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# Role of the rehabilitation nurse

*RCN guidance*





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of Nursing

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## Other related RCN publications

If you find this publication useful you may also be interested in reading, *Maximising independence – the role of nurses in supporting the rehabilitation of older people*. Publication code: 003 186.

## How to use this workbook

All you need to get started is a pad of paper, a pen and an enquiring mind.

This workbook has been designed without space for writing so that you can share it with colleagues.

Use loose sheets of paper so you can file them in your PREP or knowledge and skills framework portfolio, as evidence of reflective learning.

It's up to you how much time and effort you invest. However, if you are submitting for APEL, the depth and level of work will contribute to the outcome.

You may wish to use the workbook or sections of it for teaching colleagues at any level.

## Aims and objectives

The overall aim of this workbook is to offer a framework on which nurses can base their rehabilitation practice.

Its specific objectives are to enable nurses to:

- ◆ identify specific aspects of the nurse's role in rehabilitation
- ◆ help nurses relate theory to practice
- ◆ encourage nurses to develop their rehabilitation practice
- ◆ raise the profile of rehabilitation and intermediate care nursing in the UK.

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## Foreword

I am delighted to be writing the foreword for this revised document, published at a time of significant change within the NHS. It has been brought up-to-date, reflecting the change in emphasis from hospital to community rehabilitative and intermediate care. It will help nurses to reflect on rehabilitative aspects of their role, regardless of their area of practice or client group.

One of the most significant changes in the NHS in recent years has been the recognition that long-term conditions have a huge impact on health and social care. More than 15 million people in this country report living with a long-term condition. Whilst at present they cannot be cured, their symptoms, impairments and disability can be controlled and better managed by medication and other therapies. Thus the importance of and need for rehabilitation and intermediate care is at the forefront for all patient management.

The Long-term Conditions National Service Framework (NSF) was launched in March 2005. The NSF aims to transform the way health and social care services support people to live with long-term conditions. Key themes are: independent living; care planned around the needs and choices of the individual; easier, timely access to services; and joint working across all agencies and disciplines involved.

The principles of this NSF are also relevant to service development for long-term conditions. This NSF is a key tool for delivering the Government's strategy to support people with long-term conditions outlined in the White paper, *Our health, our care, our say* and *the NHS Improvement Plan: putting people at the heart of public services*.

The NSF applies to health and social services working with local agencies involved in supporting people to live independently. These include providers of transport, housing, employment, education, benefits and pensions. A significant aspect is the need for rehabilitation and intermediate care. Three of the quality requirements (QRs) of this NSF focus specifically on these areas, while a further seven address issues that relate to them.

This publication is a valuable resource for aspiring rehabilitation and intermediate care nurses. I commend it to you as essential reading.

**Sue Thomas**

*Nursing Policy and Practice Adviser  
Long-Term Conditions*

## Introduction

Rehabilitation began to emerge as a separate development within health care only after the First World War. Since then, there has been debate at all levels about its existence as a specialty.

The importance of rehabilitation is recognised across the spectrum of health and social care, in primary, secondary and tertiary settings. However, opinions vary as to the exact nature of rehabilitation nursing.

This document has been revised, bringing it up-to-date and reflecting the changes in emphasis – from hospital to community rehabilitative and intermediate care. Its aim is to help nurses reflect on rehabilitative aspects of their role, regardless of their area of practice or client group.

## Method

*Standards of care for rehabilitation nursing*, produced in 1994 by the RCN Rehabilitation Nursing Special Interest Group, was intended to help nurses ‘shift the focus of their practice towards rehabilitation’. The significant developments in rehabilitation practice have highlighted a need to review these standards, in line with service initiatives.

At the 1997 RCN Rehabilitation Nursing Forum Conference, delegates were canvassed for their views on the nurse’s role in rehabilitation. Broad themes were identified and a sub-group of the committee was formed to update the existing standards. It became clear that a fresh approach was needed to reflect the move towards clinical effectiveness.

Work progressed and a draft framework was presented at the 1998 conference. Here delegates had the opportunity for debate and to complete a questionnaire. The themes that emerged were grouped into categories and incorporated into the current revised framework. While some themes could have fitted into more than one category, it was felt more important to build them into the framework than worry precisely where they appeared within it.

In the light of recent developments in the field of rehabilitative nursing, it was felt that the workbook

should be reviewed. This updated version reflects the extension of nursing roles – particularly specialist and consultant nurses – and the increasing emphasis on community rehabilitation, including intermediate care.

The framework remains the focus of this document. It has been written as a workbook so that nurses can continue to build upon their own knowledge and experiences. Nurses can interpret and apply the contents within their own spheres of practice. The workbook explores each category, providing supporting evidence from practical experience and literature. Suggestions for further reading are included.

The terms ‘patient’, ‘client’ and ‘individual’ are used throughout, reflecting a range of commonly used terms in different health and social care settings.

## History of the RCN Rehabilitation and Intermediate Care Nursing Forum

The idea of establishing a forum for rehabilitation nurses was first discussed in 1988, and a special interest group was set up with the RCN in 1990. The group was committed to having an annual conference, raising the profile of rehabilitation nursing and communicating with other rehabilitation nurses to share ideas and innovations.

In 1993, the RCN accepted the group as a forum, and membership continued to grow. Following further consultation with its members, the forum extended its membership in 2002 to include nurses working in intermediate care. This reflects their increasing contribution to rehabilitative nursing.

The forum’s policy and practice group currently consists of a chair and six members. They are elected by the forum membership and hold office for a term of four years. A policy and practice group member may serve for a maximum of eight concurrent years, but may seek re-election after a break of two years. The group can also co-opt honorary members for specific pieces of work.

## Definitions of rehabilitation

In attempting to describe its purpose, rehabilitation has been defined in a number of ways. The Oxford Dictionary (1994) defines it as 'restoring a person to a normal life'. However, a survey of the literature suggests that there are wider implications for many individuals, particularly those with a chronic, progressive or permanent disability.

Here are some examples:

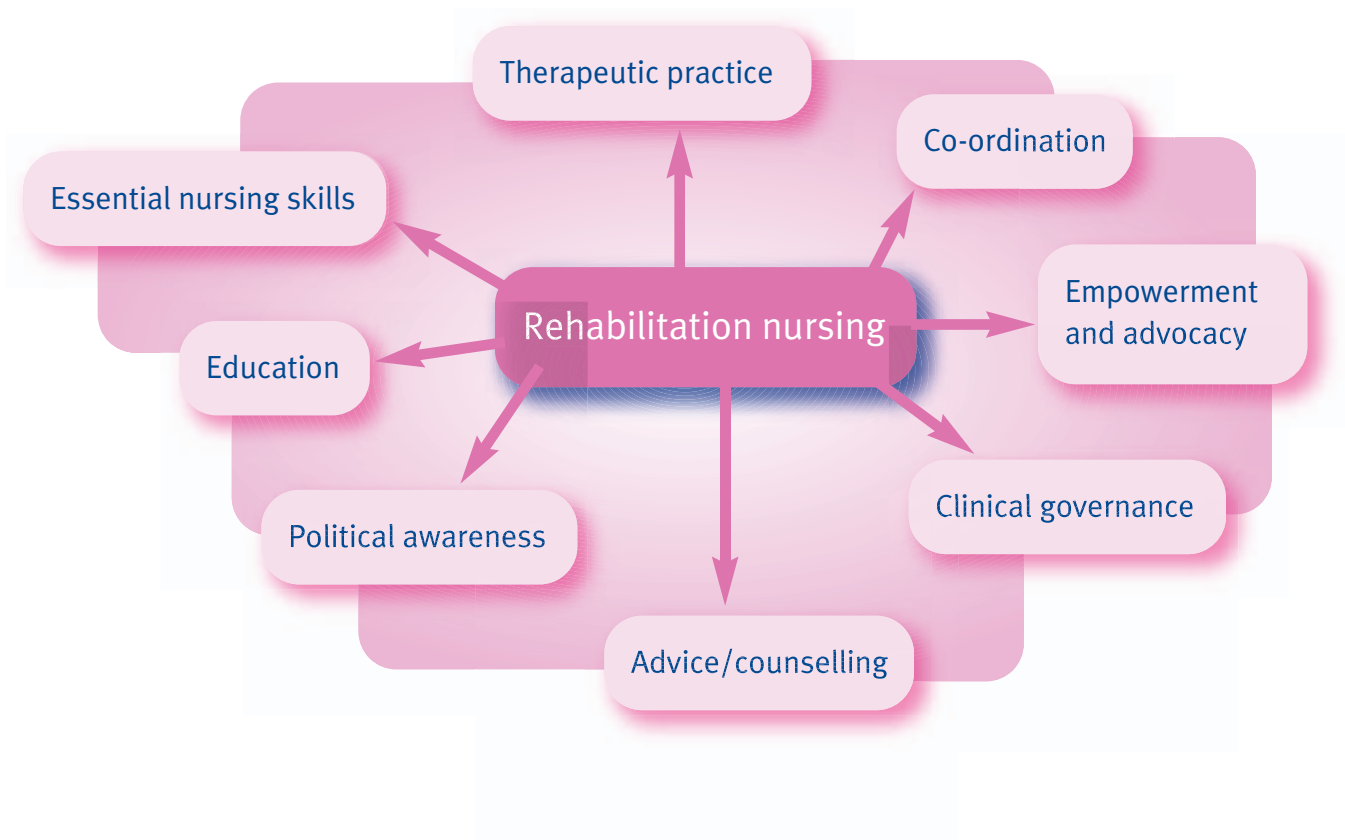
- ◆ "Re-activation – the encouragement of patients to be active within their surroundings. Re-socialisation – the encouragement of physical and or verbal contact by patients with peers, family and others. Re-integration – restoration of the patient to society and the regaining of status as a person," (Jackson, 1984).
- ◆ "Concern with the intrinsic worth and dignity of the individual. It is therefore committed to the restoration of the disabled to a life that is purposeful and satisfying, one that allows each individual the opportunity to function adequately as a family member and a member of society with the capabilities to meet the responsibilities of that society," (Licht, 1968).
- ◆ "A process aiming to restore personal autonomy in those aspects of daily living considered most relevant by patients or service users, and their family carers," (Sinclair and Dickinson, 1998).
- ◆ "An educational, problem-solving process aimed at reducing disability and handicap," (Wade, 1996).
- ◆ "...the whole process of enabling and facilitating the restoration of a disabled person to regain optimal functioning (physically, socially and psychologically) as fully as they are able or motivated to do so," (Waters, 1986).
- ◆ "An enabling process in which sometimes communities, agencies and professionals meet the social, psychological and economic needs of the disabled person," (Baker et al., 1997).
- ◆ "Rehabilitation is a person-centered, active and creative process that involves adaptation to changes in life circumstances. It is a shared activity between the ...person, people close to them, and multi-professional teams who recognise the contribution of all concerned," (RCN, 2000).

## References

- Baker M, Fardell J, Jones B (1997) *Disability and rehabilitation: survey of education needs of health and social service professionals*. London: Disability and Rehabilitation Open Learning Project.
- Jackson M (1984) Geriatric rehabilitation on an acute care medical unit. *Journal of Advanced Nursing*, 9, pp. 441-448.
- Licht S (1968) *Rehabilitation medicine*. Baltimore: Waverly Press.
- Royal College of Nursing (2000) *Rehabilitating older people: the role of the nurse*. London: RCN.
- Sinclair A and Dickinson E (1998) *Effective practice in rehabilitation: the evidence of systematic reviews*. London: Kings Fund.
- The Oxford Dictionary (1994) Oxford: Oxford University Press.
- Wade D (1996) Designing district disability services – the Oxford experience. *Clinical Rehabilitation*, 4, pp.147-158.
- Waters K (1986) The role of the nurse in rehabilitation. *CARE – Science and Practice*, 5 (3), pp.17-21.

# Framework of rehabilitation nursing

This simple framework identifies eight categories where rehabilitation nurses can influence care.



# Essential nursing skills

Despite the technological advances in health care, which sometimes appear to depersonalise our practice, caring and consoling remain central to nursing, Benner (1984) reflected on the ability of the nurse to provide a caring approach through emotional and psychological support, as well as physically helping with daily living needs. She calls this ‘presencing’, while Kirkevold (1997) describes it as a fundamental consoling function.

‘Being with’ an individual requires an empathic and close relationship, which shows that the nurse values the person inside the patient. In rehabilitative settings this is reflected not in *what* we do, but in the *way* we provide care. Essential nursing skills relate to all the care we administer and should focus on maintaining quality of life and improving it, restoring function where it is possible and preventing further illness or complications (RCN, 2000).

In England, the *Essence of care* document (DH, 2004) reflects the importance of providing patient-focused benchmarks of best practice that relate to ‘the fundamentals of care’. These are intended for use in primary, secondary and tertiary care by health and social care personnel, but focus on fundamental nursing practice.

Sometimes the emphasis in rehabilitation is on *physical* outcomes of care. This can lead us to neglect the importance of helping people with disabilities see beyond the physical and ‘make sense of their situation’ within society (Nolan, 1998).

In the past, the lead for rehabilitation programmes often came from other therapists, notably physiotherapists and occupational therapists. Nurses were expected to assume little more than an understudy’s role, providing the necessary care required by the patient who was preparing for ‘rehabilitation’. However, much of this care remained invisible and almost absent from the literature (Sheppard, 1994), despite Henderson proclaiming in 1980 that nurses were ‘rehabilitators par excellence’. She recognised that many of the components of nursing care were not so much basic but essential rehabilitation nursing skills.

These skills include: relieving pain; helping with hygiene and mobilisation; giving pressure area care; ensuring adequate nutrition; promoting and managing

continence; giving emotional support; and providing opportunities for adequate sleep, rest and stimulation. Unless such needs are fully met *and* built into an educational rehabilitation programme, all other activities will be ineffective. Today, nurses tend to be more confident in their role. They are taking a greater lead in the rehabilitation team to make sure that they are not relegated to the so-called less important ‘little things’.

However, it is not enough that knowledgeable nurses develop skills in the prevention of complications – such as pressure damage, chest infection, constipation and contractures – nor even that this kind of care is implemented effectively. It must be made explicit as an essential part of the rehabilitation programme.

The rehabilitation nurse balances the need for the patient’s safety and progress with comprehensive risk assessments and with support and encouragement. Respect for patients’ choices becomes an important factor in planning care. But it brings with it the need for education relating to decisions made about particular actions and activities. In this, the entire multi-professional team must have a consistent approach to communicating with patient and family.

The rehabilitation nurse must respect the cultural norms and traditions of individuals, even though this may require some creative managing. For example:

- ◆ a young woman whose usual practice at mealtimes was to sit cross-legged was supported in this – despite the fear of increasing tone following her stroke – by good positioning immediately afterwards, and by careful monitoring
- ◆ a woman who insisted on wearing her stiletto heels for walking practice agreed to wear appropriate footwear when sitting, before she safely negotiated the trip to the toilet
- ◆ a man who continued to smoke at home following major cardiac surgery agreed to limit the number of cigarettes he smoked each day.

These are examples of how nurses can use a range of essential skills to facilitate activities in rehabilitation.

## References

- Benner P and Wrubel J (1989) *The primacy of caring*. Menlo Park: Addison Wesley.
- Department of Health/The Modernisation Agency (2004) *The essence of care*. London: DH.
- Henderson V (1980) Preserving the essence of nursing in a technological age. *Journal of Advanced Nursing*, 5, pp. 245-260.
- Kirkevold M (1997) The role of nursing in the rehabilitation of acute stroke patients: toward a unified theoretical perspective. *Advanced Nursing Science*, 19 (4), pp.55-64.
- Nolan N and Nolan J (1998) Rehabilitation: scope for improvement in current practice. *British Journal of Nursing*, 7 (9), pp. 522-526.
- RCN Forum for Nurses Working with Older People (2000) *Rehabilitating older people: the role of the nurse*. London: RCN.
- Sheppard B (1994) *Looking back – moving forward*. Brighton: Brighton Health Care NHS Trust.

## Suggested further reading

- Walsh M (2000) *Nursing frontiers: accountability and the boundaries of care (Chapter 2)*. Oxford: Butterworth Heinemann.
- World Health Organization (1980) *International classification of impairments, disabilities and handicaps: a manual of classification relating to the consequence of disease*. Geneva: WHO.
- World Health Organization (2001) *International classification of function, disability and health*. [www.who.int/classification/icf](http://www.who.int/classification/icf)

## Activities

### 1. Ask yourself and other health care professionals – such as a physiotherapist, an occupational therapist, a dietician and a doctor – the following questions:

- ◆ What skills do you think are essential to my role as a rehabilitation nurse?
- ◆ Which skills overlap with other members of the team?

Reflect on and compare their answers with your own. Write down responses that surprised or pleased you, stating why. Discuss your reflection with colleagues.

### 2. Think about one aspect of care you give on a regular basis – for example, providing continence advice; nutritional support; wound assessment; and washing and dressing.

- ◆ Break down each stage of this activity into physical, social, emotional and educative care.
- ◆ Record which fits into the categories of:
  - ◆ enhancing and maintaining quality of life
  - ◆ restoring function
  - ◆ preventing complications.
- ◆ What makes the interventions rehabilitative?

### 3. Discuss with colleagues one standard in the Essence of care document that you practise regularly. How can rehabilitative skills be incorporated into the auditing and benchmarking exercise?

# Therapeutic practice

During the last decade, a number of writers have examined rehabilitation nursing and discussed it with increasing interest. In 1998, the English National Board commissioned a project to review the contribution that nurses make to rehabilitation within the multidisciplinary team.

While this heightened activity has helped, it has not completely clarified nursing's contribution to rehabilitation. However, it has made nurses more conscious of the importance of rehabilitation, and the effect their involvement can have on individuals and their families. The rapidly growing membership of the RCN Rehabilitation and Intermediate Care Nursing Forum is evidence of increasing interest and commitment.

Nurses have a unique place within the rehabilitation team (Williams, 1993). Nurses have 24-hour contact with the patient – daytime, nights, weekends and holidays – and this provides unique opportunities (Johnson, 1995). What makes the difference is the kind of information gathered, the observations made, and the therapeutic use of this contact time. The Oxford Dictionary (1994) defines therapy as 'treatment to cure a disease'. Nurses can be as therapeutic as any other professional group.

Specialist knowledge and skills are required to carry out therapeutic nursing practice within rehabilitation. Rehabilitation nursing has been referred to as 'hands off' rather than 'hands on' nursing. However, this oversimplifies the role the nurse plays in both the physical aspects of rehabilitation, and the psychological and spiritual elements of an individual's recovery and adaptation.

To apply specialist knowledge and skills in rehabilitation, a nurse needs to be familiar with the processes of assessment; goal setting; therapy; colleagues' roles and contributions; teaching and education; and evaluation. Nurses have a great deal to offer to the process of rehabilitation. Often they are the most important source of information when providing feedback to the team about an individual's progress, difficulties or complications.

As a patient participating in an in-patient rehabilitation programme begins to learn and relearn, their new skills need to be practised and integrated into daily life. This is where the 24-hour responsibility of the nursing team can be particularly helpful (Johnson, 1995; Kirkevold, 1997). The nurse provides support and further education during this process. Together with the individual, the nurse identifies opportunities for greater integration of newly acquired skills, both physically and socially.

If rehabilitation is a process aiming to restore personal autonomy in aspects of daily living, rehabilitation nursing can take place in a whole range of settings (Squires, 2002). These include hospitals – all areas/specialised units – community hospitals, day units, outpatient facilities, GP surgeries, nurse-led clinics, residential and nursing homes, and individuals' own homes. Not only is it important to consider where rehabilitation might take place (Bendall, 1999), but also how to create an environment that encourages rehabilitation (Whitelock, 1999).

The aim of the RCN Rehabilitation and Intermediate Care Nursing Forum is to promote rehabilitation to *all* nurses, while supporting and encouraging those who may wish to develop a more specialised role.

Nurses working within rehabilitation in defined units, areas or teams may fulfil criteria for higher levels of practice – for example, change agent, researcher and educator, in addition to expert practitioner. They may progress to fulfil roles such as clinical nurse specialist, community matron or nurse consultant (DH, 1999). In these roles they may further influence health and social care environments to encourage good rehabilitation practice.

## References

- Bendall J (1999) 'Setting the scene', in Davis and O'Connor (editors) *Rehabilitation nursing: foundations for practice*, pp. 29-52. London: Baillière Tindall.
- Department of Health (1999) *Making a difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: DH.

## CASE STUDY

### Therapeutic practice

By Jane Williams PhD, MSc RGN RM  
Senior nurse (consultant nurse in stroke care)  
East Hampshire Primary Care Trust

Mr B, a 75 year-old bachelor, was admitted after collapsing suddenly at home. A CT scan showed an extensive right parietal-occipital haemorrhage with cerebral oedema. Mr B presented with dense left hemiplegia, urinary and faecal incontinence, homonymous hemianopia, dysphagia and dysarthria. His nephew was informed that the prognosis was poor, but Mr B's condition began to improve slightly. He was now being fed cold thin fluids and a puree diet. He was still doubly incontinent and, on the day of transfer from the acute medical ward, his Barthel score was 0/20.

I met Mr B three weeks and one day after his stroke. Staff reported problems moving and positioning him. He had fallen out of various chairs and the current chair of choice was a low armchair with a 'tipped' seat to prevent him from slipping. He was being hoisted for any movement and his nursing documentation indicated a very care-orientated, rather than rehabilitative, approach to his management.

I found out who was going to look after Mr B and suggested I help her. I introduced myself to Mr B. He was alert, well oriented, a little hard of hearing, and obviously had a hemianopia that caused him to see only what was on the right side. The staff nurse said that he was washed and dressed on the bed, then hoisted into his chair. I asked if we could wash and dress his lower half this way, then sit him out to help him wash and dress his top half.

As we began, I asked Mr B to move his left leg and get ready to roll towards me. He flexed the leg at the knee and placed his foot flat on the bed. I then asked him to move his weak arm across his chest. He complied with this request too. The staff nurse was amazed. Although she was his named nurse, she had no idea that Mr B had active movement in his stroke-affected side.

We continued by washing and dressing his lower half on the bed, encouraging him to help by moving limbs when asked. He did not like being rolled and I explained that this was due to his visual problem. I suggested to the staff nurse that he might be frightened to move, especially when being rolled, as he could not see the edge of the bed. Mr B readily agreed, saying that nobody had told him his vision had been affected.

I carefully explained to him the nature of his stroke and how his problems fitted with the wider picture. He listened intently to the information, said that he felt much more at ease and felt pleased that somebody had taken charge and wanted to

Gibbons KB, Salter JP, Piece LL, and Govoni AL (1995) A model for professional rehabilitation nursing practice. *Rehabilitation Nursing*, 20 (1), pp.23-28, 36.

Kirkevoid M (1997) The role of nursing in the rehabilitation of acute stroke patients: toward a unified theoretical perspective. *Advanced Nursing Science*, 19 (4), pp. 55-64.

Johnson J (1995) Achieving effective rehabilitation outcomes: does the nurse have a role? *British Journal of Therapy and Rehabilitation* 2 (3), pp113-118.

O'Connor SE (1993) Nursing and rehabilitation: the interventions of nurses in stroke. *Journal of Clinical Nursing*, 2, pp.29-34.

Squires AJ (2002) 'Overview and future of rehabilitation of older people', in Squires, AJ and Hastings A (editors) *Rehabilitation of older people: a handbook for the interdisciplinary team*, pp.373-390. London: Chapman Hall.

The Oxford Dictionary (1994) Oxford: Oxford University Press.

Waters KR (1994) Getting dressed in the early morning: patterns of staff/patient interaction on rehabilitation wards for elderly people. *Journal of Advanced Nursing*, 19, pp.239-248.

Waters KR (1996) 'Rehabilitation: core themes in gerontological nursing' in Wade and Waters (editors) *A textbook of gerontological nursing: perspectives on practice*, pp. 238-257. London: Bailliere Tindall.

Waters KR and Lukers KA (1996) Staff perspectives on the role of the nurse in rehabilitation wards for elderly people. *Journal of Clinical Nursing*, 5 (2), pp.103-114.

Whitelock H (1999) 'The team', in Davis and O'Connor (editors) *Rehabilitation nursing: foundations for practice*, pp.53-80. London: Baillaire Tindall.

Williams JE (1993) Rehabilitation challenge. *Nursing Times*, 89 (31), pp.66-70.

United Kingdom Central Council (1998) *A higher level of practice: consultation document*. London: UKCC.

## CASE STUDY *continued*

improve the situation. I sat him onto the edge of the bed to assess his sitting balance. Mr B was over-compensating with his right side, causing him to push himself over to the left, with the result that his sitting balance was poor. To counteract this, he needed to begin feeling the floor under his feet and overcome the ‘pushing’ by reaching to the right. I wanted to increase his confidence, while demonstrating to the staff nurse what was achievable.

I found a suitable wheelchair and made sure it had two footplates and a cushion. I sat Mr B well back into the chair, so that he was sitting symmetrically. He did not slip or push – he felt comfortable. A bowl of water was placed in front of him and, with help, he washed and dried his face, hands and trunk. He was able to place both hands in the water and could feel the temperature. I explained that this provided good motor and sensory input.

Mr B needed help to put his shirt on, but I talked him through the technique and he assisted where he was able. Next, I found a mirror and he used his electric razor to shave. He attended to both sides of his face without prompting, making a very thorough job. I asked if he would like to clean his teeth, noting that he appeared to have top dentures and his own lower teeth. He readily agreed and I took him to a bathroom where he was able to manage everything, aside from putting the toothpaste on the brush. Again, he used the mirror to adjust his ‘Bobby Charlton’ hairstyle – his sense of humour was beginning to emerge!

Mr B was tired by the end of the session – it had taken approximately one and a half hours – but both he and his nurse were thrilled with the outcome. We decided that the care plans needed a drastic overhaul and we set about updating them. The main problems were identified as:

- positioning – in bed and in the wheelchair
- handling – transfer from bed to chair; chair to toilet or commode; chair to bed
- management of faecal incontinence
- hygiene needs – washing and dressing
- hemianopia.

Each care plan outlined the problem Mr B was experiencing and how this would be best managed, using a therapeutic nursing approach. Soon his named nurse understood how rehabilitation nurses might make a difference to an individual patient, and how she could be more proactive in her approach to his care. For example, I asked Mr B about his normal bowel habit at home. He told us that he was a little prone to constipation, but he normally went to the toilet after breakfast. We discussed with him whether he would like to use the toilet on the ward at this time, as part of his morning routine. He felt that this would be beneficial

– and from the next morning he became continent of faeces.

We discussed his management with the physiotherapist and occupational therapist (OT). Therapy time is very limited, causing some friction between nursing and therapy staff. We demonstrated how nursing could enhance and build upon the progress made in therapy sessions. As a result, communication and collaboration between the team improved. For example, until we discussed the washing and dressing plan, the OT did not realise where care plans were kept. She agreed that when she worked with Mr B, she would add any further instructions to the nursing plan, ensuring consistency of care.

We all enjoyed the morning’s work and had a great feeling of progress and satisfaction. The staff nurse was enthusiastic about handing over to the afternoon staff, outlining in detail the care we had prescribed and carried out.

I planned a teaching session for Wednesday that week to raise some of the issues. Before I left that day, I went to talk to Mr B. He was very emotional about the day and thanked me. He was concerned when I told him that I would only be working with him this week as part of a teaching programme. However, he seemed reassured when I said that all staff would be involved, and would learn how best to care for patients following a stroke.

He asked me how well I thought he would do. I asked him to allow me a couple more days before committing myself, but we both agreed that honesty would be the best policy. Providing Mr B with information about his stroke, and the reasons for the various aspects of his rehabilitation, meant that he could engage in the programme and work with the team. This open and honest communication enabled him to convey his feelings of uneasiness at being held closely by female nurses during transfers. He told me that he had never had a close relationship with a woman, and felt very embarrassed. Our handling techniques were adapted, and Mr B was able to relax and concentrate on the task at hand, rather than his discomfort.

During the next four days I worked with many of the nursing team and Mr B, seeing that the nursing input was therapeutic, while complementing the other therapists’ goals. By Friday, Mr B’s Barthel index had increased to 8/20. His physical progress meant that he could visit his home with his nephew. This was a significant step in Mr B’s rehabilitation, improving his morale and motivation immensely.

This case study shows how important it is to make sure that emotional and psychological aspects are developed, together with the physical elements of a rehabilitation programme.

# Co-ordination

“The rehabilitation nurse is in a pivotal position to function as the patient advocate and care co-ordinator,” (Moulder, 1988).

The role of co-ordinating a programme of rehabilitation is a complex task. The ‘team’ may consist of many individual professionals, each with their own perspective on treatment goals and plans. It is central to this process that the patient and family have their own goals and ideals (Armentrout, 1993). Teamwork can be defined as a group of people working towards common goals. The rehabilitation nurse is the communication link between all those involved (Johnson, 1995).

Providing accurate and timely information is crucial to rehabilitation care. The nurse has knowledge of each discipline’s rehabilitative therapeutic interventions, as well as a comprehensive understanding of the process of rehabilitation. This allows discussion of the team’s approach with the patient and their family.

Often the nurse has the greatest opportunity among team members for contact with the patient and their family. This contact provides unique opportunities for building close relationships with family members. If there is effective co-ordination and communication, then the patient and family are more likely to be active participants in the rehabilitative process (Benbow and Bowers, 1998), and feel that they have engaged in a partnership (Gallant et al., 2002). This is especially relevant when the patient is transferring from one care setting to another – for example, hospital to community or vice versa. The patient may be anxious at this time and skilled co-ordination facilitates organised and seamless care.

The rise in chronic disease (Symington, 1994; DH, 2005), and the increased provision of rehabilitation to people with degenerative conditions (Baker, Fardell and Jones, 1997), means that rehabilitation will be provided in many different settings (DH, 2005a). The nurse may be there at all stages in the individual’s care, providing continuity, consistency and stability for the patient and family. Community matrons may be well placed to oversee the implementation of Government plans for long-term conditions (DH, 2005b) and particularly to co-ordinate care for the most severe, complex conditions (DH, 2005c). However, all nurses involved in supporting

people with chronic disease are required to develop the more systematic patient-centred approach outlined in National Service Frameworks and other national guidance.

Co-ordination of the programme of rehabilitation is not to be confused with leadership of the team. As Baker and Kratz (1980) state: “Essentially leadership should be fluid, passing from one member to another, depending on the needs of the patient and the importance of each individual discipline’s contribution to the care of the individual patient.” At times, nurses lead the programme of rehabilitation, in addition to undertaking a co-ordinating or supportive role.

## References

- Armentrout GA (1993) Comparison of the medical model and the wellness model: the importance of knowing the difference. *Holistic Nursing Practice*, 7, pp.57-62.
- Baker M, Fardell J and Jones B (1997) *Disability and rehabilitation: survey of education needs of health and social service professionals*. London: Disability and Open Learning Project.
- Barber J and Kratz C (1980) *Towards team care*. Edinburgh: Churchill Livingstone.
- Benbow R, and Bowers L (1998) Rehabilitation using therapeutic community principles. *Nursing Times*, 94 (41), pp. 56-57.
- Department of Health (2005a) *Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration*. Leeds: DH.
- Department of Health (2005b) *The National Service Framework for Long Term Conditions*. Leeds: DH.
- Department of Health (2005c) *Case management competencies*. Leeds: DH.
- Gallant M, Beaulieu M and Carnevale F (2002) Partnerships: an analysis of the concept within the nurse-client relationship. *Journal of Advanced Nursing* 40 (2), pp149-157.

Johnson J (1995) Achieving effective rehabilitation outcomes: does the nurse have a role? *British Journal of Therapy and Rehabilitation* 2 (3), pp113-118.

Moulder P (1988) Making the inter-disciplinary team approach work. *Rehabilitation Nursing*, 13 (6) pp338-339.

Symington DC (1994) Megatrends in rehabilitation: a Canadian perspective. *International Journal of Rehabilitation Research*, 17, pp.1-14.

## Activities

### 1. Attend a multi-professional meeting with a patient and/or carer to discuss intermediate care or discharge arrangements. Afterwards reflect on the following.

- ◆ What was your involvement in the meeting?
- ◆ What areas and aspects of the rehabilitation programme did you present, and why?
- ◆ How did you help to solve any potential problems on behalf of the patient?
- ◆ Who took the main co-ordination role in this case?

### 2. Reflecting on your work with a specific client/patient.

- ◆ List the many other health care professionals you liaised with in relation to this patient's/client's rehabilitation needs.
- ◆ Do you fully understand how their roles differ from and are similar to yours, in terms of care interventions?
- ◆ If you are unsure, make a point of talking to one or two of these professionals to identify what specific issues they addressed with this client.

# Education

It is essential to include education in the definition of rehabilitation. While usually this means patient education, the education of nursing staff is important too.

Sharing information and skills across professional boundaries is vital. Sometimes nurses feel threatened when they hear therapy staff using new terminology and the jargon of rehabilitation. They need to overcome this, developing more collaborative learning opportunities for and with their colleagues, encouraging and supporting further interdisciplinary education and training.

Input on rehabilitation in nurse training and continuing professional development is increasing. This reflects the enabling roles all nurses have in their various specialties, as well as recent Government initiatives. Practice development nurses, consultant and specialist nurses, and practice educators are experts working in clinical areas. They can give educational support, alongside the more formal teaching offered by universities. The Knowledge and Skills Framework (DH, 2005) can help guide an individual's development in their role as a rehabilitation nurse.

Patient education in rehabilitation needs to be well planned. The emphasis is on increasing the skills and knowledge that patients need to take back control and responsibility for their lives. This may lead to increased independence or simply – but very importantly – enable the patient to take control and direct care given by others. These outcomes will depend on the severity of the disability (Smith, 1999).

It is paramount that this empowerment should not be confused with compliance with a lifestyle that has been recommended by health care professionals, however well intentioned. From this point of view, patients need to be seen in terms of their wellness rather than their disability (McMahon and Pearson, 1998). The term 'partnerships in care' has been used frequently to describe the changing relationship between patient and health carer. However, partnership must include power-sharing and negotiation. This can only be achieved if the patient has sufficient information about their own condition and the options available for care (Spiers, 2002).

Informed choice is also emphasised by the Department of Health (DH, 2004) in the white paper, *Choosing health*.

This acknowledges the importance of health care professionals' need for training to provide the necessary help to patients and carers. Likewise, many self-management programmes – through which the knowledge and experience held by patients is valued and developed – have highlighted good examples of partnership. These have led to Government support for the 'expert patient' initiative (DH, 2001).

Education does not simply mean transferring information and facts via a leaflet, or staging a formal teaching session. Rather, it engages patients from the onset of illness, involving them in the process of rehabilitation. It means gently and sensitively guiding them, so that they can incorporate into their new lifestyle what they have learned about their illness and recovery, and what it means. Kirkvold (1997) believes that the 'ultimate justification for health education is that the rights of the individual demand it'.

The rehabilitation nurse can use different teaching strategies to encourage independence, making use of opportunities to teach at the bedside, bathroom, gym or toilet.

Group teaching can be effective for some aspects of rehabilitative education. When a number of patients have similar conditions – such as overcoming the fear of falling – peer support can be a good motivator and the camaraderie can be enjoyable. Teaching in groups also uses time effectively, providing the group is not too large. Nishimoto and Schunk (1987) describe how the social side of group work can be linked to an improvement in cognitive functioning. These sessions can be timetabled and help patients begin to plan for themselves.

Adults learn best when they know why they are being taught (Knowles, 1980). However, each individual has a preferred learning style and this must also be taken into consideration. Pacing, timing and appropriateness of the teaching will determine how much learning takes place. Resources – such as diagrams, models, websites, video filming, 'virtual' education, and video conferencing – can be useful additions.

These all demand advanced skills in assessment, communication, knowledge and technology. They call upon the co-ordinated skills of many of the

interdisciplinary team. The nurse can contribute to assessing the patient's cognitive and intellectual ability, literacy, and any special needs resulting from physical disability – such as dysphasia – or communication difficulties – such as hearing and visual impairments. The nurse also needs to be able to assess the level of pain or discomfort, cultural and language differences, mood, motivation and anxiety. They should be in constant communication with the rest of the team, in terms of the patient's progress.

Nolan et al. (2003) highlight the family's need for education and support. This may not necessarily mean the next of kin, partner or carer, but may be someone else who is significant to the person. The individual must decide how far family members should be included in the rehabilitation process, and their wishes need to be respected, but many will value their involvement.

Rehabilitation nurses should be assertive in their education role. They should provide education and support for patients, families and other staff to ensure that the patient has the best possible opportunity for recovery, independence and control.

## References

- Department of Health (2001) *The expert patient: a new approach to chronic disease management for the 21st century*. London: HMSO.
- Department of Health (2004) *Choosing health: making healthy choices*. London: HMSO.
- Kirkevoid M (1997) The role of nursing in the rehabilitation of acute stroke patients: toward a unified theoretical perspective. *Advanced Nursing Science*, 19 (4), pp.55-64.
- Knowles M (1990) *The adult learner: neglected species*. Houston, Texas: Gulf Publishing Co.
- McMahon R and Pearson A (1998) *Nursing as therapy* (second edition). Cheltenham: Stanley Thornes (Publishers) Ltd.
- Nishimoto and Schunk (1987) Group therapy: an alternative treatment approach. *Clinical Management in Physical Therapy*, 4 (7), pp. 34-36.
- Nolan M, Lundh U, Grant G and Keady J (2003) *Partnerships in family care: understanding the caregiving career*. Maidenhead: Open University.
- Nolan M, Booth A and Nolan J (1997) *New directions in rehabilitation: exploring the nursing contribution*. London: English National Board for Nursing, Midwifery and

Health Visiting (researching professional education).

Nursing and Midwifery Council (2002) *The PREP handbook*. London: NMC.

Royal College of Nursing (2005) *NHS Knowledge and Skills Framework outlines for nursing posts: RCN guidance for nurses and managers in creating KSF outlines in the NHS*. London: RCN.

Smith M (1999) *Rehabilitation in adult nursing practice*. London: Churchill Livingstone.

Spiers J (2002) The interpersonal contexts of negotiating care in home care nurse-patient interactions. *Qualitative Health Research* 12 (8) pp1033-1057.

Thompson I, Melia K and Boyd K (2000) *Nursing ethics* (fourth edition). London: Churchill Livingstone.

## Activities

- Contact your local university and ask what rehabilitation courses or modules are offered. You might consider enrolling on one of these to extend or consolidate your knowledge and skills in rehabilitation.**
- Read the Knowledge and Skills Framework in relation to your post. How does this document help you to identify your education needs in developing rehabilitation skills?**
- Check the goals you have set with a patient.**
  - ◆ What teaching strategies are used for that patient?
  - ◆ Have you recognised the patient's own knowledge of their condition?
- Observe the nurses and other health care professionals in your ward or clinical area. Record which patient interactions make use of opportunities for teaching patients and/or family members.**

## Suggested further reading

- Davis S (1999) 'The relationship between health promotion and rehabilitation' in Davis and O'Connor (editors) *Rehabilitation nursing: foundations for practice*, pp.207-219. London: Baillière Tindall.
- Hinchliffe S (1999) *The practitioner as teacher* (second edition). London: Baillière Tindall.
- Rogers C (1983) *Freedom to learn for the 80s*. Columbus, Ohio: Charles E. Merrell.

# Empowerment and advocacy

The rehabilitation nurse will focus on enabling the patient to be as autonomous as possible – that is ‘to make self-determining choices’ (McCormack, 1993). Indeed the NMC (2004) *requires* the nurse to respect patients’ autonomy and choices concerning their lives.

Empowerment means involving patients in their own care and providing information, support and encouragement that enables them to participate in decision-making. Zimmerman and Warschausky (1998) propose that empowerment is ‘the cornerstone of identity’ and that people with rehabilitation needs are now recognised not for ‘deficits and dependence’ but by focusing on ‘assets and independence’. Restoration of identity can be seen as the ultimate aim of rehabilitation.

Patients are empowered through a process of communication and collaboration between the patient and the health care professional. ‘Empowerment is not bestowed on the individual by the professional’ (Zimmerman and Warschausky, 1998), but is a joint goal. The nurse may work with an individual or with groups of people to enable them to make decisions regarding their lives. Empowerment is motivating, enhances ‘wellness’ and provides opportunities for patients to ‘develop knowledge and skills and engage with professionals as collaborators, instead of as authoritative experts’ (Perkins and Zimmerman, 1995).

Advocacy is defined as ‘speaking in favour of someone or something’ or ‘to plead a cause’ (Oxford Dictionary, 1994). Patient advocacy is thought to be ‘an integral part of the nurse’s role in health care delivery in the United Kingdom’ (Mallik, 1998), especially where patients are unable to fully represent themselves. However, it must be emphasised that enabling an individual to express their own views and needs is the preferred option. A nurse should act as an advocate only in circumstances where this is not possible, and where the nurse is confident the views and interests of that person are fully understood.

As previously recognised in this booklet, the rehabilitation nurse spends considerable amounts of time with the patient and their family. Therefore it seems reasonable that the nurse can represent their views and values, if they feel unable to do so themselves.

For the nurse working in mental health settings, this is especially pertinent. The Mental Capacity Act (2005) provides a statutory framework to empower and protect vulnerable people who are not able to make their *own* decisions. However, nurses must not underestimate the effect their own values and beliefs may have on any situation. In such cases it may be beneficial to use an external advocacy service – for example, the Patient Advisory Liaison Service (PALS).

If there is disagreement or conflict in treatment programmes or with discharge planning, the rehabilitation nurse may find it necessary to facilitate discussion between family members, or professionals and family members. Clear and effective communication helps to avoid misunderstandings. It is crucial to prevent advocacy being used as a ‘metaphor for conflict’ between different health care professionals.

Decisions affecting the patient’s future may be challenging, especially where a health care professional or the patient suggests ending treatment. Basile (1998) suggests that ‘nurses often encounter feelings of helplessness and anger in trying to be a good advocate’. It may be possible to reduce these tensions through multidisciplinary meetings, where issues can be discussed and communication improved. In these circumstances the rehabilitation nurse may find critical thinking and reflection helpful in resolving conflict or professional issues (Martin, 1998).

## References

- Basile CM (1998) Advance directives and advocacy in end-of-life decisions. *The Nurse Practitioner*; 23 (5), pp.44-60.
- Bonney K (1999) ‘Delivering care’, in Davis and O’Connor (editors) *Rehabilitation nursing: foundations for practice*. London: Baillière Tindall.
- Department of Health (2005) *Mental Capacity Act 2005: a summary*. Online at [www.dh.gov.uk](http://www.dh.gov.uk)
- Mallik M (1998) Advocacy in nursing: perceptions and attitudes of the nursing elite in the United Kingdom. *Journal of Advanced Nursing*, 28 (5), pp.1001-1011.

- Martin G (1998) Empowerment of dying patients: the strategies and barriers to patient autonomy. *Journal of Advanced Nursing*, 28 (4), pp.737-744.
- McCormack B (1993) How to promote quality of care and preserve patient autonomy. *British Journal of Nursing*, 2(6), pp.338-341.
- Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics*. London: NMC.
- Perkins DD and Zimmerman MA (1995) Empowerment theory, research and application. *American Journal of Community Psychology*, 23 (5), pp.569-579.
- Zimmerman MA and Warschausky S (1998) Empowerment theory for rehabilitation research: conceptual and methodological issues. *Rehabilitation Psychology*, 43 (1), pp.3-16.

## Further reading

- Snowball J (1996) Asking nurses about advocating for patients: reactive and proactive accounts. *Journal of Advanced Nursing*, 24, pp.67-75.
- Willard C (1996) The nurse's role as patient advocate: obligation or imposition? *Journal of Advanced Nursing*, 24, pp.60-66.
- Woodrow P (1997) Nurse advocacy: is it in the patient's best interests? *British Journal of Nursing*, 6 (4), pp.225-229.

## Activities

1. **Contact your local PALS to find out how patients and carers may be given independent support.**
2. **Find out about any local expert patient programmes, or use the internet to find out more about the expert patient programmes already established in other areas.**
3. **Consider this scenario:**

*Mr Cooper has been discharged home, following surgery for a fractured neck of femur. Despite being independently mobile in the hospital, he insists on having a commode in the living room, against his partner's preferences. While his home assessment found him to be able to safely manoeuvre to the toilet,*

*he says that it takes him too long to get there and back.*

Does your role as patient advocate conflict with your role as rehabilitation nurse/adviser?

Think through how you might approach this issue to gain an outcome acceptable to both Mr Cooper and his partner.

# Political awareness

In order to influence services and improve care rehabilitation nurses need insight into political developments. In 1999, the Government set out its plan for reshaping the future of nursing in the UK, when the Department of Health in England published the white paper, *Making a difference*. Since devolution, there have been variations in both health policy and the pace of change in Scotland, Wales and Northern Ireland. However, fundamental to the UK-wide vision is a commitment to 'strengthening the nursing, midwifery and health visiting contributions to health and health care'.

An earlier study of disability and rehabilitation (Baker, Fardell and Jones, 1997) recommends that an organisation be created to 'bring together government, professional, educational and consumer organisations to improve the quality of care and services for people with disabilities and those with progressive and unstable conditions'. Since then, the NHS Plan (DH 2000a) heralds a number of health and social care policies that acknowledge the importance of promoting and supporting patient independence.

The Audit Commission (2000) identified systems that provided rehabilitative intermediate care services away from acute hospital wards, thereby reducing admissions and enabling more effective discharge from these areas. This was timely, since the National Beds Inquiry (DH, 2000b) reported on the number of beds being 'blocked' by people waiting for discharge plans to be realised. Much of the delay had been due to the scarcity of rehabilitation services in the community and complex funding issues.

The National Service Framework for Older People (2001) firmly establishes and targets intermediate care as a means of supporting patients to maximise their potential independence. An integrated budgeting and commissioning process facilitates this evolution, offering potential for more appropriate person-centred care.

While the role of rehabilitation in intermediate care has been clarified and its profile raised, now the challenge is to recruit and train appropriate health and social care professionals in rehabilitation. Many nurses have risen to the call and are not only making significant contributions to the service, but are also leading rehabilitation teams. Developing competency in

rehabilitation may be facilitated by the Skills for Health and Knowledge and Skills Frameworks (KSF) (RCN 2005), which propose to have the 'right workforce, in the right place at the right time'.

Squires (2002) reflects some initial concerns from social care providers that although the policy agenda emphasises joint working, delivery and financing, their roles may be marginalised and traditional values challenged. Some nurses may harbour similar apprehension and uncertainty, struggling to change their previously nurturing and paternal care to a more empowering and enabling approach, which places the patient/client in a greater position of power. Interdisciplinary working, and the preferred integrated approach fostered by intermediate care, requires further blending and blurring of roles, as well as more inclusive systems of working with the voluntary and independent sector (Davis, 2005).

Whilst intermediate care has been instrumental in promoting and developing rehabilitation services, some policies and directives have focused attention on specific groups. These include the National Service Framework for Children, Young People and Maternity Services (2004), which recognises the needs of children with disability. More recently, the National Service Framework for Long Term Conditions (DH, 2005) has clearly identified the vital role of rehabilitation for people with neurological conditions. It devotes three of its 11 quality requirements to acute, community and vocational rehabilitation.

## Local awareness

The development of primary care trusts (PCTs) in England has brought new ways of commissioning services and how they are organised and delivered. Proposed changes, and the consequences of practice-based commissioning (PBC), will further influence how services are organised and delivered. Nurses working within the area of rehabilitative services must continue to contribute to arrangements locally, by highlighting health needs and shortfalls in services. Opportunities to influence the quality agenda locally should be taken wherever possible.

## The Healthcare Commission

In the England, the Healthcare Commission (HCC) has continued to drive and monitor the Government's quality improvement plans. It is now overseeing the Audit Commission and National Care Home Inspectorate.

In Wales, the commissioning powers belong to local health groups (LHGs), which work in a similar way to their English counterparts in developing the health improvement plan (HIP).

In Scotland, both the terminology and approach are slightly different. Health improvement plans (HIPs) are the responsibility of the local health boards, while trust implementation plans (TIPs) are developed by the primary care trusts and acute hospital trusts, respectively. In primary care, the local health care co-operative (LHCC) is a voluntary structure that works with the primary care trust to formulate the TIP, which then feeds through to the HIP.

In Northern Ireland, the plan is to establish primary care co-operatives (PCCs) along much the same lines as the other three countries. However, progress has necessarily been delayed through the political situation and these are not yet up-and-running. The Department of Health and Social Services and the new Northern Ireland Health Minister are currently reviewing the situation.

## National awareness

Successive governments have proposed changes to modernise the NHS. *Making a difference* (1999) and the NHS Plan (2000) outlined a quality framework for nursing care in England. More recent Government directives – such as *Our health our choice, our say* (DH, 2005) – promise to provide more support to people with long-term needs, and expand the expert patient programme through joint health and social care teams. In its chapter, *Care closer to home* recommendations are proposed for an increase in community care and facilities that may see rehabilitation nurse specialists playing a key role in this service provision. Nurses working in Scotland, Wales and Northern Ireland will find slight variations in health policy, with different approaches to care, as discussed earlier.

The RCN Rehabilitation and Intermediate Care Nursing Forum can provide a voice to channel information and advice about any aspect of rehabilitation between members and the RCN leadership. Becoming involved in forum activities – for example, by attending a conference, becoming a member and reading the newsletters – will increase awareness of the development of rehabilitation nursing, the political context and services in the UK.

## International awareness

Hoeman (2002) looks forward to more international collaboration between rehabilitation nurses. Rehabilitation and service provision varies in different countries with many of the differences culturally or economically driven. It is interesting for rehabilitation nurses to extend their knowledge and skills through contacting or visiting rehabilitation facilities abroad. Alternatively, you can attend international conferences organised every two years by the RCN Rehabilitation and Intermediate Care Nursing Forum networking with fellow rehabilitation nurse from around the world.

Here are some useful international contacts.

- ◆ The Association of Rehabilitation Nurses (USA): [www.rehabnurse.org](http://www.rehabnurse.org)
- ◆ The Australasian Rehabilitation Nurses Association (ARNA): [www.arna.com.au](http://www.arna.com.au)
- ◆ RCN Rehabilitation and Intermediate Care Nursing Forum  
20 Cavendish Square  
London W1G 0RN  
[www.rcn.org.uk](http://www.rcn.org.uk)
- ◆ RCN International Office  
20, Cavendish Square  
London W1G 0RN  
email: [international.office@rcn.org.uk](mailto:international.office@rcn.org.uk)
- ◆ National Rehabilitation Information Centre (USA): [www.cais.com/navic/](http://www.cais.com/navic/)
- ◆ Rehabilitation in Multiple Sclerosis (RIMS) – a network of European MS rehabilitation services and multidisciplinary teams: [www.rims.be](http://www.rims.be)

## The influence of senior nursing roles in rehabilitation

Intermediate care and rehabilitation specialist nurse posts are now integral to many interdisciplinary teams in acute and community trusts, in many cases acting as co-ordinators or team leaders. In particular, the growth of intermediate care services across the country has provided many opportunities for nurses to influence and develop rehabilitation services for people with disabilities.

Consultant nurses specialising in stroke care, rehabilitation and intermediate care are expert practitioners who remain in clinical practice. Their roles have an important strategic and service development function and are afforded similar levels of recognition and autonomy as their medical consultant colleagues, making these important levers for change and quality improvement. They 'provide a stronger focus for clinical leadership, helping to improve quality and shape services to make them more responsive' (DH, 1999).

The NHS Improvement Plan (2004) describes a new clinical role for nurses. Known as community matrons, these experienced, skilled nurses use case management techniques with patients who meet a criteria that denotes high intensity use of health care. With special intensive help, these patients are able to remain at home longer and to have more choice about their health care. The case management work of community matrons is central to the Government's policy for the management of people with long-term conditions.

## References

- Audit Commission (2000) *The way to go home: rehabilitation and remedial services for older people*. London: Audit Commission.
- Baker M, Fardell J and Jones B (1997) *Disability and rehabilitation: the case for action*. London: Disability and Rehabilitation Open Learning Project.
- Davis S (2005) *Rehabilitation: the use of theories and models in practice*. Edinburgh: Churchill Livingstone.
- Department of Health (1999) *Making a difference*. London: DH.
- Department of Health (2000) *The NHS Plan: a plan for investment, a plan for reform*. London: DH.
- Department of Health (2000b) *National Beds Inquiry*. London: DH.
- Department of Health (2004) *The National Service Framework for Children, Young People and Maternity Services*. London: DH.
- Department of Health (2004) *The NHS Improvement Plan: putting people at the heart of public services*. London: DH.
- Department of Health (2005) *The National Service Framework for Long Term Conditions*. Leeds: DH.
- Department of Health (2005) *Our health, our care, our say*. London: DH.
- Elliott A (1999) 'The specialist nurse in rehabilitation' in Davis and O'Connor (editors) *Rehabilitation nursing: foundations for practice*. London: Baillière Tindall.
- Hoeman S (2002) *Rehabilitation nursing: process, application and outcomes* (third edition). St Louis: Mosby.
- National Institute for Health and Clinical Excellence (NICE): [www.nice.org.uk](http://www.nice.org.uk)
- Royal College of Nursing (2005) *NHS Knowledge and Skills Framework outlines for nursing posts: RCN guidance for nurses and managers in creating KSF outlines in the NHS*. London: RCN.

## Suggested reading

There are a number of other useful documents published by the Department of Health. Alongside those referred to above, they can be read or downloaded free on the Department of Health's website: [www.doh.gov.uk/public/wgpaper.htm](http://www.doh.gov.uk/public/wgpaper.htm) :

- ◆ The new NHS, modern, dependable
- ◆ Saving lives: our healthier nation
- ◆ Caring about carers
- ◆ The National Service Framework for Older People.

You might also like to visit the Skills for Health website: [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk)

## Activities

1. Make contact with a nurse or a rehabilitation facility in a different country. Write a comparative reflection of similarities and differences. Consider sending it for publication in the forum's newsletter, *Step Forward*, or the information board/intranet where you work.
2. Find out if your trust has a consultant practitioner or specialist nurse in rehabilitation. If so, make contact with them to find out more about their work.
3. Contact the RCN to ask how you might become more involved in promoting the role of the nurse at a local, national or international level.

# Advice and counselling

It is not unusual to include counselling when defining the role of the nurse in rehabilitation. Most nurses require well-developed skills in this field. However, there is a dilemma, as counsellors do not usually offer advice or try to help solve the client or patient's problems. On the other hand, nurses spend a great deal of their time in problem-solving with or on behalf of the patient. Also, much of their work involves health promotion – therefore advice. However, both advice and counselling are skills required by nurses working in rehabilitation.

Tschudin (1995) differentiates between advice, which makes reference to feelings, and counselling which starts with feelings. She suggests that counselling involves listening to the person as a whole and being willing to use ourselves in the process. The individual needs to know that they have been heard and understood.

However, the British Association for Counselling and Psychotherapy (2007) says that it is 'a way of enabling choice or change'. Further it is an opportunity 'to explore various aspects of life and feelings, talking freely and openly in a way that is rarely possible with friends or family'.

Rehabilitation nurses can use counselling skills to support the emotional needs of their patients. For example, Nolan and Nolan (1998) draw attention to the need for nurses to adopt a stronger role in counselling and health promotion in cardiac rehabilitation. They suggest that nurses could effectively manage cognitive behaviour therapy – for example, advising dietary changes and supporting patients to give up smoking – and also take a more dominant role in giving honest and realistic advice.

By skilled listening, focusing and clarifying, the nurse can help the patient think about the options available, both in the short and long-term. Challenging these options, and teaching the patient problem-solving skills, can allow the patient to exercise control over the decision-making process, restoring self-esteem. Nurses must recognise the limit of their competence and, when necessary, refer the patient to more experienced professionals, such as psychologists and professional counsellors.

They must also accept that their input is likely to be temporary and short-lived. It is often given in response to a crisis situation, for example when the patient acknowledges the consequences of the disability. However, knowing how to give time to talk and make time to listen is an invaluable skill, demonstrating the importance that the nurse attaches to the patient as a whole person.

In their advisory role, nurses help patients to set goals which are realistic and achievable. They then support them in the implementation of the care that is planned as a result. Once long-term objectives are agreed, they help the patient divide them into short-term goals that are quicker to achieve. This motivates the patient to continue along what can be a difficult journey of recovery.

Nurses may also advise on equipment, as well as behavioural, social, emotional or physical aspects of care, as part of their health promotion role. The experienced nurse will be able to balance this against the less directive elements of counselling.

Nurses involved in counselling need to recognise the stresses involved in the work they do, finding support for themselves through co-counselling, support groups or clinical supervision.

## References

- British Association for Counselling and Psychotherapy (2007) *What is counselling?* Online at: [www.bacp.co.uk](http://www.bacp.co.uk)
- Nolan M and Nolan J (1998) Cardiac rehabilitation following myocardial infarction. *British Journal of Nursing*, 7(4), pp. 219-225.
- Thomson I, Melia K and Boyd K (2000) *Nursing ethics* (fourth edition). New York: Churchill Livingstone.
- Tschudin V (1995) *Counselling skills for nurses* (fourth edition). London: Baillière Tindall.

## Activity

1. **Consider the quotes below. As a nurse, how do you identify with these thoughts in your rehabilitation role?**
  - ◆ “Supporting is the skill of giving sustained help.”
  - ◆ “We stand beside them, behind them or in front, but not in their place.”
  - ◆ “When people spoke a lot they looked...very little; when they listened a lot they also looked a lot” (Fast, 1978).
  - ◆ “The fact that we deal with people who are vulnerable makes us vulnerable too.”
  - ◆ “We help the person, not the problem.”

Reference: from Tschudin V (1995) *Counselling skills for nurses* (fourth edition). London: Baillière Tindall.
2. **Reflect on your most recent day at work. How much time did you spend actively listening to your patients during the day?**
3. **In what ways do you feel rehabilitation nurses are vulnerable?**

## Suggested further reading

Sayre-Adams J and Wright S (1995) *The theory and practice of therapeutic touch*. New York: Churchill Livingstone.

# Clinical governance

Clinical governance is defined as ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care’ (DH, 1999).

The three elements included in the framework are:

- ◆ clear lines of responsibility and accountability
- ◆ quality improvement
- ◆ risk management.

Guidance from the RCN (2000) promotes clinical governance as ‘everyone’s business’. For it to work, all professionals and all levels of staff should be involved. Hence its inclusion as a specific role for the rehabilitation nurse.

Clinical governance involves creating and auditing health care environments in which effective rehabilitation flourishes. It aims to tackle some of the differences in the quality of care that exist across geographic and specialty boundaries. To some extent this workbook has similar objectives: it attempts to explore and make explicit the rehabilitative nature of nursing, and its impact on the quality of care in all health care situations.

The idea that the nurse is an essential presence in the rehabilitation team is still relatively new in some areas. One of our first responsibilities in fulfilling this therapeutic role is to find evidence of effective rehabilitation nursing practice. Many of us rely on anecdotes, gained through our experience as rehabilitation nurses. There are few audit or research projects available to confirm that real improvements in patient outcomes are the direct result of nurses working within rehabilitative frameworks.

As a result, we welcome the emergence of qualitative research. Its value lies in its ability to explain more precisely the complex role of the nurse in rehabilitation. The work of Waters and Luker (1996) and Sheppard (1994) provides local evidence of the changing culture of nursing in rehabilitation settings. However, quantitative data has been scarce, although more is being produced under the banner of clinical governance. Hopefully this will support nurses in their rehabilitative role.

Validated and reliable patient outcome measurements are essential to ensuring and demonstrating effective high quality care. The tools to undertake these measurements may come from improved national and international networking, benchmarking, and collaboration between rehabilitation nurses from different specialties and areas.

Nurses have an essential contribution to make to the scoring of formal interdisciplinary outcome measures – such as the Barthel index (Mahoney and Barthel, 1965), functional independence measure (FIM) and UK FIM + FAM (functional assessment measure) (Turner-Stokes et al., 1999a). In these measures of patient ability and rehabilitation progress, patients are scored on what they actually do in practice, rather than what they are capable of in an ideal setting. In this respect the nurse’s perspective is often more accurate than a treating therapist, as it more closely reflects how a patient might perform at home, without prompting.

Validated measures of rehabilitation nursing dependency – such as the Northwick Park nursing dependency score (Turner-Stokes et al., 1998) and Northwick Park care needs assessment (Turner-Stokes et al., 1999b) – can show clear progress towards independence, and a reduction in care hours required over a period of rehabilitation. These specifically relate to areas of nursing intervention, and potential cost savings for care in the community can be demonstrated.

Whether incorporated in computer networks or paper-based documents, multidisciplinary clinical protocols that clearly state nursing interventions in rehabilitation – for example, integrated care pathways – may also provide evidence of nurses’ contributions. Likewise structured evidence-based guidelines, such as *The essence of care* (DH, 2006), which encourages service audit and benchmarking with other similar services, can begin to identify where nurses make a difference. There is also flexibility to customise these guidelines to reflect important aspects of rehabilitation care, such as patient education and encouraging autonomy and independence.

The National Institute for Health and Clinical Excellence (NICE) is responsible for providing national guidelines on the promotion of good health and prevention of ill

health. To date, NICE has produced evidence-based guidance on a number of conditions particularly relevant to rehabilitation nurses – for example, falls, multiple sclerosis and chronic fatigue syndrome. Services are encouraged to measure their performance against these guides.

Risk management, a key element in clinical governance, is not new to nurses. Our professional code of conduct (NMC, 2004) underlines the nurse's responsibility to ensure that the patient comes to no harm. Nurses are used to carrying out risk assessments and audits, but there are some areas of rehabilitation practice that pose potential dilemmas for nurses.

Since much of our work is based on promoting independence in patients and, in some cases, allowing a degree of calculated risk, many nurses have found the European Directive on manual handling restrictive. The key to this issue is the accurate, continual assessment and recording of risk at each stage, but further research is required into this difficult area. The RCN Rehabilitation and Intermediate Care Nursing Forum has encouraged and supported nursing research at Salford University on the subject of moving and handling patients during the rehabilitation process. The findings of this study are eagerly awaited.

## References

- Department of Health (1998) *A first class service: quality in the new NHS*. London: The Stationery Office.
- Department of Health (2006) *The essence of care: benchmarking for promoting health*. London: DH.
- Nursing and Midwifery Council (2004) *The NMC code of professional conduct: standards for conduct, performance and ethics*. London: NMC.
- Royal College of Nursing (2000) *Clinical governance: how nurses can get involved*, p.3. London: RCN.
- Sheppard B (1994) *Looking back, moving forward: developing elderly care, rehabilitation and the nurse's role within it*. Brighton: Brighton Health Care NHS Trust.
- Smith M (1999) *Rehabilitation in adult nursing practice*. London: Churchill Livingstone.
- Turner-Stokes L, Tonge P, Hunter M, Nielson S and Robinson I (1998) The Northwick Park dependency scale – a measure of nursing dependency that translates

into care needs in the community. *Clinical Rehabilitation*, 12, 304-319.

Turner-Stokes L, Nyein K, Turner-Stokes T and Gatehouse C (1999a) The UK FIM + FAM: development and evaluation. *Clinical Rehabilitation*, 13, 277-288.

Turner-Stokes L, Nyein K and Halliwell D (1999b) The Northwick Park care needs assessment (NPCNA) – a directly costable outcome measure in rehabilitation. *Clinical Rehabilitation* 13, 253-268.

Waters K and Luker K (1996) Staff perspectives on the role of the nurse in rehabilitation wards for elderly people. *Journal of Clinical Nursing*, 5 (2), pp.103-114.

## Activities

- 1. Do you know how your organisation is taking forward the principles of clinical governance? If your trust has an intranet, look at the clinical governance page. What are the implications for rehabilitation in your specialty?**
- 2. Look at the NICE website – [www.nice.org.uk](http://www.nice.org.uk) – and select guidance on an area which is pertinent to your practice. How can you deliver care that meets these required standards?**
- 3. Reflect on one working day, writing down the activities you performed in your role as a rehabilitation nurse.**
  - ◆ What evidence base can you find for your actions?
  - ◆ Did you enable or disable your patient in any way?

## Suggested further reading

Whitelock H (1999) 'The team' in Davis and O'Connor (editors) *Rehabilitation nursing: foundations for practice*. London: Baillière Tindall.

# Conclusion

This workbook has been designed to give you the opportunity to examine and extend your practice and experience in the field of rehabilitation nursing. It is not intended to be an in-depth study for those working solely in specialised rehabilitation units, nor for any specific age group or branch of nursing, but for all nurses in all care settings.

Changing the emphasis from acute in-patient care towards care closer to home requires nurses to be more innovative and creative in their approach to rehabilitation. The evolving role of the nurse in rehabilitation will lead to practice based on evidence, challenging you to become actively involved in research and education.

When rehabilitation is included in all pre- and post-registration curricula, its importance to all branches of nursing will be clearer. Understanding the nature of rehabilitation nursing will enable nurses to underpin their practice with a sound theoretical base.

Nurses at all levels play a vital role in helping individual patients maximise their independence, exercise choice and regain control in their lives. Working at advanced levels of rehabilitation, specialist and consultant nurses provide practical support, promote and enhance the therapeutic dimension of rehabilitation nursing and raise the profile of the role of the nurse in rehabilitation.

Completing this workbook will give you a foundation on which to build further knowledge and expertise in rehabilitation. We hope you will be inspired to introduce rehabilitative approaches to providing care, and to influence service developments in your area.



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