

Nurses' perceptions of their role in rehabilitation of the older person

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Abstract

Aim The aim of the study was to explore nurses' perceptions of their role in rehabilitation of the older person.

Method Nine participants were interviewed in two rehabilitation units in Ireland. Data were transcribed and analysed using Colaizzi's (1978) framework.

Findings Three main themes emerged: care delivery, collaboration and autonomy/empowerment.

Conclusion Nurses have an important role in the rehabilitation of older people, which is often undervalued and ill-defined. Nurses need to recognise and articulate their contribution and value.

Keywords Patient-focused care, rehabilitation nursing, research, role perceptions

Introduction

Globally, the number of people aged over 65 is increasing, but increasing life expectancy is often viewed with pessimism (Atwal et al 2006). The needs of this population group and the provision of services appropriate to their needs must be considered. Services cannot be implemented without skilled and dynamic nurses (Atwal et al 2006), because care has moved from an illness-orientated to a health and person-centred service (Department of Health and Children (DoHC) 2001). The provision of high quality care in a cost-effective and efficient manner is a priority in Ireland (DoHC 2001, 2003, National Council for the Professional Development of Nursing and Midwifery 2008). Irish nursing rehabilitation programmes enhance functional ability after acute and chronic illness, trauma, surgery and following ailments that have arisen as a consequence of ageing or developmental disabilities. However, there has been limited inquiry about the contribution nursing makes from an Irish perspective.

Literature review

Internationally, rehabilitation is an important healthcare philosophy (Hoeman 2002) and the role of rehabilitation nursing could be expected to be clearly defined. However, while researchers believe nurses have an integral role in rehabilitation and there is scope to develop their potential, role boundaries are not clearly defined and nurses often feel undervalued (Low 2003, RCN 2007, Kirkevold 2010). Confusion about what constitutes rehabilitation makes it difficult to distinguish it from other forms of care and support (RCN 2007). Early descriptions of rehabilitation were based on medical concepts of cure, with the restoration of former function the primary desired outcome. However, a philosophical change occurred, assisted by the inclusion of social factors in representing disability in the International Classification of Functioning, Disability and Health (World Health Organization (WHO) 2002). Disability was acknowledged as a socially created problem rather than an individual attribute, which had far-reaching implications for healthcare provision (WHO 2002).

While a definition may be lacking, the overall aim and spirit of the nurse's role is to maximise the potential of older people to achieve optimum quality of life (RCN 2000, 2007). Rehabilitation is generally described as an active, dynamic, continuous process which has physical, social and psychological aspects (Davis 2006). Nurses' practice in rehabilitation focuses on what the older person can do and uses evidence based, person-centred care to enable the person to maximise their potential to achieve optimum quality of life (RCN 2000, McCormack 2004). Nolan and Nolan (1997) noted that essential components of rehabilitation were patient participation, family participation and a team approach. Young et al (1999) highlighted two other essential ingredients: goal-setting and the interactive, cyclical process of comprehensive assessment and intervention. The RCN (2000) outlined the nurses' role in rehabilitation as:

- Providing psychosocial and emotional support, enhancing lifestyles and relationships, enabling life review, facilitating self-expression and ensuring cultural sensitivity.
- Maximising independence and functional ability.
- Educative, for example, health promotion.
- Enhancing the daily living experiences of older adults such as promoting a nutritionally balanced diet and relieving pain.
- Team functions, including administrative and supervisory responsibilities.

However, there is evidence that the contribution of nurses to the process has not always been valued nor nurses regarded as an equal member of the team (Long et al 2002, Kirkevold 2010). Furthermore, older adults do not associate nurses with a rehabilitative role, but rather expect nurses to assist and support them in their daily care (Long et al 2002). While various descriptions of the role of nurses in rehabilitation of the older person can be found in the literature and acknowledging that nurses play an integral part in the rehabilitation process (RCN 2007, Barreca and Wilkins 2008, Clarke 2010), no study has been undertaken to explore nurses' perceptions of their role in rehabilitation of the older person in the Irish context.

Aim

The aim of the study was to explore nurses' perceptions of their role in rehabilitation of the older person.

Method

A Heideggerian phenomenological approach was chosen, because the focus was an in-depth view of nurses' perceptions rather than description. This method focuses on human experience, seeking to uncover meaning and essence while acknowledging that only those who experience phenomena are capable of communicating them (Parahoo 2006). Nurses working in a rehabilitation unit in two research sites were invited to participate and nine took part. All participants were female, their experience ranged from three to 22 years and five had undertaken postgraduate education in gerontology or rehabilitation of the older person. The interviews were conducted in a venue of the participant's choice, audio-recorded, transcribed verbatim and lasted between 50 and 70 minutes. The interview schedule was guided by a cursory literature review and the researcher's experience of working in rehabilitation. Data analysis was guided by Colaizzi's (1978) framework which is used widely in nursing. It involves verbatim transcription of the interview followed by reading the transcripts, extracting significant statements and phrases, formulating meaning of the significant statements, organising meanings into themes, integrating results into a rich description of the experience, formulating a structure of phenomenon and seeking validation from participants who compare the descriptive results with their lived experiences (Doody 2011).

Ethical considerations

Ethical approval was obtained from the scientific research ethics committee of the service providers.

Findings

Data analysis revealed three main themes: care delivery, collaboration and autonomy and empowerment. These themes were created by giving meaning to participants' statements to create essences, which were organised into sub-themes to formulate the main themes. Table 1 summarises the themes and essences that were identified in the findings. The care delivery theme emerged from participants describing a holistic assessment of the older person's needs, providing patient-focused care, showing an understanding of the needs and desires of the person by getting to know them. The collaboration theme describes the work of nurses in the multidisciplinary team (MDT), their communication and co-ordination role with staff, MDT and family and that the patient is vital to effective team working. The autonomy and empowerment theme emerged from participants describing their role in supporting patients to

participate and make decisions related to their own care through education and training. Care delivery Patient care was to the fore in the participants' minds when asked to consider their role in rehabilitation. Assessment of patient need was identified as a major aspect of the nurse's role: 'Assessment, we see the physical problems, but added to this is the holistic aspect of care, it is the key to success if you can see the emotional aspect, the psychological aspect, I think that is probably even more important than the physical aspect.' (P8).

Table 1. Summary of themes and essences

Theme	Essences
Care delivery	Assessment Patient-focused Knowing the patient Consistency of care Goal setting Discharge
Collaboration	Nurse in healthcare team Communication and co-ordination Families and relatives
Autonomy and empowerment	Patient Nurse Education and training

Being patient focused when assessing patients was considered essential. To achieve this, goals had to be set in collaboration with the patient and be meaningful to them: 'You think sometimes, they need to be here, but you have to take a chance and let them home or listen to what they are saying and even though he might be borderline that's what he wants to do, but let him go, with maximum support and follow up on him.' (P2). Participants saw their role in caring as paramount. The main factors were the relationship with the patient and knowing the patient; to understand what the patient's fears or hopes were and to engage in a purposeful and meaningful relationship with the patient at a time when they are most vulnerable: 'I always keep in mind who they are, where they have come from, and what they want to happen. I always ask them: "How do you think you are doing? What do you want? Is there anything you feel that isn't happening that should be happening?"' (P1). 'All the time I see the person sitting beside their fireplace, never in long-stay settings and that is what we have to plan for when they come in.' (P3) While involving patients in goal setting was the nurse's desire, there was concern about whether or not patients were adequately involved in this and if the structures were nurse or patient focused: 'In ways we probably decide for them, but, to be fair, if you get feedback from them you know the direction you are going and it guides you to where you want them to go and maybe what their goals are.' (P8)

Collaboration The complex nature of rehabilitation means that it cannot be achieved by one professional group alone and has become synonymous with teamwork. Participants identified the nurse as the linchpin between therapy staff, medical staff, patients and families, with the nurse taking on other team members' duties when required: 'The nursing staff are expected to carry out patients' exercise regime at the weekend but the physio will not toilet the patient

when in their department as they perceived it a nursing duty. It is expected of us and it is taken for granted but I have no problem doing it because I think it's part of our care for the patient and it is in their interest, at the end of the day.' (P8). Despite the perceived lack of recognition of their skills and knowledge, participants were aware that they must clarify role expectations and boundaries and communicate these to others in the team: 'I think it lends strength to our arguments, when we use something that's measurable when trying to justify why we've done something. To be listened to and taken seriously we need to have the correct terminology and scales and measurements that people can relate to when we're saying what our role is.' (P9). The idea of the nurse as linchpin for communication and co-ordination of patient care was identified as central: 'Communication is the single biggest skill, be it when gathering information, assessing patients in our daily work or when working with the team. You have to collate all that information to clear, concise items when co-ordinating care, be it in hospital or for when they go home.' (P5).

It was acknowledged that discharge planning takes significant time and often the family is not involved until it is nearly time for the patient to be discharged. However, participants spoke of family involvement as an important aspect of care. Family involvement is essential, particularly where a prolonged admission can cause difficulties, and it is important that this involvement is continuous: 'I know when I admit a person I always try to include the relatives, so I introduce them to the care plans, I ask their opinion, just to demystify the whole system for them.' (P1). 'You need to build a good relationship with the relatives... this is important so they know who they are talking to and you can find out a lot of information about home and what they are going to do when the patient goes home.' (P2).

Autonomy and empowerment Respect for autonomy and integrity is essential when dealing with someone's wellbeing. Empowerment was considered important because caring for a vulnerable older patient places them at risk of becoming dependent. The nurse needs to focus on increasing independence: 'Now we are empowering patients, I suppose in a way removing our own power and giving them the power to be in charge of their own health and wellbeing and allowing them decide what they want... not what we feel they should have. You have to stand with your hands behind your back and let them do it for themselves.' (P8). It was acknowledged that other issues can impinge on the time available to support the patient to achieve autonomy: 'There is nothing as stressful as phones ringing and nobody answering them; and there are so many appointments that they expect the nurse to be there for, meet the doctor, occupational therapist, physiotherapist or whoever, and you are trying to educate the patient and facilitate what they want, but it is difficult to facilitate the patient to identify what they want or what their needs are when you have all these distractions.' (P6, P9).

Continuing professional development can be costly and requires personal time and effort but it forms an important part of the strategy for modernising the health service. It is also expected of qualified nurses. There were mixed messages about further study, funding for attendance at study days and conferences, study leave and the fact staff were not always replaced on the unit. However, those who had undertaken further study saw its relevance to their work and could use the knowledge in practice to support patients: 'I got my introduction to theories in a much broader sense and to care planning. It definitely made me more

confident...the whole aspect of evidence-based practice and creating policies and procedures and how they were created in relation to research and the introduction of research has all been beneficial. I am using the knowledge and I think more about what I am doing now.' (P9).

The relationship between nurse, patient and family should be seen as a partnership if outcomes are to be successful. To create this partnership patients and their families should be educated and supported. Educational strategies should be evaluated from all perspectives and adjusted to ensure optimum success: 'I suppose the challenges are about teaching and enabling the person and their family to go from their present state to a position where they can cope. Quality of life is what it's all about and, whatever their potential is, I hope to meet it and you're always trying to take every opportunity for teaching.' (P7).

Discussion

As is the case in qualitative research, a cautious interpretation of findings is prudent because they may not be generalisable. This study provides an insight into how registered nurses perceive their role in rehabilitation of the older person. While only nine participants contributed to the study, contextual information has been provided so the reader may be able to relate the findings to their own practice, work area or experience. In addition, as five of the participants had undertaken postgraduate education in gerontology or rehabilitation of the older person they may be over-represented in the sample. This possible overrepresentation could cause heterogeneity of the sample compared with the Irish nursing population working in rehabilitation of the older person. This study's findings highlight the importance of family involvement, therapy integration/carryover, integrating their work and assuming the role of co-ordinator and patient educator to enhance the older person's confidence and promote independence. These findings mirror those of Kirkevold (1997), Burton (2000), O'Connor (2000), RCN (2000), Long et al (2002), Davidson et al (2005) and Barreca and Wilkins (2008), although different terms are applied. While the RCN (2000) uses different terminology, what was found in this study sits well with the notions of support, restoration, education, life enhancement and team functions, including communication. However, in light of developments in rehabilitative nursing and the move towards clinical effectiveness, the RCN (2007) reviewed the role of the nurse in rehabilitating older people. This revised version reflects the extension of nursing roles, particularly specialist and consultant nurses, identifying eight categories where rehabilitation nurses influence care through therapeutic practice, co-ordination, empowerment and advocacy, clinical governance, advice/counselling, political awareness, education and essential nursing skills (RCN 2007).

Again, while different terminology is used this framework fosters the concepts of previous studies, except perhaps in relation to clinical governance which has been an addition. The importance of the older person's contribution to the assessment cannot be overemphasised (Pryor and Smith 2002, RCN 2004, Davis 2006), and where possible it should encompass the older person's own goals for the future (RCN 2000, Squires and Hastings 2002). Participants in this study accepted the older person might not always be as involved as they should be in

setting goals; this prohibits the nurse from 'being-in-the-world' and sharing existence with the patient (Barreca and Wilkins 2008). While the aim of providing rehabilitation information is to encourage patients' participation, this is often only as an active participant in a programme where control is held by the health system and its medical and nursing members (McKain et al 2005). Nurses need to ensure that they do not misinterpret a patient's inability to perform selfcare activities as inability to participate in clinical decision making (Florin et al 2006). In a caring context, respect for autonomy and integrity is essential for the wellbeing of another person (Ford and McCormack 2000). If patients are given the right information they have better opportunities to participate and make decisions related to their own care. This process requires staff to recognise that empowerment is important when caring for the older person at risk of becoming dependent (Leino- Kilpi et al 2000).

While a person-centred approach to assessment requires recognition, respect and trust (Ford and McCormack 2000), in this study, participants recognised the importance of patient-focused care as opposed to person-centred care and were cognisant of understanding the needs and desires of the older person. Nurses require skills and knowledge to make sound clinical assessments and judgements to deliver appropriate care (An Bord Altranais 2009). Participants felt that they did not always have enough time for 'being with' and getting to know the person. While a holistic assessment provides complete picture of the person's needs and the most appropriate means for the nurse providing care (RCN 2000), it is recognised that finding the time for rehabilitation nursing is difficult (Barreca and Wilkins 2008). However, goal planning can be accommodated through the aspiration of restoring personal autonomy and empowerment (Davis 2006).

The idea that the nurse is an essential presence in the rehabilitation team is relatively new and there is a need to produce evidence of effective rehabilitation nursing practice to be recognised in the care team. Establishing a relationship with other MDT members based on understanding and mutual respect enables consultation and collaboration in providing best practice (An Bord Altranais 2009). However, for this to happen nurses need to be familiar with the correct terminology and with the scales and measurements adopted because the use of validated assessment tools minimises any conflict that may occur as a result of differing perceptions. This enables healthcare team members to report clinical observations in a systematic way (An Bord Altranais 2009).

Conclusion

One of the strengths of the study is that it allowed nurses to consider and share the meaning of their perceptions of their role in rehabilitation. The skills, knowledge and educational requirements that inform nursing practice in this area of care are complex. However, the findings of this study highlight how essential it is for patient and family/carer involvement in goal setting, re-enabling the older person to maximise their potential for optimal quality of life, establishing a shared meaning between MDT members, and the nurse using further education and training in the implementation of evidence-based practice.

For evidence-based practice to be implemented there is a need to move beyond 'practice wisdom' and to work collectively as a team (Doody and Doody 2011). This process would promote high quality care, however, for this to happen, nurses need to take responsibility for their professional contribution and be given a similar status to other team members. Nurses have an important role in rehabilitation, although their role's often undervalued and ill-defined. Nurses need to recognise their value, become more confident of their contribution and articulate their value in the process. While there is a need to have an understanding of the principles that underpin rehabilitation, nurses are aware that a 'one size fits all' approach does not work because each individual's situation is different. However, there is a need for consistency and continuity of care that are evidence based.

Clinical nurse specialist (CNS) posts have been created in Ireland over the past decade in areas such as 'care of the older person' and 'rehabilitation of the older person'. These specialist nurses have a role in achieving the vision for advancing nursing practice, care and rehabilitation of the older person. However, this can only be achieved if the CNS adopts and fulfils the components of the CNS role and takes on a leadership role in the profession (Doody and Bailey 2011). Nurses and CNSs working in rehabilitation need to create evidence about their practice outcomes.

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