Developing the nurse’s role in rehabilitation

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Abstract

Background This article reviews literature on developing the role of nurses in rehabilitation. It explains why the nurse’s role in rehabilitation should be allowed to develop, and suggests ways that nurses might achieve their potential in this field. The author presents a meta-analysis of rehabilitation nursing, and uses this synthesis to make suggestions for the development of the service. Issues are raised to provoke thought and discussion.

Conclusion It is clear from the literature that nurses have an integral role in rehabilitation, but that the boundaries of the role are not clearly defined. Nurses should have access to more education and training, which will help them show evidence of their influence and effectiveness.

The background section

These key words are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review.

Role of the nurse


The RCN (1991) sees the all-day, all-week presence of nurses during the patient’s stay in hospital as being particularly significant to rehabilitation. The continual presence of a nurse with a patient allows that nurse to know the patient and his or her condition at any given point. In reference to district nurses, Goodman (2000) sees them as significantly

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placed because of their continuity of contact with patients. However, although the presence is there, this does not necessarily mean the care is effective. Nolan and Nolan (1997) note the potential for an expanded nursing role in the community to address rehabilitation needs, but Gibbon (1994), without including a rationale for her statement, suggests that district nurses do not see themselves as having a significant role, only providing a service when no one else can meet the patient’s needs. She goes on to state that it is difficult to find literature identifying positive effects from district nurses’ work in rehabilitation, and suggests that the district nursing services’ work is influenced by the accessibility of support services and/or whether the district nurse’s role is recognised by others. Cantrell (1998) argues that district nurses could be more involved in rehabilitation, but that other members of the healthcare team do not see rehabilitation as part of district nurses’ domain. In the findings from their action research study, Booth and Waters (1995) do not only acknowledge the nurse as being part of the team, but suggest that the nurse is central. Their research shows the nurse co-ordinates care, part of which is sharing information on patients’ conditions and any change affecting them, with other disciplines. Although the nurses’ role as co-ordinator is crucial, this is just one of the important purposes they fulfil in rehabilitation. The research by Booth and Waters (1995) also showed that nurses provide rehabilitation support to therapists, and lead therapeutic programmes where appropriate, which shows how the role of the nurse is always expanding. In their role as co-ordinator, nurses, with the family and/or carer and other health disciplines, will construct an individual plan of care to meet the needs of the patient (Henderson 1991). Jinks and Hope (2000) suggest that nurses are primarily co-ordinators of direct and indirect patient care. They also claim that nurses are the ‘glue’, maintaining the holistic overview of care given by all members of the healthcare team. Thompson and Bowman (1997) agree by stating that nurses are ideally placed to co-ordinate and deliver a rehabilitation programme. A patient’s contact with members of the multidisciplinary team outside the nursing profession is usually for a short period only. It would normally consist of a therapy session or consultation, but time is limited because of the need to cover many patients and locations. Tyson and Turner (1999) believe these limited periods can cause a deficit in care, with nurses and doctors reporting difficulty referring and communicating with other professions not in their ward area. It is also usual for rehabilitation departments to close at weekends and public holidays, causing a break in patients’ therapy. This may have the effect of prolonging a patient’s stay in hospital. The contribution that nursing can make to rehabilitation is shown in a survey by Thompson and Bowman (1997), which concluded that 84 per cent of cardiac rehabilitation programmes in England and Wales were co-ordinated by nurses to good effect. A nurse-managed stroke recovery group, developed by Pasquarello (1990), and nurse-led multidisciplinary programmes, initiated by Farzan (1991), and Easton et al (1994), showed improvements in patient treatment. Nurses have current knowledge and information about a patient’s condition, including whether the patient is in a position to accept therapy or not. The information may be then passed on to the other disciplines, helping to ensure the patient receives the best possible care. According to Smith (1999), the nurse is in the ideal position to communicate information about the patient’s health status to the other members of the team at any particular time. In addition, Belbin (1993) states that nurses can also clarify goals and promote decision-making as part of their role in co-ordinating the care the patient receives. Scott and Cowen (1997) emphasise that good communication across the multidisciplinary team is essential. The article shows anecdotal evidence that documentation of care given had not reflected what was actually provided. For example, plans had to be recognised, be specific to the needs of patients, and exclude any ambiguity. Patient care had also to be clearly defined. Lack of communication between members of the multidisciplinary team had caused dislocated care. This prompted the conclusion that quality was also affected. The capacity to work as a team was clearly identified, which should increase good quality care. The nurses introduced a working model, which allowed substantial improvements to be made, including the improvement of documentation and communication, in turn allowing problems to be addressed promptly. This literature indicates a consensus of agreement that in the rehabilitation process, nurses provide continuity. It is, therefore, essential that they be empowered to function fully in that role, but, as Gibbon and Thompson (1992) state, the nurse’s role in rehabilitation has not been specified nor clearly defined. According to Stokes (2000), clarification of the unique contribution of nurses and their shared roles across the multidisciplinary team is definitely required. This would give recognition of their contribution to the process. However, Goodman (2000) and Nolan and Nolan (1997, 1999) suggest that nurses are unclear about their position in rehabilitation. Booth and Waters (1995) found evidence that although nurses saw themselves as being able to do a bit of everything,
their roles in co-ordinating rehabilitation care demonstrated the diversity of their skills. This was rarely acknowledged by any other team member apart from themselves.

Evidence suggests that they were ignored, and that the concept of their role was devalued by other members of the multidisciplinary team. This suggestion conflicts with the assertion made by Long et al (1995), who state that the multidisciplinary team comprises a number of professional people who, collaboratively and co-operatively, share their special knowledge and skills with the understanding of the value of contributions by the whole team to the patient's care. This ideal of the multidisciplinary team should include a shared respect and recognition of each other's roles.

Jones et al (1997), however, claim that, until the critical role of nurses in rehabilitation work is recognised, resourced and rewarded, the nursing role will continue to be devalued. They also suggest that there is a possibility that participative care may be substantially diminished, because of inherent loss of self-esteem, and impetus. Such conflict cannot allow for quality in the patient's rehabilitation.

Perceptions and experiences of nurses

Jones et al (1997) make the claim that although nurses see themselves as participants, the nursing role in rehabilitation is not recognised or valued by nurses. Winters and Luker (1996) suggest that nurses perceive the process as being largely the domain of the therapy disciplines, such as physiotherapy and occupational therapy. It may then be argued that, if the therapy disciplines do not see nurses as having a valued place in the rehabilitation process, then they should not be surprised at nurses' views of the process.

Nolan and Nolan (1997) claim that nurses have been placed in a secondary role where they simply reinforce the rehabilitation given by the other members of the multidisciplinary team. Booth and Waters (1995) cite conflicting literature showing that rehabilitation is not seen as a nursing role. This contradicts the literature which states that nurses are ideally placed and have the potential to be rehabilitators par excellence (Henderson 1980).

Nolan and Nolan (1999) support the nurse rehabilitative role, claiming that if nurses are to realise their full potential in rehabilitation, they need to acquire a greater range of knowledge and skills. Stokes (2000) elaborates, suggesting competencies should be clearly specified and combined with an appropriate programme of education and training towards that advancement in nursing.

Gee (1995) argues that any advanced nursing practice implies an overlap of roles, and means challenging assumptions about the nurse's role to clarify these and to ensure effective collaboration. This opens the possibility of causing conflict with other team members and making them feel vulnerable about their own position.

For example, it could be argued that many occupational therapist duties, such as supervising washing and dressing, and developing muscle co-ordination, come within nursing.

Although the nurse's advanced role in the introduction of rehabilitation may appear to be valuable and necessary, it could also be argued that it would add to the existing pressure on nurses and their already demanding workload. Shortage of nurses is always an issue.

Jinks and Hope (2000) declare that a number of studies also found evidence indicating that matching appropriate staff to their work activities was not always possible. The obstacle was shortage of staff. Ward sisters were as likely to exercise health-care assistants' (HCAs) duties, and HCAs were as likely to be at the bedside of a dying patient as a registered nurse. Jones et al (1997) argue that, until there are adequate levels of staffing to make rehabilitation goals achievable, the nursing role will continue to be devalued. Further complications arise from the use of bank or agency staff, who are often not familiar with the ward's specialty. They are also neither in continual contact with, or know, the patients. This can have a detrimental effect on rehabilitation continuity.

However, the unique function of nurses must be considered to identify possible positive effects of their input to the rehabilitation process. Harmer and Henderson (1955) declared that the nurse's particular purpose is to aid sick or well individuals in their efforts for those activities that contribute towards improved health and/or their recovery, and those that patients would execute independently, if they had the required strength, will or knowledge. This would help patients to gain independence as quickly as possible. This declaration, made over 45 years ago, alludes to nursing participation in rehabilitation. Henderson (1977) refers to this text, stating that the sooner people can care for themselves, find health information, or even carry out prescribed treatments, the better.

Goal setting

Henderson (1977) also states that the patient's needs should be modified by the nurse, depending on the particular condition of the patient at any particular time. Normally, this would include setting goals to aid the rehabilitation process. Playford et al (2000), addressing goal-setting in rehabilitation, focus particularly on goals related to disability, impairment, or handicap itself.

No less important are the rehabilitative goals to achieve during the patient's daily living activities. The loss or temporary absence of any of these can have a devastating effect on their lives. For example, the patient may need help to eat, drink, dress,
and go to the toilet. This will require clearly set goals to support and prompt them towards gaining independence through their recovery.

Nurses, through their constant contact with patients, are also in a position to recognise the psychological state of patients. This is crucial to patients’ progress, as goals set by services such as physiotherapy and occupational therapy are unlikely to be achieved if patients are, for example, depressed. Additionally, the atmosphere in the ward can also have a strong influence on the psychological status of the patient.

According to Pryor (2000), it is of extreme importance to the rehabilitation outcome that the atmosphere is conducive to satisfying the patient’s needs. Waters (1986) notes that it is the responsibility of the nurse to help create an appropriate rehabilitative milieu, which will add its own contribution to the positive rehabilitative outcome.

Although there is no mention by Playford et al. (2000) of achieved goals, the authors have fulfilled the purpose of their study, but it is difficult to find any new revelations. For example, Armstrong (1982) previously stated that there is a greater acceptance of patients’ views of their felt and expressed needs. Pike and Forster (1997) and Gaucher and Coffey (1993) also advise that patients should be involved in goal setting.

Playford et al. (2000) dispute goal setting, claiming lack of evidence of its positive effect. However, Mallik et al. (1998) disagree, declaring that rehabilitation processes stand or fall on the quality and relevance of goals set. Whatever views there are on goal setting, the process continues. The ideal is that each member of the multidisciplinary team, in collaboration with the other members, prioritises their goals in the rehabilitation programme. However, goal setting is only one area of the rehabilitation process which requires the competence of the health team members.

### Competency

Nurses involved in the rehabilitative process need to be competent in giving effective care. Bradshaw (1997) states that there is no blueprint for nursing education or its quality, and argues that ‘fitness for purpose’ is not defined and therefore cannot be accurately measured. Nursing competency needs fundamental guidelines to eliminate ambiguity.

Tschudin (1994) states that professionals have to be competent in their practice, and that competence is ethically essential to nursing practice. She also claims that, when it is absent or reduced, the implications for nursing practice are too great. Additionally, she states that nurses have to be given the freedom to practise their expertise in a personalised way. Certain practices have to be standardised and, thus, carried out correctly, but beyond that, the care given has to be individual.

However, if the responsible nurse’s competence is in question, with relevant rehabilitation input either wrongly, or not given, then clearly section 1:3 and 4 of the Nursing and Midwifery Council’s (NMC) Code of Professional Conduct (NMC 2002) is being broken.

### Services and legislation affecting rehabilitative care

It is not only lack of competence that affects the quality of care that patients receive – services providing care in the community are also important. It needs to be considered whether services that are available meet the patient’s needs. The government followed the White Paper Caring For People (DoH 1989) with the NHS Community Care Act (DoH 1990).

According to Kohnet (1992), the act demanded that local authorities took more responsibility for planning and co-ordinating the range of community care services in their area, including a needs assessment. However, it was not clear how ‘needs’ are defined, or whether the local authority and patient are in agreement with what the patient believes to be his or her needs.

The needs being met are also dependent on the funds available, which has the potential to limit the choices of the individual. Needs must be prioritised if resources are limited so that the patient receives the optimum level of care available to help with rehabilitation.

Although the ideals outlined in the act are commendable, including the design and arrangement of the provision of more effective community care to meet people’s needs, the literature reports that many patients are not being offered rehabilitation services. According to Waugh (1998), set out in the Scottish Health Purchasing Information Centre Report 1998, cardiac rehabilitation is not being offered to the extent required – some areas of the country receive a good service, while the quality of service is poorer in other areas.

The British Heart Foundation (BHF), in its Cardiac Rehabilitation Factfile 9 (1995), has also expressed concern for patients not always receiving the benefits of cardiac rehabilitation. This deficiency in care has a detrimental effect on the debilitated patient’s present and future health. Thompson and Bowman (1997) are heard on video explaining the importance of rehabilitation.

The conclusions drawn from their involvement with research in Wirral show that the earlier the intervention, the more beneficial the outcome. The findings also conclude that rehabilitation should continue directly after patients are discharged, as it is likely that they will be more responsive to suggestions to alter their lifestyle at the time rather than at a later date. It is common knowledge that rehabilitation is often not continued until six weeks
after a patient’s discharge from hospital. As the patient’s advocate, the nurse cannot ignore any situation where patients should be receiving rehabilitation and are not. Nurses must act positively to change the situation according to their position.

Section one of the Code of Professional Conduct (NMC 2002) states that nurses must always act in such a manner as to promote and safeguard the interests and wellbeing of patients.

It is an extension of the nurse’s role in rehabilitation to incorporate the societal change approach; that is, where the aim is to effect changes in the physical, social, economic, and political environment, making it more conducive to good health (Ewles and Simnett 1999).

Expanding this, it could be suggested that the role of the nurse is to inform those with the required authority to effect change, when change is necessary. The nurse is not only concerned that the appropriate care is being given, but also that the quality of care is appropriate.

One of the fundamental principles of the government’s White Paper, Designed To Care (Scottish Office 1998), the attainment and assurance of quality (mentioned six times in the first section of the paper, and 14 times in the second), as one of the key objectives of the NHS in Scotland.

Nursing influence

Armstrong (1982) states that the nurse is the key figure influencing the quality of patients’ stay in hospital. Thompson (1995) found that patients believed that doctors should be the best givers of information about their illness, but are usually the worst providers, whereas Thompson (1990) found that nurses are much more reliable in educating patients. Staniszewska and Ahmed (2000), in a qualitative study, presented interesting information about patients’ expectations of nurses. Some were quoted as commenting: ‘The nurse will advise and guide me through my hospital experience’; ‘…provide proper care for me all the time’; and ‘Nurses will always be there when I need them’. Such expectations suggest the patient has trust, respect, and belief in the nursing staff, which gives much potential for rehabilitative progress to be made by the patient guided by the nurse.

The quality of the patient’s rehabilitation must also depend on successful partnerships within the

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multidisciplinary team. If the team agrees that nurses are co-ordinators of patients’ care, then nurses must be empowered to function fully and be granted that responsibility. This would lead to improving the quality of patients’ rehabilitation.

Conclusion

Nurses play an integral part in rehabilitation and they must be allowed to reach their potential. Central to nurses’ development in this area is the education already occurring in pre-nursing training, in conjunction with development of knowledge and training, particularly in their own areas of health care, whether in general nursing practice, or specialist care. It is also imperative that practising nurses recognise the role they have in the process. There is a certain amount of uncertainty about the boundaries of the nurse’s role — it may be that it is not possible to define the boundaries and that this could be because of changes and expansion in nursing practice.

Rehabilitation requires every member of the multidisciplinary team to collaborate with other members. In their co-ordinating role, nurses can reach their potential as rehabilitators par excellence. No single member of the team can work independently. Nurses are with the patient all day and are aware of any changes in the patient’s health. This information is readily available to any member of the multidisciplinary team, helping them all work together towards the best possible outcome for the patient. The nurse alone is in contact with all of the rehabilitation disciplines and it can be argued that the nurse has the most important role in rehabilitation. Further recognition of the nurse’s role in rehabilitation by the other members of the multidisciplinary team is necessary to give the nurse recognised status. However, from the literature, it appears that this is not always the case, with nurses often given a secondary place. This can leave them feeling unappreciated and devalued. Nursing brings its own expertise, not to be undervalued, but to be more openly recognised and appreciated.

The literature has been produced by professionals with nursing backgrounds, and it would be helpful to compare literature on the same subject from different disciplines in the multidisciplinary team. If they exist, they were found to be quite elusive. However, given such a substantial consensus of opinion in the literature, backed by research evidence, indicating nurses have a critical role in rehabilitation, it would be difficult to argue against the case that nurses must be allowed to reach their full potential in this growing area of care.

Implications for practice

■ There should be a concerted effort to recruit more rehabilitation nurses.
■ To maintain continuous patient care, it would be useful to assess the possibility of providing rehabilitation services on weekends and during public holidays.
■ Nurses should be made aware of and be encouraged to achieve their potential in rehabilitation. By showing evidence of their influence and effectiveness in this area, their central position will be accepted. This would confirm their value in this care area.