced air warming. The sample size of 50 has been inflated from a required sample size of 30, to allow for attrition. Blinding of the outcome assessor was maintained. Genius aural canal thermometers and Mon-a-Therm temperature sensing indwelling urinary catheters measure maternal temperature.

Results to date
32 participants have completed the study and data collection is expected to be complete by December 2015.

Conclusion
Findings from this study will confirm or refute the hypothesis that preoperative warming is effective in reducing the incidence of postoperative hypothermia in women receiving intrathecal morphine for caesarean section.

Greening the OR - A devil of a time

Rubie McIntosh*¹

¹ St Vincent’s Hospital, New South Wales, Australia

Introduction
As ACORN makes clear in our Environmentally Sustainable Perioperative Practices guideline, perioperative healthcare professionals have an obligation to actively promote and take actions to minimise our waste, including waste reduction through recycling. The Operating Suite (OS) produces up to 30% of total waste generated by hospitals, and is one of the largest users of supplies within the hospital. As hospitals look for ways to reduce their environmental impact, it makes sense to start with departments that have the largest environmental footprint.

Method
A working party, with representation from all areas, was formed to address waste management in our OS, with a focus on recycling. What needed to change and how we could implement changes in our environment, without compromising patient safety, was established by audits, holding a forum to get staff ideas, and liaising with Environmental Services.
Results and Conclusions

We identified a sporadic system of recycling products, and items thought to be recycled were not. Negotiation has commenced to ensure more items are recycled. We identified the need to address our use of clinical and general waste bins. New bins and colour coded signage is being implemented. By implementing these changes and establishing good recycling processes in the OS, we connected to current social trends within our community, enhanced pride in the workplace via visible improvements in waste reduction and recycling, and energised all members of the OS team to continue exploring ways to reduce our environmental impact and respond to the community’s needs.

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Mock trial
15:20 – 17:50

Please find below some information regarding the mock trial presentation.

On the day of the ‘Prosecution’….

1. **At the beginning of the session and prior to “court” commencing we will discuss the following matters:**
   - The main offence creating sections
   - The reasons why most companies are prosecuted
   - Why due diligence involves all employees
   - How to adopt a pro-active mindset
   - Understanding what a safety management system is
   - The importance of your safety management system
   - Delegation and reporting, monitoring and reporting
   - How to protect against the “careless worker”
   - Industry practice principles
   - What constitutes “reasonable practicability”
   - Applying the 80/20 rule for a more strategic safety focus
   - Court etiquette and procedure

2. **The Mock Court session will commence**

Deloitte will facilitate the Mock Court by playing the role of Prosecutor and Defence Lawyer and volunteers from ACORN will play the roles of witnesses (3), the judge (1) and court officer (1).

3. **De-brief**

At the conclusion of the proceedings we conduct a “de-brief” where the jury (audience members) give their verdict and we then have the opportunity to discuss the issues raised and how they relate to your workplace and most importantly, what can be done moving forward for continual improvement.
Marilyn Hamilton
Inspector, New South Wales Police Force
Australia

15:20 – 17:50 Friday 27 May 2016, Concert Hall

Marilyn Hamilton is the second presenter for the Mock Court on the 27 May 2016. Marilyn is a high level communicator and facilitator delivering Mock Courts in the specialist areas of WH&S and Risk Management over the past 10 years. To this end Marilyn has presented numerous Mock courts to a great number of different industry areas including the Banking Sector, Mining, Oil Refining; Government Departments; Industrial Sector and various private enterprises. In a full time capacity Marilyn is an Inspector with the New South Wales Police Force. Marilyn joined the NSW Police in 1989 and spent a large majority of her career as a police prosecutor attached to NSW Police Legal Services. Whilst attached to Legal Services Marilyn completed her legal studies and was admitted to practice as a Solicitor in New South Wales in 2001. She is presently attached to the Counter Terrorism & Special Tactics Command. Marilyn has completed a Diploma in Law through the Legal Practitioners Admission Board and a Bachelor of Policing (Prosecutions). She particularly enjoys the Mock Court as it allows her to practice her advocacy skills after retiring from court work some time ago.

Albert Giubin
WHS Specialist, Sustainability Services, Risk Advisory, Deloitte
Australia

15:20 – 17:50 Friday 27 May 2016, Concert Hall

Albert is a highly accomplished training, risk and people management professional with a wealth of experience in areas including evidence identification, preparation and presentation, safety leadership, due diligence and corporate governance. Albert developed his high level of advocacy and communication skills prosecuting a range of complex criminal cases on an almost daily basis over 15 years in a variety of jurisdictions. Albert is also a former Commissioned Officer with the NSW Police who planned, co-ordinated and controlled numerous; high profile policing operations, counter terrorism incidents and assessments, critical incidents, crime scenes and complex investigations. Albert is extremely passionate about training, and committed to ensuring that each training assignment produces genuine and sustainable business improvement. He has worked across a wide variety of clients and industries from NRL clubs on Code of Conduct compliance to Global Oil & Gas companies on incident investigation techniques. Albert is a specialist presenter who engages his audience to achieve greater participation and understanding of WH&S compliance issues. Albert is a high level communicator and facilitator delivering Mock Courts and Hypothetical’s in the specialist areas of WH&S and Risk Management. Albert is a former high ranking Commissioned Police officer and Prosecutor with 25 years’ experience. Albert is a highly accomplished Advocate, Investigator and Manager.
Know the worth of risk. Mock Courts offer high impact health & safety training

Why not book your own Mock Court – you be the Judge – or a witness!

Deloitte’s Mock Courts are a unique, interactive and innovative training presentation for business leaders and their work teams. Led by former WorkCover lawyers and based on real life cases, the simulated Mock Court prosecution challenges people’s thinking, pushes attendees out of their comfort zone, galvanises action and demonstrates health and safety management responsibility in a fun and high impact way.

The objective of the Mock Court is to provoke attendees to re-evaluate the priority of managing the risk of health and safety as well as understanding their personal responsibility and the actions required to ensure the organisation’s system is being measured, monitored and maintained.

One of the reasons why this training has proved so successful in the past is the role the audience plays. Deloitte will facilitate the training by playing the role of Prosecutor and Defence Lawyer and volunteers from our client’s organisation will play the roles of witnesses (3), the judge (1) and court officer (1).

Deloitte’s national Mock Court training program is a very effective way to eliminate complacency and put health and safety back on the agenda, whilst leaving a fun and lasting impression on those taking part.

Visit our website to find out more: www.deloitte.com/au/safety.

To arrange for a tailored Mock Court proposal for your organisation at any location in Australia, please contact our team:

Neelam Sharma
Training Co-ordinator
Deloitte Touche Tohmatsu
Tel: +61 2 9322 5391
neelsharma@deloitte.com.au

Tony Morris
Partner
Deloitte Touche Tohmatsu
Tel: +61 2 9322 7570
tonymorris@deloitte.com.au

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### SATURDAY MAY 28

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<td>09:00 – 10:00</td>
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Please note the program is subject to change at any time at the discretion of the Organising Committee.
SATURDAY MAY 28

**Medtronic Breakfast Session**

07:30 – 08:45
Grand Ballroom section 1
Breakfast session title: Learn today. Empower tomorrow.
Outline: Medtronic improves the lives of more than 2 people every second. Patient’s lives are positively impacted every day in your O.R. You are a key part of their journey and our goal is to support you, in more ways than one. Recover and Recharge with us to learn more.

Breakfast will be provided and available spaces will be limited to the first 50 delegates. Please forward your RSVP to Rebecca.causer@medtronic.com by no later than Friday 20th May.

10:00 – 10:30
Chancellor Room 5
Hazardous Exposure Prevention in the Operating Theatre
- Overview of the hazardous exposure risk to staff working in the operating theatre
- Presentation of study results: Traditional canisters versus a closed system
- Future research: Plans for a global health economics study

Presenter: Martlie Horn, Nurse Unit Manager, Kareena Private Hospital

Enquiries:
Karen Nasuta
karen.nasuta@stryker.com

**Stryker Pop-Up Showcase**

13:45 – 14:25
Partners in Health & Education Precinct (Exhibition)

3M Australia, Discover your inner creative with SoluPrep™
Saturday 28 May 2016

Keynote address
9:00 – 10:00

Connecting the dots: How to rub people up the RIGHT way

Amy Scott*¹

¹ Motivational Speaker

Successfully connecting with yourself and others is vital if you want to play to your natural strengths along with theirs. It helps ensure that you are truly getting the best out of yourself and them in any team. True connection isn’t about liking someone or being their best friend. It’s an acknowledgement of who they are, who you are & having an ability to work with them in that space. It takes courage, communication and compassion. Communicating effectively is one way of ensuring that you authentically connect with others. This presentation will provide you with a taste of the New Zealand made “Dots” communication tool. It’s fresh, funky, down to earth, practical and easy to immediately apply. Find out why some people can’t help but seem to “rub you up the wrong way” or why you can manage to get along with and work with some people better than others. You’ll get a sense of what combination of “dots” you are and what combination of “dots” your workmates, colleagues, family members, friends and even your patients are! Amy has worked with truck drivers, police officers, grandparents, pilots, accountants, nurses, CEOs, funeral directors and everything in between! Strap yourself in for a fast paced presentation that will leave you with communication tips that will stay with you for a lifetime. Here’s to a life full of less “rubbing of people up the wrong way” and MORE “rubbing of people up the RIGHT way”! To find out more check out www.amyscott.co
Any ‘devil’ can tempt us: Understanding violation and migration in the perioperative setting

Jane Reid*

1 Bournemouth University, United Kingdom

Short cuts and work-arounds, are a feature of daily life domestically and professionally, such as failing to separate household waste for recycling or wearing scrubs to the hospital canteen. Amalberti et al (2006) describe such acts, as violations because they occur as deliberate digressions from standard practices and in the case of our professional lives, deviations from established organisational procedures, processes and protocols. Our collective challenge is that depending upon the context violations can also be justified, as creative ways of managing difficult situations; while this can prove true, in the majority of cases, violations are unconscious acts of deviance, that are extremely seductive, because they ‘appear’ easier to execute and offer a range of perceived immediate benefits, including time savings. Unless the circumstances, surrounding any and all deviations from desired practice, are properly examined through a safety science lens (Emanuel et al 2008) the situation can rarely be rectified, or improved upon, because the underlying reasons/justifications are rarely properly surfaced.
Session 19: Clinical
11:35 – 12:20

Preventing retained surgical sponges

Victoria Steelman*

1 The University of Iowa, Iowa City, Iowa, USA

Topic overview

Although considered ‘never events’, retained surgical items remain the most frequently reported sentinel event to the Joint Commission. This presentation will describe the incidence of retained items and the devastating outcomes to patients. Is the surgical count enough? The effectiveness of surgical sponge counts will be presented, focusing on a published Healthcare Failure Mode and Effect Analysis that identified 57 potential failure points that can occur during the management of surgical sponges. Causes of these failures will be discussed along with the potential value of interventions targeted toward these causes. Research on the effectiveness of adjunct technology for the prevention and detection of retained sponges will be reviewed. But, is adjunct technology cost effective? The results of two published cost analyses will be presented, one focusing on the cost of nonproductive operating time searching for missing sponges and a multi-hospital analysis on the cost effectiveness of purchasing and using adjunct technology. This evidence serves as a call to action for perioperative professionals to do more to prevent retained surgical sponges.

Presentation objectives

This presentation will:
• describe the outcomes to patients of retained surgical sponges
• list causes of potential failures in the surgical sponge count
• discuss the effectiveness of adjunct technology for prevention and detection of retained sponges
• discuss the cost-effectiveness of adjunct technology for prevention of retained surgical sponges.

A solution for your solutions: A quality initiative nursing process

Catherine Steel*

1 Princess Alexandra Hospital, Brisbane, Australia

Operating Theatre (OT) nurses, who appreciate the known risks, work pressures and the human factor influences affecting patient safety, collaborated to design the 2015 revised version of the pre-populated medicine and fluid labels for the aseptic field. The Australian Commission for Safety and Quality in Heath Care ACSQHC acknowledged the residual risk with pre-populated label sheets previously use and proposed design changes. In 2014, the ACSQHC suggested pre-populated sterile medicine and fluid labels include a St Andrews cross watermark on non-injectable medicines and fluids and injectable. Also non-injectable substances were to be segregated from injectable medicines and fluids on the pre-populated label sheet. However, the ACSQHC sought OT nurses feedback on the predicted positive patient safety effects of these enhancements. This quality initiative engaged experience Queensland intra-operative nurses in a focus group and challenged them to reflect on their experiences and the relevant literature from
associated disciplines with the aim of designing the revised label sheet design. Following action research methodology, this paper describes the psycholinguistic attributes infused throughout the collaborative nursing process to provide intra-operative nurses with a solution for their solutions. In 2014, the pilot design was evaluated positively and is currently promoted in the revised ACSQHC medicine and fluid labeling standard specific for the intra-operative aseptic field.

Session 20: Education
11:35 – 12:20

Clinical supervision - Helping each other to make a positive change

Leanne Glennie*¹
1 Royal Hobart Hospital, TAS, Australia

Introduction
Dealing with sick and injured patients’ day in and day out in an environment that is highly challenging, complex and constantly undergoing change, can take its toll on nurses. To help nurses work through their stresses within the workplace, it is imperative that they are given the proper and adequate support from their employers (Cross, Moore & Sherene 2010). One of the tools associated with practice development that has been adopted to help nurses feel supported within the workplace is clinical supervision. Historically, clinical supervision has been primarily aimed at nurses working within the mental health sector (White & Winstanley 2009); however, only very recently is it now being slowly introduced within the acute care setting.

Method
Clinical supervision is a supportive process in which nurses are able to address issues through confidential discussions and guided reflection to make sense of the stresses they experience on a daily basis within the workplace (Cross, Moore & Sherene 2010).

Results
The beneficial outcomes associated with clinical supervision is the reduced levels of burnout experienced among nursing staff and improved safety and quality associated with person centred care (Smythe & Young 2008).

Conclusion
Nurses feel supported and listened to which gives them the confidence and drive to continue to take ownership of their feelings and issues and look to ways of improving workplace stresses and to develop their skills and knowledge in providing safe and effective quality care (Horton-Deutsch & Sherwood 2008).

References
The Devil is in the detail - The importance of education in recruitment and retention of perioperative nurses

Belinda Manners*¹

¹ Canberra Hospital, ACT, Australia

Topic overview

Combating the long term issue of recruiting and retaining nurses to the specialty of Perioperative Nursing is a challenge that most organisations have faced at some time, many may be facing this challenge now. How do we attract nurses now and retain them for the future? In an attempt to combat this issue, ACT Health Staff Development Unit has for some time facilitated a very successful Perioperative Nursing Foundation program closely aligned with the structured, ACT Health Transition To Practice Program (TTPP). These programs are key recruitment initiatives for ACT Health and have delivered the latest evidence and best practice education outcomes, including structured rotations, support and development pathways that enhance skills, attitude and performance. Providing the Perioperative Nursing Foundation program with a framework designed to transition nurses into the specialty has been a key to attracting and retaining nurses to the Perioperative unit at the Canberra Hospital. This ACORN accredited foundation program has retained over 60% of program participants in employment within the Perioperative unit since its inception in 2002. This program has set graduates on a pathway to success with a large percentage of past participants promoted to management and education roles. The key to attracting staff and retaining them long term is in the detail of a structured and supported orientation and education program.

Presentation objectives

This presentation will:

• describe the Perioperative Nursing Foundation Program and it’s alignment with the Transition To Practice Program at Canberra Hospital
• discuss the impacts on recruitment and retention to Canberra Hospital and The Perioperative Unit.

Session 21: Management

11:35 – 12:20

Accountability in perioperative services and it’s impact on safety

Renae Battie*¹,²

¹ CHI Franciscan Health, Tacoma, WA, US
² AORN, Denver, US
Topic overview;
• define accountability
• discuss various definitions of accountability
• relate accountability to safety culture
• discuss current state of health care
• discuss current issues around outcomes based health
• discuss evidence based practice and impact on outcomes
• discuss mindfulness and how it impacts situational awareness
• define mindfulness
• relate mindfulness state to situational awareness
• connect situational awareness to improvement of safe environment of care.

Session 22: Research
11:35 - 12:20

Island time: The challenges of urology in the Solomon Islands
Sally Collins*¹
¹ Orange Health Service, Orange, Australia

Topic overview
In July 2015 a small Urology Team from Orange Base Hospital undertook a two-week volunteer trip to Gizo Hospital in the Solomon Islands. The aim was to provide high-quality endoscopic surgery to patients who would otherwise be unable to access appropriate healthcare. A total of 15 procedures were undertaken and all patients were discharged home with good outcomes. In addition to this, local Perioperative nurses were able to develop knowledge and skills pertaining to endoscopic urological surgery. Many logistical, professional and cultural challenges were encountered, such as the international transportation of endoscopic instruments and irrigation fluid, differing local customs and operating theatre culture, sterilisation and intra-operative troubleshooting.

Presentation objectives
This presentation will:
• educate delegates about the logistical, professional and cultural challenges of providing high quality urology surgery in the Solomon Islands
• inspire and empower delegates to consider using their professional skills in a developing nation
• discuss realistic expectations and goals of overseas volunteering as a Perioperative Nurse, and strategies to maximise efficacy and efficient use of resources.
New house, new home, new address, new RAH

Kim Hepper*¹
1 NewRAH Project, SA Health

**Topic overview**

The new Royal Adelaide Hospital presents a once in a lifetime opportunity to redesign a care delivery system, which will:
- Promote a patient centred approach to the provision of the Clinical Services;
- Include a number of basic principles related to physical design and environment, to behaviours, attitudes and the general culture of the organisation and its staff, and to systems supporting patient care. What does this mean for the perioperative environment?

**Presentation objectives**

This presentation will:
- Review newRAH design
- Outline Model of care: new vs. old equipment, new vs. old systems, new ways of working, new language
- Commissioning & transition training orientation.
Closing speaker
12:25 – 13:25

The warrior code

Nadine Champion*¹

¹ Motivational Speaker

10 Seconds of Courage is that pivotal moment of choice - to play it safe or take a chance and live a bigger life. It’s the courage to believe in yourself, to pursue your goals, create your own success, dream bigger for yourself personally and professionally, to share your ideas without fear of the outcome and be brave enough to go after what you truly believe in. As a lifelong martial artist and champion fighter, I have learnt a lot about facing challenges and overcoming obstacles. The key often lies in Changing Your Thinking by focusing on how altering your response to a difficult situation can positively effect the outcome. For twenty years I have dedicated myself to studying with a true martial arts Master and I will teach you some of the most important lessons I have learnt - how to have more courage, resilience, respect, determination, deeper self knowledge and how to be successful even when the going gets tough. Courage can also be a collective experience, requiring team work & supporting each other to succeed. Oftentimes we have to align ourselves with others who will help us to be strong, especially when we can’t achieve certain outcomes alone. Whether we are pursuing success or simply facing life’s challenges, we can all use 10 Seconds of Courage.
[P001] Improvement program to enhance complete operation preparation for percutaneous nephrostomic lithotripsy

Theme: 1. Clinical

Shu Ya Chang*¹

¹ Kaohsiung Medical University Hospital, Kaohsiung Medical University

Background
From December 2012 to March 2013, 8 of 20 patients undergoing percutaneous nephrostomic lithotripsy suffered from surgical interruptions. Those events directly reduced surgery fluency, prolonged operative time and caused a threat to patient safety. Hence, the improvement program was motivated.

Objective
To enhance nursing staffs’ knowledge of instruments and equipments; to reduce human error and to prevent potential patient injury.

Methods
Conduct education program, establish standard operation protocol, renew operation manual.

Results
Complete operation preparation rate increased from 59.6% to 92%. The surgical interruption period reduced from 26.9 minutes to 10 minutes.

Conclusion
The improvement program might reduce surgical interruptions, increase efficiency, avoid adverse events and finally fulfill better care quality.

Keywords: Percutaneous nephrostomic lithotripsy (PCNL), patient safety
Standards unwrapped: From guidelines to reality - and a plume free workplace

Theme: 1. Clinical

Jenny Cubitt*, Penny Smalley*

1 Canterbury Hospital, Sydney, Australia

Has the NSW Ministry of Health guideline had an impact on your perioperative practice? What role can ACORN play in working towards national recognition of the hazards of surgical plume and the need to eliminate it from every workplace where energy based devices are used? What is ICSP and what does it mean to you? Are you having a ‘Devil of a Time’ getting an effective plume management programme accepted and supported in your facility? You are not alone! It is apparent that even though the evidence exists and there are world wide mandates, standards, laws, and best practices on management of surgical plume, there are still too many healthcare facilities that have not implemented a 100% plume free initiative. Evidence notwithstanding, perioperative nurses need to develop a strategic plan including tools to help overcome barriers, and ensure successful implementation. This plan may include: audit, acquisition of appropriate equipment, collaboration with key stakeholders, education and training, and documentation tools. Laws and standards can promote motivation for compliance, but only through collaboration, education, and perseverance, can we achieve our common goal and finally clear the air of surgical plume in our workplaces, for ourselves and for the generations of perioperative professionals to come.


Keywords: plume, hazards, exposure, standards, occupational health and safety
Reduced incidence rate what the tourniquet didn’t remove by nurses

Theme: 1. Clinical

Huang Wen-Chin*¹

¹ National Cheng Kung University Hospital Dou-Liou Branch, Dou-Liou, Taiwan

Method

1. Collect 2013 the incidence rate about 3
2. Analysis of fall events for the following reasons:
   1. The personal negligence for personnel causes.
   2. The foam rubber gloves were bound to the right upper arm for patient, covered up by clothes or bedding and clothing but didn’t find.
   3. Tourniquet an amount on the work car the shortage.
   4. Use foam rubber gloves because of similar to clothes color, the disadvantage recognizes.
3. Improvement measures:
   1. Everybody delivers 1 Tourniquet and along with take while going to work.
   2. Guide to educate a special note at the unit.
   3. Strictly forbid to use foam rubber gloves to replace Tournique, uncertain expect to examine.
   4. The use musted be bound to clothes most outside while stopping bleeding to bring layer.
   5. Place 2 Tourniquets at least on all work cars, by night shift the whole car again confirm.
   6. The patient must really examine the body top tube road and body valuation, and modify the medical history to sign to accept while turning origin, increase ‘have already really examined a body top tube road, move in addition to stop bleeding to bring’ item.
   7. Cure the car table’s top to plus warnings ‘stopped bleeding to bring to pull out to have no.
   8. Tourniquet the improvement, the both ends to bring to mark by the refreshing color or the color, recognize a degree by increment.

Results

After getting involved through the above-mentioned measure the incidence rate is 0%.

Conclusions

Change Tourniquet through the creativity clever thought, let it preserves the function to also remind the occurrence of personnel's mistake.
[P004] Improvement of the completion rate for examination of bone bank specimens

Theme: 1. Clinical

Hsiao-Fen Huang*¹, Shiu-Pen Lin¹

¹ National Cheng Kung University Hospital, Tainan, Taiwan

Allograft bone is taken from other people to donate bone grafting, namely general bone bank, these bones before use through careful screening process’ and is intended for use after determining no infectious agent. The setup of bone bank is to improve the quality of medical services and respond to the needs of clinical studies. The items of screening of infective pathogens are including
1. Human immunodeficiency virus
2. Hepatitis B
3. Hepatitis C
4. Syphilis
5. Aerobic and anaerobic cultures
6. Pathology.

It was usually to detect that bone specimens without examination reports in routine checking. The specimen would be discarded if the patient did not have an examination after checking out. That would waste the medical resources and make lack of bony specimens. The purpose of the project is to improve the completion rate for examination of bone bank specimens.

[P005] Using HFMEA to improve fire prevention and adaptability in operation room

Theme: 1. Clinical

Feng-Lan Huang*¹

¹ National Cheng Kung University Hospital, Tainan, Taiwan

Fire is unpredictable and unavoidable. It’s much important that patient and family’s safety cannot be ignored. The medical institution should minimize the possibility of the fire, so it’s necessary to familiar with the operating of firefighting equipment and implement the evacuation exercise on usually. As a result, fire can be extinguished or slowed down the spread at the first time to minimize the damage of staff and property. Failure mode and effect analysis are preventive kinds of analysis way. This project units different professional to confirm the processes including environment and instrument checked before operation, operation start, informing and extinguishing of the fire, and self-defense groups mobilization. Failure mode may exist in analysis processes. Discuss the potential cause of failure of fire in the operating room, and propose four countermeasures against potential problem to avoid serious disaster. First, improve crew’s adaptation and cognition to prevention of fire in the operating room by regular training. Second, enact and modify relevant clause to complete the
preventive task. Next, amperage and PBL with clear mark is necessary. Adding emergency broadcasting and evacuation device can improve useful resources. The final one is emergency response training, drilling responsibility of the task and the ability to change by simulating on the table. In regular training, different division and staff participate it in turn to upgrade crew’s adaptability.

[P006] Decreasing the incidence rate of pressure sore in operating suite

**Theme: 1. Clinical**

Chiung-Yao Huang*¹, Shu-fen Li¹

¹ National Cheng Kung University Hospital, Tainan, Taiwan

Pressure sore is not just a common problem in operating suite, but also a vital quality indicator. It could increase the length of stay and the medical cost. There were 2200 surgeries per month in our institute. The incidence rate of pressure sore was 0.68% in 2013. Causes identified included:

1. Patient’s comorbidity and poor skin condition
2. Surgical difficulty, need more time
3. Lacked a policy about operating positioning.

This project was developed to solve the problem of pressure sores by setting up standard preventive procedures, a nursing follow up system, routinely case discuss and continuing education courses. Results: After implementing the resolution measures, found that the incidence rate of pressure sore was 0.63% in 2014. This study attempted to improve nursing staff’s recognition of pressure sore to achieve higher quality of patient care.

[P007] Engaging the team in the surgical safety checklist

**Theme: 1. Clinical**

Tracey Lee*¹

¹ Auckland District Health Board, Auckland, New Zealand

**Introduction**

Following the introduction of the Surgical Safety Checklist (SSC) Auckland District Health Board subsequently adopted a paper checklist led by the Operating Room nurse. In an audit observing compliance and team engagement in the checklist process comparing ADHB with another local hospital, it was evident there was increased engagement by all team members when the checklist domains were displayed as wall mounted posters with migrated leadership in the process so; the Anaesthetist led Sign In; the Surgeon led Time Out; and the Nurses led Sign Out.

**Method**

Once the migrated leadership proposal was presented to the Surgical Board consisting of Surgical, Anaesthetic Clinical Directors, Service Managers and Nursing Leaders’ a trial was conducted and then a plan created for rollout across all five operating room departments. Every discipline was introduced the changes by a member of the same discipline.
with opportunity for feedback and changes to the process and the content. Changes and rollouts were supported by communication via emails, posters, notice boards, and staff meetings as well as project team presence during rollout week.

**Results**

Recent audits have revealed a significant increase in engagement with the SSC and an increase in compliance with regards to completing the Sign Out.

**Conclusion**

Effective clinical and executive leadership and support was vital in supporting the project group along with effective methods of communication from the interdisciplinary project team, and openness to the ideas and feedback of each discipline which ensured an effective and smooth rollout of the changes.

**[P008]**

Improving timeliness and accuracy of patient-tracking dashboard during operation day

**Theme: 1. Clinical**

Shu-Fen Li¹, Hsueh-Hui Chou¹, Tzu-Jung Wu¹

¹ National Cheng Kung University Hospital, Tainan, Taiwan

The patient-tracking dashboard is the system that can show the current location of patients, such as operation room, recovery room or intensive care unit, during the operation day. The dashboard can provide information regarding current status of the surgical patients to their families in the surgical waiting room in order to reduce the level of anxiety. The subject hospital is a large medical center in Taiwan. There are 30 operating rooms and the average number of surgeries per month is 2700. Due to the large amount of surgeries, the patient-tracking dashboard was not able to show the real-time status all the time. Families reported low satisfaction and complained of incorrect information on the dashboard. The purpose of this project is to improve the timeliness and accuracy of information about status and location of patients on patient-tracking dashboard. Three improving strategies, including standardization of the policy of updating patient status, auditing accuracy of dashboard and reviewing the auditing results on a regular basis, were implemented. The correction of patient status was increased from 95 % to 97%. This project successfully improves the timeliness of information displayed on the patient-tracking dashboard and increases families’ satisfaction.
[P009]
Sharps safety in operating rooms

Theme: 1. Clinical

Smitha Sebastian*¹

1 St Vincent’s Private Hospital, Melbourne, Australia

Blood-borne viral infections from sharp injuries remain one of the most significant occupational hazards among healthcare workers throughout the world. The worldwide statistics indicate high incidence of sharp injuries among healthcare professionals. Sharp injuries are a foreseeable risk, causing several blood-borne viral infections. Several studies indicate operating theatres as high-risk areas for sharp injuries. Operating room personnel sustain significantly large number of sharp injuries. This is mainly attributed to the nature of the job, involving handling of large number of sharps. Some other significant contributing factors include the fast pace nature, emergency situations, inappropriate handling and disposal of sharps including recapping of hypodermics. Fatigue is also considered to be an important contributing factor. Sharp injuries have several physical, psychological and financial impacts. The psychological impacts incorporate anxiety, depression and post traumatic stress disorder. The financial impacts also are very significant in terms of lost time injuries, associated medical tests, prophylactic treatments and treatment of associated long-term illnesses. The intraoperative sharp safety prevention strategies could include the use of blunt atraumatic needles for suturing, double gloving, establishment of a neutral zone, using instruments to handle sharps, avoiding recapping of hypodermic needles, minimising handling of sharps, safe disposal of sharps and handling of sharps in AS/NZS 4031 standard containers. Continuous awareness and a dedicated sharps prevention educational program for theatre staff, emphasizing clear communication skills and standardized procedures of sharps handling will prove vital in making operating rooms -sharp safe!

[P010] Lessons learned in simulation: Human factors in anaesthetic nursing

Theme: 1. Clinical

Pete Smith*¹

1 NSW OTA, Australia

Introduction
This poster discusses Lessons Learned in Anaesthetic Simulation. It takes the simulation exercise encountered, and seeks to discover what prospective Human Factors lessons learned from the simulation could be useful in considering our critical event response in emergencies in Anaesthetic Nursing.

Method
In order to map our event responses, we used several modelling techniques to explore task sequences, divisions of labour, egress and communication pathways in various scenarios. We then sought input from all involved in order to overcome input bias, and sought opportunities to improve the way we respond to such events, both simulated and real.
Results
The result of our human factor mapping exercise was an improvement in team functioning. It also resulted in the development of an effective educational resource for novice anaesthetic nurses. It demystified the seemingly overwhelming complexities of their first immersion into such events, and allowed for mentorship and training by giving them structured task-sets to concentrate on and master. From a debriefing perspective, the tool we created enhanced stress inoculation by adding a visual aid to verbal post-event reflection.

Conclusion
Lessons Learned in Simulation positively informed our approach to Human Factors in Anaesthetic Nursing. Both simulation and human factor modelling proved essential in developing more effective ways of responding to emergencies.

[P011]
Thermal care collaborative
Theme: 1. Clinical

Jed Duff¹, Kim Walker¹, Karen-Leigh Edward², Margaret Butler¹, Robyn Williams*¹

¹ St. Vincent’s Private Hospital, Sydney, NSW
² St. Vincent’s Private Hospital, Melbourne, VIC

Background
Perioperative inadvertent hypothermia is preventable and guidelines exist which synthesise research findings into evidence-based recommendations (1). Although the recommendations are relatively simple and inexpensive they are often not adhered to in clinical practice. Up to 70% of patients will experience hypothermia postoperatively when recommended prevention practices are not implemented (3-6).

Method
A retrospective audit of 400 patients was conducted to identify the incidence of perioperative inadvertent hypothermia and compliance with evidence-based recommendations at four Australian hospitals. Research has now been undertaken to identify mitigating strategies to overcome barriers to evidence-based perioperative hypothermia prevention.

Results
350 patients met the inclusion criteria. The mean age of patients was 56 (SD 19). The majority (74%, n= 260) had elective surgery with orthopaedic procedures the most common surgical type (28%, n=98). The incidence of perioperative inadvertent hypothermia in the population was 32% (n=101) and the lowest recorded temperature was 34.0°C. 80% (n=280) of patients did not have a temperature documented intraoperatively and only 8.8% (n=29) had at least one documented temperature for each perioperative phase (pre, intra, and postoperative). 45% (n=133) of intraoperative patients and 77% (n=97) of postoperative patients did not receive active warming when indicated. Contrary to recommended practice, 47% (n=137) of patients were hypothermic at discharge from the Post Anaesthetic Recovery Unit.

Conclusion
The next stage of the research is near completion. The research is to identify mitigating strategies to overcome barriers to evidence-based perioperative hypothermia prevention. Describe the development of a perioperative thermal care bundle. Outline the implementation and evaluation of the care bundle.
The project of improve operating room personnel to reduce needlestick injuries

Theme: 1. Clinical

Hui-Chuan Yang¹, Yu-Hsuan Hsu¹, Hung-Ju Tsai¹

¹ Operating room, Changhua Christian Hospital, Changhua city, Taiwan

Introduction

According to World Health Organisation statistics indicate that each year there are nearly three million healthcare professionals because of sharp objects stabbed. While 127 needlestick injuries occurred in our hospital in 2013, 27 (21%) have occurred in the operating room (OR); in 2014 more increased to 61 (40%) of the hospital, where the OR nurses increased 8 to 22 in 2013. Analysis the reasons of OR. Personnel is cognitive inconsistency to a secure area; verbal remind and action occur simultaneously. No norms handover sharp objects display and located. Personnel handling hazardous materials is unsafe. Therefore, initiated this project reduce the number of needlestick injuries in OR.

Methodology

1. Using sterile sheet of different colors, to establish clear safety zone, so staff consistency awareness.
2. When submitting dangerous instrument, changes the timing of verbal remind stationary operation, and to check dangerous objects.
3. Standardized display and located when being handover dangerous objects.
4. Conduct educational courses to prevent needlestick injury, and standardized approach when dealing with dangerous objects.
5. Provided the anti-puncture container for sharp instrument, and safety needles.
6. Care the personnel, who occurrence of needlestick, to explore the true cause.

Result

After promote the project, the number of needlestick in OR dropped to 31 in 2015 January to August, where dropped to five of OR nurses, which improves margin of 77%.

Conclusion

To protect the OR nurses health, by promoting the project to construct a safe working environment, selected the appropriate device, continuing education and training and to encourage needlestick event notification, to reduce needlestick.
[P013] Ketorolac Tromethamine spray for the prevention of postoperative sore throat

Theme: 1. Clinical

Hsiu-Ling Yang¹, Fu-Chao Liu², Pei-Kwei Tsay³, Huang-Ping Yu², Hsueh-Erh Liu³

1 Nursing Department, Linkou Chang Gung Memorial Hospital, Taoyuan, Taiwan, R.O.C.
2 Department of Anesthesiology, Linkou Chang Gung Memorial Hospital, Taoyuan, Taiwan
3 School of Nursing, College of Medicine, Chang Gung University, Taoyuan, Taiwan

Introduction

A postoperative sore throat is one of the major complaints in recovery room. The purpose of this quasi-experimental study was to compare the efficiency of reducing postoperative sore throat by ketorolac Tromethamine spray and distilled water spray.

Methods

Surgical patients under general anesthesia were recruited from a medical center. Each operative room was randomly assigned to group K (treated by 5% Ketorolac Tromethamine spray) or group D (treated by distilled water spray). Before intubation, each ETT cuff was scattered 10 times of spray by physicians that might cover 20 cm long of the cuff. All patients in that room received the same spray. Each group had 95 patients fitted the inclusion and exclusion criteria and completed data collection. The intensity of sore throat was measured at 1, 3, 6, 24 hours after operation. All data was managed by SPSS for Windows (version 21.0). Descriptive and inferential statistics (Chi-square test, t test, generalized estimating equation regression analysis) were performed to identify the proposed relationships.

Results

Between these two groups, similar characteristics at the baseline were found. The intensity of postoperative sore throat was significantly lower in group K then group D at each point of assessments (p < 0.001). Meanwhile, the results of GEE found that patients in group K reported less intensity of sore throat than patients in group D.

Conclusions

This study demonstrated that 5% Ketorolac Tromethamine spray could prevent sore throat reported by patient under general anesthesia. Clinical application is strongly suggested.
Surgery related anxiety reduction through customer service experience management

Theme: 3. Management

Hyun Sun Choi*

1 Asan medical center, Seoul, Republic of Korea

Introduction
The purpose of anxiety reduction through customer service experience management is to provide a positive experience for the surgery.

Methods
Through survey, interview, and the customer service experiences of staff on duty, factors increasing patients’ anxiety, such as lack of providing information related to surgery, inappropriate entrance surroundings, its wait time, and unorganized staff response, were found and intervened.

Results
Apps and videos of surgical procedures and the operation room environment were produced and were provided to patients prior to surgery and also, the waiting area was changed to a patient-focused environment. Average operation room transfer time information was given to the nursing staff on duty and the waiting room entrance delay ratio was decreased from over 21 minute waiting time: 68%->25%. A respond manual for all employees in operating room was produced and provided a standardized and consistent service. After service improvement education, the customer service recognition and implementation rate increased from 70%->92%. Patients’ anxiety level score measured was 7 prior to intervention, but after the intervention, moderate level score of 4 was the most scored.

Conclusion
Interventions and activities that reduce pre-operative anxiety were important, in particular, change in the staff’s individual interest and an attitude was also found to be highly important. Therefore, systematic institutional arrangements of the hospital, is necessary in order to induce continued interest of staff and responsibility.
Improving operation room efficiency by managing operation schedule

Theme: 3. Management

Eun mi Jeong*¹, myeong rye Bong¹, myoung sook Kim¹

¹ Asan Medical Center, Seoul, Republic Korea

Introduction
This project is looking for improvement on efficiency of operation room (OR). The aim was to find ways to integrate and manage operation schedules in each rosette.

Methods
This project was implemented from March to September in 2014 and was compared with the last year’s data for analysis. We established and announced related OR regulations. Depending on the regulations we made flow of the schedules and controlled op. schedules. We made OR scheduling office and unified every control of operation schedules. We established system for exchanging patient’s information in order to figure out the surgeon and anesthesiologist available for surgery. Virtual OR for emergency operations was developed so that schedules can be inputted quickly to make the related departments identify the patient accurately.

Results
Daily average of operation cases was increased by 9.7 cases comparing to that of last year. Utilization rate of op. during working time was improved by 0.9% and overall utilization rate was decreased by 0.9%. Gap of each rosette’s regular utilization rate was decreased by 44.7% and number of patients during evening-night duty was decreased by 10.9%. Rate of cancelled schedules caused by delayed operation was decreased by 26.4%. Emergency operation cases during hours that have empty OR (13:00~15:00) was increased by 32.2%.

Conclusion
It requires related department’s continuous attention and effort to follow OR regulations and rules of scheduling. For this management system, the role and authority of OR scheduling office’s need to be enhanced, and more support of manpower will be needed.
The experiences of the women who accept breast reconstruction surgery after undergoing mastectomy

Theme: 4. Research

Wei Chi Wang

1 Kaohsiung Medical University Hospital, Kaohsiung Medical University

Background

Women who accepted breast reconstruction surgery after undergoing mastectomy are faced with psychological stress of adapting to their reconstructed body. These experience and their true state of mind are not very well documented in the established literature.

Purpose

This research evaluates the psychological state of women whom underwent breast reconstruction surgery after mastectomy throughout the entire course experience.

Methods

Using qualitative research method with purposive sampling approach for the women whom received breast reconstruction after mastectomy surgery within the recent two years. In-depth interviews were performed with resulting date analyzed with Colaizzi method.

Results

Includes three main themes:
How did the patients feel during the surgical procedure
The reaction about breast reconstruction surgery
Unexpected changes on the body after the surgery

Conclusion

The results of this study will help caregivers to understand more about the psychological state of mind of the patients whom received breast reconstruction after mastectomy surgery. This may be contributory when caring the patient.

Key Words: Mastectomy and breast reconstruction, qualitative research, experience history

Improving of loaner instrumentation validation of cleaning processes for reducing orthopedic patients infection rate in Taiwan teaching hospital

Theme: 1 Clinical
Introduction

Properly and adequately cleaning orthopedic surgical instruments has report of patient infection rate in our hospital. We borrowed specialty Orthopedic Surgical instruments and implants from vendors and without the burden of purchasing these items. Before surgery, instruments were come from other hospital and become contaminated from blood, tissue, and bone as well as body fluids that potentially contain infectious, pathogenic organisms making proper surgical instrument reprocessing critical to patient safety. Instruments and implants must be received in time to be properly reprocessed by the borrowing facility. Sometime vendors frequently deliver loaner items to us just before the scheduled procedure; thus, loaner items may arrive at the user facility with insufficient time for them to be appropriately according to published standards and recommended practices. This caused in staff members rushing to process the instrument trays, which often leads to missed steps or errors in reprocessing. If items are not properly cleaned, then they cannot be adequately sterilized; this puts patients at risk. Inadequate decontamination processes also place the health care worker at risk.

Method

There were 15 patients (1.3°) got high fever after discharged and happened during May to December 2014 (8 months). To avoid infection control and lack of planning on the part of a hospital or vendors, we arrange orthopedic leader and 2 assistants use Surface Test uses adenosine triphosphate (ATP) bioluminescence technology to assess the cleanliness of a surface and measure the efficacy of cleaning for loaner instruments in Jan 2015 till August (8 months). The selection of instrument sets for testing was left up our schedule with the recommendation that we choose every Monday - Wednesday and Friday loaner instruments that were high risk, difficult to clean and with visible soil levels that range from highly soiled to lightly soiled. Instruments were tested before reprocessing. The result Data (total 190 swabs tested) is shown as RLUs (Relative Light Units) per swab for a series of loaner surgical instruments before sterilization.

Results

After we plan to monitor all of the instruments, to detect the vendors to rewash loaner instruments in hospital for 8 months. The levels of contamination on the unprocessed instruments (hand wash) at this site show values that are higher and after rewash it reduces the level of contamination by about 1 to 2 logs, a significantly smaller reduction in comparison. Till August 2015 (8 months), there was only 4 patients got fever (0.3° infection) and an effort to reduce the risks of SSIs associated with loaner items.

Conclusion

We should develop a standardized, thorough system for handling loaner instruments, implants, and equipment. To implement successful loaner management system begins with a well-written multidisciplinary policy. To improving communication and policies and procedures delineated in the policy should include; ordering, transportation, checking in, and pre-procedure processing requirements; documentation and tracking processes; it can improve the quality and safety of loaner instrumentation and implant use. For Peri-operative personnel addressing the tracking, processing, and sterilization concerns of loaner implants and instruments by developing an interdepartmental policy and monitoring that policy for compliance is instrumental in decreasing the risks of HAIs and SSIs and promoting optimal patient outcomes.
Social program

If you would like to register for any networking opportunities or no longer wish to attend, please contact the Conference Secretariat as soon as possible.

Welcome reception
Thursday 26 May 2016
18:00 – 19:30
Partners in Health & Education Precinct
The Welcome Reception will be a great opportunity to catch up with friends and colleagues.
A ticket is included with full Conference registration. Additional tickets may be purchased in advance for $75 each.

Conference dinner
Friday 27 May 2016
19:00 – 23:00
Macquarie Wharf No. 2 Cruise Terminal, Hobart
The Conference Dinner will be the highlight of the social program! Join with us in celebrating with the theme ‘our winter wonderland will be the place to have a devil of a time’. Enjoy delicious Tasmanian produce coupled with some outstanding entertainment. Spend the evening with friends and take the time out to have a dance and celebrate the Conference!
A ticket is included with full Conference registration. Additional tickets may be purchased in advance for $125 each.

ACORN 2016 charity walk
Friday 27 May 2016
6.30am for a 6.45am departure.
Approximately 45 minute’s duration and 3.5kms
Meeting point: Foyer, Hotel Grand Chancellor Hobart
Cost to register: $12 AUD
As part of ACORN 2016, we are pleased to invite you to a charity fundraising walk around beautiful Hobart to take place before Friday’s Conference program begins.
To register for this walk, please visit the ACORN stand in the exhibition. The cost to enter the charity walk is $12 AUD. You will receive an ACORN hat and $5 of your registration fee will go to the Pacific Island Hospitals to purchase much needed equipment.
The approximate 3.5km walk will begin at the Hotel Grand Chancellor Hobart and will continue along Franklin Wharf towards the Salamanca Markets. From there participants will walk through Kings Park on the way back to the hotel. Please see the map for an outline of the walk route.
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Contact Person: Robyn Freer / Samantha John
Building A, 1 Rivett Road
North Ryde NSW, 2113
Phone: Robyn: +61 412 580 006 / Samantha: +61 412 935 430
Email: rmfreer@mmm.com / sjohn@mmm.com
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Contact Person: Mark Stewart
27 Llewellyn Ave
Villawood NSW 2163
Phone: (02) 8718 2888
Email: Mark.Stewart@multigate.com.au
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Contact Person: Denis Cantin  
Level 3 – 75 Miller Street  
North Sydney NSW 2060  
Phone: 0418 441 388  
Email: denis.cantin@medline.com  
Web: http://au.medline.com/

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Morning tea pop up showcase

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**Booth Number: 60**

Contact Person: Karen Nasuta (Product Manager)  
8 Herbert Street  
St Leonards NSW 2065  
Phone: 02 9467 1087  
Email: karen.nasuta@stryker.com  
Web: strykermeded.com

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97 Waterloo Rd  
North Ryde NSW 2113  
Phone: 02 9429 3100  
Email: Samantha.lord@medtronic.com  
Web: www.medtronic.com.au

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Contact Person: Kylee Carmody or Wendy Rowland
Phone: 0414 412 306
Email: kylee.carmody@acorn.org.au or wendy.rowland@acorn.org.au
Web: www.acorn.org.au

Atherton
Booth Number: 49
Contact Person: Jean Danré
364 Darebin Road
Alphington VIC 3078
Phone: +61 404 811 030
Email: jdanre@atherton.net
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Richmond VIC 3121
Phone: 03 9270 7289
Email: Andrew.barker@ansell.com
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2 McCabe Place
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Phone: 0477 803 883
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Phone: (03) 9239 2700
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1-7 Vision Street
Dandenong South VIC 3175
Phone: 03 9706 3600
Email: scott.mcphedran@defries.com.au
Web: www.defries.com.au

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**Booth Number: 72**  
Contact Person: Azi Hosseini  
11B Grand Avenue  
Camellia NSW 2142  
State, Country, Post code:  
Phone: 0499985773  
Email: Azi.hosseini@dndhealthcare.com  
Web: www.dndhealthcare.com

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**Booth Number: 53 and 54**  
Contact Person: Andrew Pickering – National Sales Manager Hospital  
Unit 2A Clayton Business Park  
1508 Centre Road  
Clayton VIC 3168  
Phone: +61 3 8588 1007  
Email: apickering@ebosgroup.com.au  
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Contact Person: John Beevers  
2 Drake Avenue  
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Phone: 0499-990-926  
Email: john.beevers@ecolab.com  
Web: www.ecolab.com

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Contact Person: Adrian May  
128 Lytton Rd  
Bulimba QLD 4171  
Phone: 0738991300  
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21 Aristoc Road  
Glen Waverley VIC 3150  
Phone: 0409 865 105  
Email: adam.swan@endovision.com.au  
Web: www.endovision.com.au


ETHICON

**Booth Number: 66 & 67**
Contact Person: Gordon McBean  
1-5 Khartoum Road  
North Ryde NSW 2113  
Phone: +61 428 033 985  
Email: gmcbean@its.jnj.com

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**Booth Number: 3**
Contact Person: Andrew Hetherington  
36-40 New St  
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Phone: 03 9879 5022  
Email: Andrew.hetherington@fphcare.com.au  
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Address: 10/1886 Princes Highway,  
State, Country, Post code: Clayton, VIC, 3168  
Phone: 0431 659 929  
Email: paul.kreutzer@getinge.com  
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Contact Person: Ty Bailey
Address: Level 5, 1 Thomas Holt Drive, Macquarie Park, NSW, 2113
State, Country, Post code:
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Contact Person: Celia Beinke
Head office Ernst & Young Centre
L25, 680 George Street
Sydney NSW 2000
Phone: 1300 422 247
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Phone: 1300 133 804
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Suite 1A level 1 669 old Princes Hwy
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Phone: 02 85369696
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Web: www.kemprecruitment.com.au

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**Booth Number: 61**
Contact Person: Adrian Bordignon
Level 8/15 Talavera Road
North Ryde NSW 2113
Phone: 0411 844 969
Email: adrian.bordignon@lifehealthcare.com.au
Web: www.lifehealthcare.com.au

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**Booth Number: 29**
Contact Person: Michael Larkin
1/41 Gatwick Rd
Bayswater North, VIC, 3153
Phone: 1300 664 642
Email: Michael.larkin@marlinmedical.com.au
Web: www.marlinmedical.com.au

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Matrix Surgical

**Booth Number: 31**
Contact Person: On site: John Condiodorio 0438 000
289 Admin: Jean Sheridan
5/200 Wellington Road
Clayton Victoria 3168
Phone: 1300 616 366
Email: customerservice@matsurg.com.au
Web: matrixsurgical.com.au

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Booth Number: 4
Contact Person: Mark Storr
Address: 81 Whiting St, Artarmon
State, Country, Post code: NSW 2061
Phone: 02 9439 6677
Email: info@medopt.com.au
Web: www.medopt.com.au

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Booth Numbers: 12 & 13
Contact Person: David Armstrong
76 Tennyson Road
Mortlake NSW 2137
Phone: +61 (0) 2 9743 3888
Email: sales@medicaldevices.com.au
Web: www.medicaldevices.com.au

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Booth Number: 17
Contact Person: Derek Foltin
174 Parramatta Road
Camperdown, NSW
Phone: 02 8594 9100
Email: dfoltin@nstenning.com.au
Web: www.nstenning.com.au

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Booth Number: 62
Contact Person: Tim Sjodin: Surgical Sales Manager
3 Acacia Place
Nottinghill Victoria 3168
Phone: 1300 132 992
Email: tim.sjodin@olympus.com.au
Web: www.olympusaustralia.com.au

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Booth Number: 21
Contact Person: Lisa Veale
Unit 27, 107-113 Heatherdale Road
Ringwood Victoria 3134
Phone: 0414 514 748
Email: lisa@reveale.biz
Web: www.revealesurgical.com.au

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Contact Person: Joe Mazzitelli
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Phone: 0417 853 446
Email: casimiri@Sentrymedical.com.au
Web: www.sentrymedical.com.au

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Suite 76 Ground Floor 50 St. Georges Terrace
Perth WA 6000
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**Booth Number: 5**
Contact Person: Shaun Prescott/Ian Glasson
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Mitcham VIC 3134
Phone: 03 9264 8988
Email: saleshc@stirlingfildes.com.au
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Contact Person: Bonnie French
University of Tasmania, School of Health Sciences
Locked Bag 1322
Lanceston TAS 7250
Phone: 03 6324 5405
Email: bonnie.french@utas.edu.au
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Contact Person: Janette Francis
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Hobart

Hobart offers a contrasting blend of heritage, scenery and culture, with world class activities and attractions nearby.

Nestled amongst the foothills of Mt Wellington, Hobart combines heritage charm with a modern lifestyle in a setting of exceptional beauty. It’s no wonder Lonely Planet has called Hobart one of the top ten spots to visit in the world right now.

Hobart is Tasmania’s capital city and the second oldest capital in Australia, after Sydney. Located at the entrance to the Derwent River, its well-preserved surrounding bushland reaches close to the city centre while beaches line the shores of the river and estuary beyond.

With its captivating history, picturesque waterways, rugged mountains and gourmet experiences, the city has something for everyone.

Climate in May

The average minimum temperature in May in Hobart is around 7°C and the average maximum temperature is around 14°C.

Airport and transport

The distance from Hobart Airport to the Conference Venue is an approximate 20 minute drive or 18km in distance. The airport provides a range of transport options for travellers.

Airport shuttle bus

The Tasmanian Redline Airporter bus offers airport-city-airport services daily. An adult fare is just $18 one way or $32 return. Tickets can be purchased at http://www.tasredline.com.au/index.php/airport-shuttles/ or by calling 1300 385 511. Bookings are advised to be made at least 24 hours beforehand, however can also be made 2hrs prior to pickup.

Taxis

The taxi rank is conveniently located right outside the terminal building. Taxis from the Airport to Hobart city cost approximately $45.
Disclaimer

Every effort has been made to present all the information contained in this program book as accurately as possible. ACORN, the Organising Committee, ICMS Australasia and its agents act only to procure and arrange these activities and do not accept responsibility for any act or omission on the part of the service providers. No liability is accepted for any inaccuracy or misdescription, nor for delay or damage, including personal injury or death, howsoever caused resulting from or arising out of reliance upon any general or specific information published in this brochure. In the event of unforeseen circumstances, the organising committee reserves the right to change any or all of these details.

Personal insurance

Participants shall be regarded in every aspect as carrying their own risk for personal injury or loss of property, including baggage, during the conference. We strongly recommend that, at the time of booking your travel and tours, you take out a travel insurance policy of your choice. The policy taken should include loss of accommodation
monies paid through cancellation, medical insurance, loss or damage to personal property, financial loss incurred through disruption to accommodation or travel arrangements due to business failures, strikes, or other industrial action. The organisers are in no way responsible for any claims concerning insurance.

**Liability**

In the event of industrial disruptions or service provider failures, neither the ACORN, the Organising Committee members nor ICMS Australasia Pty Ltd, accept any responsibility for losses incurred by delegates and partners.

**Privacy**

Personal information, as defined under the national privacy legislation, The Privacy Amendment (Private Sector) Act 2001, will be treated in accordance with the National Privacy Principles and only shared with related or third parties in accordance with those principles. Please complete the section of the registration form relating to privacy if you do not wish your personal information to be included in the published delegate list.
The following is a list of sponsors and exhibitors (current at the time of publication), their exhibition booth locations and a floor plan of our exhibition space.

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