



Royal College  
of Nursing

# Maximising independence

*The role of the nurse in  
supporting the rehabilitation  
of older people*





# Contributors

This guidance was developed by the following project group members:

**Valerie Thomas**, Steering Committee Member, RCN Forum for Nurses Working with Older People (lead author)

**Clare Ruff**, Steering Committee Member, RCN Forum for Nurses Working with Older People

**Sandra Binnie**, Steering Committee Member, RCN Forum for Nurses Working with Older People

**Pauline Ford**, RCN Gerontological Nursing Adviser

Members of the RCN Forum for Nurses Working with Older People and the RCN Mental Health and Older People Forum were also involved in the development of this document.

## Acknowledgements:

Mary Clay, Angela Kydd, Pauline Ford and Brendan McCormack, all of whom were contributors to *Rehabilitating older people; the role of the nurse* (RCN, 2000) which is superseded by this publication.

### RCN Legal Disclaimer

This publication contains information, advice and guidance to help members of the RCN. It is intended for use within the UK but readers are advised that practices may vary in each country and outside the UK.

The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. Whilst every effort has been made to ensure the RCN provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the RCN shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this website information and guidance.

Published by the Royal College of Nursing, 20 Cavendish Square, London W1G 0RN

©2007 Royal College of Nursing. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the Publishers or a licence permitting restricted copying issued by the Copyright Licensing Agency, 90 Tottenham Court Road, London W1T 4LP. This publication may not be lent, resold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the Publishers.

# Maximising independence

*The role of the nurse in supporting the rehabilitation of older people*

## Contents

Introduction	2
1. The rehabilitation context	3
2. The health status of older people	4
3. Rehabilitation in practice	5
4. Intermediate care	6
5. The nurse's role in rehabilitation	7
The framework of the nurse's role	8
Outcomes measurement	8
Nurse education	8
6. Conclusion	9
References	10

# Introduction

This publication is an updated version of *Rehabilitating older people; the role of the nurse* (RCN, 2000) and reflects current trends and research in relation to the rehabilitation of older people. It aims to clarify the role of the nurse in rehabilitation, and to offer some thoughts on issues which nurses should consider when working in practice. The role of the nurse within rehabilitation should be person-focused, and nurses are encouraged to work in a facilitating role to maximise the independence of the older person.

The core principles of the RCN's Gerontological Nursing work include practice that emphasises re-enablement. The older population in Britain is changing, and increasingly older people want to express their needs and aspirations. We know from what older people tell us, and a wealth of research evidence, that they want to remain independent as long as they possibly can. For many older people exercising choice about how they live remains the reality, but for others increased frailty and illness pose a real threat to maintaining independence and well being (RCN, 2004).

## 1

# The rehabilitation context

Promoting independence for older people is a key theme in current health and social care policy and has led to an increased focus on rehabilitation services. For example, the National Service Frameworks (NSFs) have set new national standards and service models of care across health and social services for all older people (Department of Health, 2001; Welsh Assembly Government, 2002; and the Scottish Executive, 2007). Rehabilitating older people is not a new concept, and the need to consider rehabilitation as an approach was emphasised even before the National Health Service was founded (Warren, 1946).

Horne (1998), Farrell et al. (1999) and Edwards (2002) have all highlighted the link between a lack of rehabilitation and an over reliance on expensive residential and nursing home care, suggesting that services for older people often fail to support them to live independently and do not acknowledge an individual's expectation of living an 'ordinary' life. These issues should be of prime importance to nurses working with older people.

Nurses have an important role in the rehabilitation of older people, but it has long been undervalued and remains ill-defined (Nolan and Nolan, 1997). There are many definitions of rehabilitation but it is apparent that, whatever suggestion is adopted, rehabilitation is tied-up with the processes which exist at various levels within the hierarchy of health, and that similar concepts are labelled differently by different writers (Sinclair and Dickinson,

2001; McDowell and Newell, 1996). The report by the Royal Commission on Long Term Care for the Elderly (1999) welcomed the notion that increasing awareness of the role of rehabilitation is an integral part of long term care. It also emphasised the fact that age-specific morbidity and disability could be reduced, if more attention were given to prevention.

Widespread confusion about the meaning of rehabilitation makes it difficult at times to distinguish from other forms of care and support (RCN, 2007). The words 're-ablement', 'enablement' and 're-enablement' are used interchangeably throughout current policy documents, and nurses have a continuing challenge in identifying an innovative role in this semantic minefield. However, if we empathise with the function of rehabilitation, the inter-changeability of these terms becomes an incidental. The confusion in terminology use has arisen, in part, since the wide scale promotion of the concept of intermediate care and the publication of related guidance documents from the Department of Health (DH) and the Welsh Assembly Government (WAG) in which the terms 're-ablement', 're-enablement' and 'enablement' have become synonymous with some forms of social care services or teams.

Rather than debating on the terminology used, it may be more helpful to consider instead the impact of impairment, disability and handicap on the daily lives of individuals (World Health Organisation, 1980).

**Impairment** refers to the reduction in physical or mental capacities, which may not always be visible and may not have adverse consequences for the individual. However, where the effects of impairment are not corrected, a disability may occur. **Disability** refers to the restriction in the person's ability to perform a function they consider to

## A mobility impact assessment framework

Impairment	Disability	Handicap
Disrupted physiology and pathology as a result of age	Reduction in the person's ability to function	Effect on social function
Osteoarthritis of the knee	Difficulty in walking or driving	<ul style="list-style-type: none"> <li>◆ unable to shop for self</li> <li>◆ unable to continue to collect grandchildren from school</li> <li>◆ unable to continue playing golf/go dancing</li> <li>◆ unable to get in and out of the bath unaided</li> </ul>

be normal, such as walking or shopping. Disabilities may or may not limit an individual's ability to fulfil a normal social role, depending on the severity of the disability and on what the person wishes to do. **Handicap** refers to social disadvantage – such as loss of income or social interaction – which in turn has an effect on the health and wellbeing of the person (McDowell and Newell, 1996). This differentiation is vital if nurses are to adopt a person-centred approach to rehabilitation.

The table on page 3 reviews the impact on an older person of a change in just one activity of daily living – mobility. However, the framework is useful to apply when considering the impact of any change in function or ability.

On the basis of this hierarchy, functional ability can be described as the degree to which an individual is able to perform socially allocated roles free from physical limitations. In the examples given, it may appear that the older person can simply no longer 'do some things'. However, these activities may well be fundamental to how an older person views their role in society, and being unable to do one or more of these activities may be the one thing which has the most effect on their general well being.

This has particular relevance for the concept of rehabilitation, and if nurses are to fulfil a crucial role and provide care to its fullest potential they must understand the underpinning principles of rehabilitation, as well as potential intervention (Smith, 1999). While the term rehabilitation is frequently used in literature related to this topic, Nolan and Nolan (1998) suggest that definitions should incorporate the person's perspective, and their need to feel valued and to be able to construct a meaningful future which supports their social function/roles.

## The health status of older people

Though ageing does bring an increasing risk of disability, the assumption that older age is inevitably associated with disease, disability and frailty does not reflect the reality for the majority of older people (National Statistics Office, 2004). This means that practices must focus on what an individual **can** do and indeed **wishes to do**, rather than on stereotypes.

Long held beliefs about the ageing process are now being seriously questioned. Grant (1996) points out that much of what was once considered to be inevitable deterioration is in reality the result of individual behaviour and environmental conditioning. Although changes in physiology are part of ageing, the accumulated evidence shows that many of the disease processes we think of as 'usual' can be modified and minimised through education and preventative interventions.

This means that rehabilitation needs to encompass all the individual's daily activities and should have three main focal points (RCN, 1997):

- ◆ enhancing and maintaining quality of life
- ◆ restoring physical, psychological and social functioning by recognising the health potential of the individual
- ◆ preventing disease and illness.

## 3

# Rehabilitation in practice

As previously discussed, rehabilitation is a complex concept and it is not easy to provide an all encompassing definition. It may be more helpful to provide a description of the role of rehabilitation:

*“Rehabilitation should aim to maximise the [person’s] roles fulfilment and independence in his or her environment, all within the limitations imposed by the underlying pathology and impairment and availability of resources. This helps the person to make the best adaptation possible to any difference between the roles achieved and the roles desired.”*

(Wade, 1992)

Achieving this is a challenge for every nurse, regardless of the practice setting. While only some of the elements of this approach may be achievable in particular settings, the approach to rehabilitation and the person-centred focus should remain constant.

An appropriate rehabilitation programme should be based on a comprehensive assessment through the single assessment process (DH, 2001), the single shared assessment (SE, 2001) or the unified assessment process (WAG 2001) and should address the domains relevant to the person.

The following, adapted from RCN (2005), takes account of the physical, emotional, mental and spiritual domains of an individual.

## Physical:

- ◆ enhance sensory and motor functioning
- ◆ actual and potential strengths and abilities of the person
- ◆ understand symptoms and what they mean from the perspective of the person
- ◆ help to adapt to changes in function
- ◆ incorporate the perspectives of carers and family in the adaptation to changes.

## Emotional:

- ◆ understand and respect the coping strategies used by the person
- ◆ suggest ways of reducing stress, tension and anxiety, including complementary therapies if appropriate and acceptable
- ◆ provide advocacy, or access to advocacy, in all aspects of decision making as and when required
- ◆ facilitate a range of support systems for the person, and all other carers and family
- ◆ be sensitive to, and respect, different cultural perspectives and needs.

## Mental:

- ◆ identify and take account of previous life history and usual routines
- ◆ undertake appropriate mental health assessments to provide an understanding of the person’s ability to adapt and adjust
- ◆ if required, provide a range of activities to decrease mental confusion and optimise mental functioning
- ◆ offer choice and enhance autonomy relevant to cognitive state.

## Spiritual:

- ◆ ensure the person is able to maintain contact with their social world
- ◆ be aware of, and facilitate, the continuity of all religious and spiritual activities.

Easton (1999) offers a definition of rehabilitation which addresses the complex health and social needs of older people. This is an adapted version:

*Rehabilitation is a lifelong process in which the [person] works with the family, the rehabilitation team and society to achieve his or her optimum level of functioning as a holistic person, with the goals of preventing secondary complications, fostering maximum independence, maintaining dignity and promoting quality of life.*

## 4

Several writers clearly identify that rehabilitation is a continuous process, independent of the setting in which it is provided (Easton, 1999; Edwards, 2002). Within the context of services for older people, health care has increasingly become a community oriented activity (rather than one focused on secondary hospital care). Clay and Wade (2003) cited research which demonstrated that during the inpatient stay, one-third of older people admitted to secondary care lost life skills – such as transferring from bed-to-chair or eating without assistance.

Another challenge has been the shift away from single professionals to teamwork, and most importantly to individuals and their carers (Keir, 1996). In spite of the acknowledged need for interprofessional and interorganisational working, rehabilitation services for older people still operate in a discrete policy area and there is little evidence of strategic planning (Nazarko, 2001). As the number of hospital beds has decreased, so the level of intense rehabilitation delivered in hospitals has also reduced.

The emphasis on moving people through the system more rapidly, and the earlier discharge of people, has denied older people the chance to recover after a period of illness or trauma. *The National beds inquiry* (DH, 2002) concluded that for about 20 per cent of older people, admission and protracted lengthy stays in acute hospital beds are inappropriate and would be unnecessary if alternative facilities were in place. The assumption was that the alternatives would be in place, and this has seen the development of a range of services under the intermediate care banner.

## Intermediate care

Intermediate care (IC) is a concept which is already familiar to many people working in health and social care in the United Kingdom (Martin et al., 2004). The term is used to describe a range of services which aim to prevent inappropriate admission to hospital, facilitate supported discharge for patients who no longer need to be in hospital, and to avert premature admissions to long term care (DH, 2001b; WAG, 2002).

Central and devolved governments all have high expectations of IC in terms of promoting independence and quality of life for older people, and solving the system pressures within the acute hospital sector (Stevenson and Spencer, 2002). However, there is a lack of consensus on the definition of IC, and it is often defined most easily by exception, for example, the lack of the need for acute medical or surgical intervention (Griffiths, 2000).

The Department of Health (1999) and the Welsh Assembly Government (2002) state that IC should be regarded as those services that meet all the following criteria:

- ◆ targeted at people who would otherwise face unnecessarily prolonged stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS care
- ◆ provided on the basis of comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- ◆ have a planned outcome of maximising independence and typically enabling patients/users to resume living at home
- ◆ involve cross-professional working, with a single assessment framework, single professional records and shared protocols
- ◆ time limited up to six weeks, but may be as little as one to two weeks.

Both bodies view IC as a function of services which work within a seamless continuum of services linking health promotion, preventative services, primary care, community services and social care, and make it clear that such services

## 5

are best provided in the person's own home – or as close to it as possible.

Irrespective of the focus on the form or function of IC, both the Department of Health and the Welsh Assembly Government tried to distinguish it from other forms of transitional care by emphasising the need to provide active therapy through an interdisciplinary approach to maximise independence. However, IC should not be seen as a substitution for inpatient care; rather it should be considered as a person focused option on the rehabilitation menu. The maximum time period of six weeks sends out a clear message that IC is not about 'warehousing or dumping' older people, nor is it about marginalising them from relevant mainstream services (Stevenson and Spencer, 2002).

In essence, rehabilitation services – including IC – should be seen as a proactive choice which has been made on the basis that it addresses the needs and wishes of the older person. The decision to transfer to another service should not be based on financial considerations, or taken in response to pressures from within other parts of the system.

## The nurse's role in rehabilitation

Nurses, occupational therapists, physiotherapists and various other disciplines are integrated members of the interdisciplinary team involved in rehabilitation. An interdisciplinary approach has been demonstrated to be far more effective than professional groups working in isolation (Edwards 2002; Smith 1999). All disciplines in the team need to be clear about their role in a collaborative approach to person-centred care.

Person-centred care is a key feature in both policy and practice, and reflected in the relevant NSFs in England, Scotland and Wales. Person-centred care demonstrates a way of caring where no one person is the arbiter of decisions (McCormack, 2003), and person-centred care is a central concept within rehabilitation as it aims to transform the [person's] experience. The role of the nurse is to be there, offer personal support and practice expertise, but always to enable the [person] to follow their own path. This requires the nurse to be aware of the balance between autonomy and other factors such as staff relationships, organisational processes and issues of power (McCormack, 2003).

A nurse working in a rehabilitative role is sometimes viewed as a coordinator of the [inter] disciplinary team and the manager of the nursing team (Luker and Waters, 1996). The nurse is usually the individual who comes most frequently into contact with the person, and is able to offer continuity of care. Therefore, the nurse should be aware of the need to:

- ◆ motivate the older person towards self-care
- ◆ provide the older person with evidence on which to make informed decisions
- ◆ teach the older person skills that may enhance his or her quality of life, maintain optimum functioning and prevent deterioration
- ◆ listen to the older person, in order to evaluate the success of the care provided from the person's point of view.

(adapted from RCN, 2005)

The goal of rehabilitation nursing is to promote adaptation, which includes the assessment of coping mechanisms, to determine if responses are adaptive or ineffective (Johnson Lutjens, 1991). Adaptive responses are essential if people are to achieve their potential.

## The framework of the nurse's role

A nurse engages in four different types of role functions when working with older people within a rehabilitation ethos:

1. Supportive functions include; providing psychosocial support and emotional support, assisting with transition and life review, enhancing lifestyles and relationships, facilitating self-expression and ensuring cultural sensitivity.
2. Restorative functions are aimed at maximising independence and functional ability, preventing further deterioration and/or disability, and enhancing quality of life. This is undertaken through a focus on rehabilitation that maximises the older person's potential for independence, including assessment skills and undertaking essential care elements.
3. Educative functions involve the nurse teaching self-care (for example, self-medication and health promotion). In conjunction with other disciplines the nurse can facilitate a number of educational activities to increase confidence and competence in the activities of daily living.
4. Life enhancing functions include all activities aimed at enhancing the daily living experience and maximising the independence of older people. This may include things such as relieving pain and ensuring adequate nutrition.

(adapted from RCN, 2005)

## Outcomes measurement

Developing an evidence base of the effectiveness of a model of care that is characterised by diversity and difference is problematic in practice. Conceptual difficulties, and the interaction of various factors, compound the problem of measuring independence and quality of life in relation to person-centred rehabilitation interventions.

Services for older people often fail to help them live independently and do not acknowledge the person's expectation to live their ordinary lives (Horne, 1998; Farrell et al., 1999; Edwards, 2002). Traditional negative measures such as morbidity, mortality, infection rates and unscheduled readmission to hospital (McDowell and Newell, 1996) cannot recognise and measure a model of care which reflects the needs of the individual.

As previously stated, all rehabilitation programmes should be person focused and reflect the goals of the person. Exercising choice may indeed lower the score on scales which assume that people with a lower score – due to immobility, for example – have a lower quality of life than someone with a higher score. Tools may not reflect the fact that an individual chooses to manage an activity of daily living – such as hygiene – in a particular way. McDowell and Newell (1996) confirm the need for those involved in delivering these services to use an appropriate range of tools, which have the sensitivity and specificity to discern and evaluate the inputs and outcomes of rehabilitation interventions. However, at the present time, none of the central or devolved governments are able to recommend such tools.

## Nurse education

Nurses working in practice and education must recognise that older people are the main adult users of health services, and indeed are the 'core business of nursing in health and social care' (Age Concern England and RCN, 2007).

Educational programmes must be developed which acknowledge the fundamental human and citizenship rights of older people. Involving older people in curriculum planning will address some of the inherent issues of ageism and discrimination and is to be encouraged. However, both service and education must promote the positive aspects of working with older people within a person-centred model of care and appreciate the nurses who choose to undertake these valuable and rewarding roles.

## 6

## Conclusion

The aim of rehabilitation is to maximise the older person's role fulfilment and independence in his or her [chosen] environment. This has to be balanced with the limitations imposed by the underlying pathology and impairment, and the availability of resources facilitating the adaptation between the roles desired and what was achievable (Wade, 1992).

The process of adaptation is important, as older people who need some form of rehabilitation are usually in a major identity crisis or are in mourning over the loss or disruption of physical, emotional or cognitive abilities.

The role of the nurse is to be there, offer personal support and practice expertise but always to enable the person to follow their own path.

# References

- Age Concern England and Royal College of Nursing (2007) *Preparing student nurses work with older people in progress*
- Clay M and Wade S (2003) Rehabilitation and older people, *Nursing Older People*, 15(7), pp.25-29
- Department of Health (2000) *Shaping the future NHS: long term planning for hospitals and related services: consultation document on the findings of the National Bed Inquiry*, London: DH
- Department of Health (2001a) *The national service framework for older people*, London: DH
- Department of Health (2001b) HSC 2001/001 (LAC (2001)01) *Intermediate care*, London: DH
- Easton KL (1999) *Gerontological rehabilitation nursing*, London: WB Saunders
- Edwards A (2002) A rehabilitation framework for patient-focused care, *Nursing Standard*, 16(50), pp.38-44
- Farrell C, Robinson L and Fletcher P (1999) *A new era for community care: what people want from health, housing and social care services*, London: King's Fund
- Grant L (1996) Effects of ageism on individual and health care providers' responses to health ageing, *Health and social work*, 21(1) pp.9-15
- Griffiths P (2002) Nursing-led in-patient units for intermediate care: a survey of multidisciplinary discharge planning practice, *Journal of Clinical Nursing*, 11:3 pp.322-330
- Horne D (1998) *Getting better? Inspection of hospital discharge (care management) arrangements for older people*, London: DH
- Johnson Lutjens, L (1991) *Castille Roy: an adaptation model*, London: Chapman and Hall
- Luker K and Waters K (1996) Staff perspectives on the role of the nurse in rehabilitation wards for the elderly, *Journal of Clinical Nursing*, Vol. 5 pp.105-114
- McCormack B (2003) A conceptual framework for person centred practice with older people, *International Journal of Nursing Practices*, 9(3) pp.202-209
- McDowell I and Newell C (1996) *Measuring health: a guide to rating scales and questionnaires*, Oxford: OUP
- Martin GP, Peet SM, Hewitt GJ and Parker H (2004) Diversity in intermediate care, *Health and social care in the community*, 12(2) pp.150-155
- Nazarko L (1997) Improving hospital discharge arrangements for older people, *Nursing Standard*, 11(40) pp.44-47
- Nazarko L (2001) A new perspective on an old problem, *Nursing Times*, 97(30) pp.52-53
- Office for National Statistics (2004) *Focus on older people*, London: HMSO
- Royal College of Nursing (1997) *What a difference a nurse makes: an RCN report on the benefits of expert nursing to clinical outcomes in the continuing care of older people*, London: RCN
- Royal College of Nursing (2004) *Caring in partnership: older people and nursing staff working towards the future*, London: RCN
- Royal College of Nursing (2005) *Nursing homes: nursing values*, London: RCN – no longer in print
- Royal Commission on Long Term Care (1999) *With respect to old age: long term care – rights and responsibilities*, London: Stationary Office (Cm 4192-1)
- Scottish Executive (2001) *Shared single assessment of community care needs*, Edinburgh: SE (CCD 8/2001)
- Scottish Executive (2007) *Co-ordinated, integrated and fit for purpose: a delivery framework for adult rehabilitation in Scotland*, Edinburgh: SE
- Sinclair A and Dickenson E (1998) *Effective practice in rehabilitation: the evidence of systematic reviews*, London: King's Fund
- Smith M (1999) *Rehabilitation in adult nursing practice*. London: Churchill Livingstone

Stevenson J and Spencer L (2001) *Developing intermediate care: a guide for health and social services professionals*, London: King's Fund

Wade DT (1992) Stroke rehabilitation and long term care, *The Lancet*, 339 pp.791-793

Warren M (1946) Care of the chronic aged sick, *The Lancet*, 1 pp.841-843.

Welsh Assembly Government (2002a) *Intermediate care guidance* WHC (2002) 108/NAWF 43/02, Cardiff: WAG

Welsh Assembly Government (2002b) *Health and social care for adults: creating a unified and fair system for assessing and managing care: guidance for local authorities and health services*, Cardiff: WAG

World Health Organization (1980) *International classification of impairments, disabilities and handicaps: a manual of classification relating to the consequences of disease*, Geneva: WHO



Royal College  
of Nursing

November 2007

Review date: November 2009

Published by the  
Royal College of Nursing  
20 Cavendish Square  
London  
W1G 0RN

020 7409 3333

**RCNONLINE**  
[www.rcn.org.uk](http://www.rcn.org.uk)

**RCNDIRECT**  
[www.rcn.org.uk/direct](http://www.rcn.org.uk/direct)  
**0845 772 6100**

*The RCN represents nurses and nursing, promotes  
excellence in practice and shapes health policies.*

ISBN 978-1-904114-77-2

Publication code 003 186