Effective rehabilitation for older people

This article describes a new model which aims to ensure that older people who are discharged from hospital are sufficiently confident, independent and self-caring.

The ESHUN-SMITH model explains the care given to older patients when they are admitted to Holcot ward, Northampton General Hospital NHS Trust. Holcot ward is a rehabilitation ward within the hospital’s new elderly care centre. The model was developed five years ago on Cavell ward by the author and the ward’s co-manager Sue Smithon. It was used as the basis of nursing practice for more than four years before patients on that ward transferred to the new purpose-built centre. Although initially designed for a pre-discharge ward, the principles and values that underpin it can be applied to almost any nursing environment.

The Eshun-Smith model spans all aspects of patient care, including the assessment of the individual’s needs on admission, the setting of care goals and the planning, implementation and evaluation of care. The emphasis of the model is to encourage patients to perform for themselves those activities of living that are considered critical or essential. These are the activities that everyone has to be able to perform if they are going to be able to live successfully on their own, or at least cope safely, when they are finally discharged home from hospital.

After a period of illness many older patients may lose their ability to perform basic self-caring activities. The reason for transferring them to a rehabilitation ward is, primarily, to assist them to regain confidence in performing those activities. A review of nursing practice on Cavell ward revealed that this objective was not being fully met. It showed that up to the time of discharge, many of the patients remained anxious at the prospect of going back home, fearing that they would not be able to cope. It also showed that soon after discharge, often within two months, many of the patients were re-admitted into hospital for social or non-acute medical reasons, indicating that they had, in fact, not been able to cope.

Two main causes for this anxiety were identified which may be broadly described as inappropriate attitudes and the absence of a cohesive or integrated programme of rehabilitation, as described below.

Inappropriate attitudes

Staff attitudes Among the staff, there appeared to be some reluctance to accept that it is important in rehabilitation nursing to encourage patients to do things for themselves. Most of the staff saw their role mainly as that of giving the traditional hands-on care. This traditional role is still very important and has an invaluable place in all types of nursing. However, in rehabilitation nursing, doing things for people is not enough. Here, it is part of the nurse’s function to encourage those patients who can, to do things for themselves. Most of the nurses found it difficult to accept this approach.

Patients’ attitudes Many of the patients of course enjoyed having everything done for them. They felt, to some extent correctly, that they were in hospital to be looked after and they saw no reason to behave differently.

Relatives’ attitudes Relatives’ expectations were often the same as the patients epitomised by the regularly heard statement that ‘My mother can not possibly walk to the bathroom’. The whole informal culture of the ward was one where patients were encouraged to become dependent.

Lack of cohesive programme of care

There was an absence of a pre-planned programme to re-educate patients, or to encourage them to look after themselves. Care plans were devised for separate or discrete problems and clinical activities were carried out to resolve these. There was no specific attempt to fit these activities into a wider programme which sought to restore patients’ self-care ability. In addition, the care given by the multidisciplinary team was not sufficiently integrated into the overall ward practice.

It was unanimously agreed that what the ward
needed was a new direction for its practice – a paradigm shift – and that the change should be from giving hands-on care all the time to getting patients who are able to do so, to care for themselves.

The Eshun-Smith model relies on a number of concepts from existing nursing theories. Henderson (1966), Orem (1980) and Wiedenbach (1964) were particularly influential. Henderson’s ideas, for example, are important because of the link she draws between the nursing environment and the nurses’ role in promoting the health of his or her patients. She states that the environment can act upon a patient in either a positive or negative way; it is therefore the function of a nurse to alter the environment in such a way as to support the patient.

She goes on to say that independence is valued by the patient more than dependence and, therefore, individuals will perform activities leading to health if they have the knowledge, capacity or will (Henderson 1966). Henderson is saying that there are activities which, if performed by the individual, will lead to health and therefore independence. If the patient lacks the knowledge, capacity or the will to perform these activities, it is the function of the nurse to change the environment, thereby assisting the patient to acquire the necessary abilities. Henderson also talks about the importance of the nurse and patient working together as partners.

Orem (1980) stresses the need for self-care and this goes to the heart of the ward’s work. Orem also admits that where patients have done their best but are unable, for one reason or another, to become self-caring, then nurses must step in to provide help to make up the deficit (Orem 1980).

In addition to these basic approaches to care, the staff turned to Wiedenbach because they liked the emphasis she gives to patients’ self-esteem. Wiedenbach stresses the importance for respect of the dignity, worth, autonomy and individuality of each patient (Wiedenbach 1964).

All these concepts were integrated to create the new model. The core values of the model are the promotion of the patients’ ability for self-care and the restoration of patients’ self-esteem. The two go together, as people will not aspire to become self-caring if they have no regard for their own self-esteem.

**Theoretical basis**

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**Description of the model**

Figure 1 depicts the model. It shows how patients are received on admission, how their needs are assessed, their care planned, implemented and evaluated up to the time of discharge. The concept of partnership and respect for the autonomy of the patient is demonstrated by the way in which patients and carers are involved in everything.

Figure 2 depicts the care objectives of the model. The figure highlights the relationship between the restoration of self-esteem and the promotion of self-care ability. Within the first aspect there is an emphasis on the development of a patient-centred ward culture. As part of this, it has become standard practice, for example, to involve patients in care planning and goal setting. There are other activities, such as patients’ forums, all of which are meant to re-vitalise patients’ interest in their own welfare.

The second aspect of the care objectives – the promotion of self-care – breaks down initially into four main areas in which patients should have some capability before they are considered able to look after themselves independently on discharge. In the personal area of care, they should be able to do things like getting in and out of bed independently and washing and dressing themselves.
In the household area, it is important that they are able, for example, to make a hot drink for themselves. In the social area, they should be able to do something to pass the time, such as watching TV, listening to music, knitting, reading or some other hobby.

In the medical area it is important that they understand any illness they may have and how to take their medication.

The model permeates all aspects of the ward’s practice. However, there are three areas of application that are especially worthy of note. These relate to admission interviews and care planning, discharge planning and the monitoring of patients’ ability to perform the self-care activities.

**Admission interview and care planning** On admission the nurse, patient and carer discuss and identify problems or needs. Together, and as far as this is possible, they set goals or objectives and plan how best these goals can be achieved.

**Discharge planning** The admission interview marks the first stage in the patient’s discharge planning. Patients are encouraged right from the beginning to start considering whether they want to return home to live on their own, move in with their family, or go into residential or sheltered accommodation.

During this initial interview, aids, equipment and other social needs are identified and planned for. Knowing what they want so early gives the nursing staff and members of the multidisciplinary team advance notice and time to arrange appropriate back-up services for when they are discharged.

This early approach to discharge planning does not stop patients from changing their minds, and they sometimes do in the light of the progress they make during their stay.

**Monitoring performance** The patient’s ability to perform self-care activities is monitored throughout his or her stay on the ward. Six activities, all specific and measurable, are selected from the care objectives to make up the Eshun-Smith self-care assessment charts (Figs 3 and 4).
The six activities are as follows:

- Getting on/off bed.
- Using the toilet.
- Transferring/walking.
- Washing and dressing/undressing.
- Eating and drinking/using the kitchen.
- Learning about own illness; and medication/self-medication.

The activities are classified into those that are critical and those that are desirable.

- Critical activities (Fig. 3) are activities that patients must be able to perform before they are considered ready for discharge to their own homes.
- Desirable activities (Fig. 4) are activities that patients are encouraged to perform. They are not considered critical because assistance can always be arranged for those patients who are unable to perform them.

Both day and night staff assess patients’ ability to perform these activities on admission and throughout their stay on the ward. Nurses and members of the multidisciplinary team work closely together and maintain an on-going dialogue to implement the care, and monitor patients’ progress. Carers are encouraged to take an active interest in the evaluation of the care being given.

**Scoring of performance** Patients must score the maximum 15 points on the critical activities (Fig. 3) before they are considered safe for discharge home. The scoring is as follows:

- 5 = fully independent.
- 4 = requiring minimum help of one person.
- 3 = requiring moderate help of one person.
- 2 = requiring maximum help of one person.
- 1 = requiring the help of two or more persons.

With the desirable activities (Fig. 4), a minimum score of nine out of 15 may be enough for discharge, even for patients living alone, because nurses can always arrange for help, formal or informal, to make up the deficit.

The simple quantitative measures in the assessment tool allow a measure of objectivity when decisions are being made on patient perfor-

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**Fig 3. The Eshun-Smith assessment plan – critical activities**

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<th>ACTIVITY</th>
<th>ADMISSION</th>
<th>END OF WEEK 1</th>
<th>END OF WEEK 2</th>
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<td>Getting on/off bed</td>
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<td>Eating and drinking/using the kitchen</td>
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**Assessment Index:**

- 5 = Fully Independent
- 4 = Minimum Assistance of 1
- 3 = Medium Assistance of 1
- 2 = Maximum Assistance of 1
- 1 = Requires Assistance of 2
mance and discharge, but it is important to stress that the staff continue to rely on their professional judgement and experience.

**Conclusion**

It is possible to note a number of the effects that the model has created. The promotion of self-care ability means that patients are discharged home feeling generally more confident in their ability to look after themselves. This gives them a feeling of independence which, in turn, tends to improve their sense of self-worth.

The emphasis on the participation of patients and carers in care planning, and the use of the patients’ forum have raised the patients’ self-esteem, and made them aware that the patient is at the centre of all ward activities.

The model’s multidisciplinary approach has increased co-operation between disciplines in providing rehabilitation care and resulted in more effective discharge planning. As the model insists on greater co-operation and continuous communication between all parties, patient care – its planning, implementation and evaluation – has become a much more effective process than before. The self-care programme has since been extended to include an outreach project whereby nurses from the ward go out to visit patients who have recently been discharged to ensure that they continue with the activities that they practised on the ward and that they are motivated to succeed at home.

It is possible that the self-care approach to older rehabilitation nursing, plus the introduction of the outreach nurse programme, have combined to help newly discharged patients to cope better at home, thus reducing the rate of social re-admissions.

**REFERENCES**

