Nursing aspects of geriatric rehabilitation

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Rehabilitation, the steady progress of the patient from a state of relative dependence to the greatest degree of independence of which she is capable, involves the progressive withdrawal of nursing care, which must be skilfully adjusted to the patient's increasing capabilities. For this reason the first requirement of a nurse working in geriatric rehabilitation is that she should be an adaptable person, receptive to the idea that phased withdrawal of nursing care is as important as giving the traditional nursing care in which she has been trained. She must also be possessed of the clinical judgement to assess for herself, to a certain extent, these changes in the patient's capabilities.

This adaptability in the nurse is reflected also in the nursing care which she gives to the patient in the acute stage of the illness, whether this be a stroke, chest infection, injury or any other illness which causes the patient to be temporarily acutely sick. The medical and nursing treatment of the acute condition will have to be modified in geriatrics so as to allow rehabilitation to take place when the acute stage is over. Rest has but a small part to play in the treatment of acute illness in the elderly, and in general it is usually safe to allow the elderly patient to do as much as she feels up to doing. In the treatment of such conditions as cardiac infarction and acute rheumatism general physicians and paediatricians are now beginning to follow the geriatric lead. At the beginning of the illness the nurse must take care to prevent those complications of inactivity which would later hinder rehabilitation. The prevention of pressure sores by regular turning of the patient and by such mechanical aids as alternating pressure mattresses, the prevention of foot drop by the use of a cradle in the bed, the prevention of joint contractures by putting all the joints through a full range of movement several times a day, are all vital precautions in nursing the acutely-ill geriatric patient who will later come to rehabilitation. Of particular importance is the prevention of frozen shoulder in the hemiplegic patient; by raising the hemiplegic arm right above the patient's head every time she goes to the bedside the nurse will be able to prevent a painful and disabling complication which could take months to cure. Similarly the nurse has to be vigilant at this stage to prevent faecal impaction with its attendant horrors of double incontinence, demoralization, excoriated skin and all too often catheterization of the bladder with consequent urinary tract infection. Muscle weakness and mental apathy or confusion, from inactivity and lack of environmental stimuli, are other complications of any acute illness which will prejudice rehabiliation, and again the nurse should be persistent in guarding against those things. In practice all these complications are most easily avoided by getting the patient up and dressed in her own clothes and shoes at the earliest possible moment, and the good nurse will learn to recognize this moment.

What the nurse needs to understand

As the acute illness, with its attendant need for full nursing care, phases into the stage of recovery and rehabilitation, the nurse needs understanding of several things. First, she needs to understand the nature of the patient's illness so that she will know whether relapses or other symptoms could be precipitated by activity. For instance it is important for her to know whether dyspnoea in an obese woman is the result of obesity and being 'out of training' or whether this may be a symptom of relapse of the patient's recent cardiac failure. Again she will need to know whether the patient suffers from depressive symptoms which have no organic basis. Secondly, she will need to understand a little of the psychology of the older patient. There is a natural tendency

for old people to withdraw, detach themselves from their environment and become increasingly dependent on others, and the return to independence after illness may not be spontaneous, but often needs to be deliberately fostered in them. The forgetfulness, the slowness in understanding and in learning anything new, such as the use of a walking aid, the tendency to reminisce instead of concentrating on the matter in hand, all these things demand understanding, kindness and patience on the part of the nurse. She should also know something about the common emotional disturbances in old people who come into hospital—the emotional lability of pseudobulbar palsy for instance, or, very important, the conflicting fears of never getting well enough to go home and having to go home while not well enough to manage. This is a common cause of emotional conflict in the elderly patient in hospital. She should also understand the frustrations which occur when all power and authority has been passed on to the next generation, frustrations which may lead the patient to use the only effective action which remains against a seemingly hostile world—bedwetting. Thirdly, every nurse working in rehabilitation must understand its aims and its scope and she must be in agreement with them. Just one nurse who believes only in loving care, the equivalent of the 'smother-love' of the over-protective mother, can undo all the progress achieved by a whole rehabilitation team.

The atmosphere—and spoiling it

Successful rehabilitation depends so much on providing the motive for the patient and the atmosphere round the patient. The patient has to see independence and return to community life as a normal and desirable thing; for this reason she must be made to understand that there will be a secure life adapted to her capabilities when she reaches her maximum independence. There is no place for threats of permanent hospital internment in the attempt to motivate the rehabilitation patient. The accent must be on a constructive and realistic plan for the future. Secure in the knowledge that rehabilitation will proceed and the future life will be planned according to her abilities, the patient becomes free to respond to the rehabilitation atmosphere around her.

This atmosphere flourishes best in a ward where every patient is up, dressed, making progress, quietly but firmly expected to do her best, and treated as an individual, accorded the dignity of retaining her own clothes and personality and as far as possible a little authority. The system of progressive patient care which groups together patients with similar nursing needs greatly facilitates the establishment of the rehabilitation atmosphere around those patients who need it. A good rehabilitation ward is one form of therapeutic community. The nurses, present in the ward all the time, will largely make and maintain this atmosphere, but anyone can easily spoil it. The nurse must be on her guard against anyone spoiling her carefullly built up atmosphere and be ready to educate such a person.

I can illustrate this with an anecdote from my own experience. I used to share a ward with a surgeon whose patients were mostly about 30 years younger than mine. Every morning a clerk would bring along a menu from which the patients selected their choice of meals for the day. After a time a vigilant staff nurse on the ward began to wonder why all the geriatric patients seemed to have mince and milk pudding for every meal, and we then discovered that the clerk was showing the menu to the surgical patients only, as in her opinion the geriatric patients would not know what they wanted to eat. Now most of these patients were mentally alert women undergoing physical rehabilitation; one of them has since returned to full-time work as a secretary with the local gas board. She and her companions certainly did know what they wanted to eat, and when this thoughtless and rather distressing behaviour on the part of the clerk was corrected morale in the ward rose a good deal and the patients made more progress.

The rehabilitation atmosphere in the ward affects the patient's relatives also. When

they visit and see the patient up and dressed in a ward that is a hive of activity, they begin to feel that the patient is recovering and will soon be leaving hospital. They then add their own encouragement which adds to the therapeutic effect.

With doctors, therapists and aides of all kinds taking part in the patient's formal rehabilitation treatment it is up to the nurse to make sure that the patient realizes who all these people are, what they are doing, and how they are all working together to help her regain her independence. The patient as an individual has a right to know this, and she will only be fully motivated and co-operative in rehabilitation if she understands both the ultimate aim and the means whereby the therapeutic team hope to achieve this aim. When I was working as a registrar in Hastings, a woman whom I examined in the outpatient clinic was heard to complain that she had not seen the specialist, only 'his call girl'. This is an extreme example of mistaken identity in hospital, but it does illustrate the point. Although we tell our patients who we are they do tend to forget, they get flustered, they cannot read the name badges on our lapels and they get into a general muddle about the large numbers of hospital staff and their functions. It is the nurse, on the ward for long periods of time, familiar and trusted, who is the only person able to keep most elderly patients *au fait* with the plans for their rehabilitation and the people involved.

Practical nursing and rehabilitation

Let us now consider the more practical nursing aspects of rehabilitation. It is one of the most important duties of the nurse in rehabilitation to ensure that the physical functions of which the patient is capable are translated into useful daily activities and used as such. This has two effects: It gives the patient further practice in her activities and it adds meaning to her achievement. The difference between walking in the physiotherapy department and walking to the lunch table, or between learning to dress and dressing because one is getting up in the morning, constitutes the difference between formal physiotherapy or occupational therapy and true rehabilitation, which relates the patient to her everyday life in the environment, which is temporarily a ward environment. The nurse, as part of the ward environment, constantly present, is the only person who can do this. She is the one who takes over where the other members of the rehabilitation team leave off, to co-ordinate the different facets of rehabilitation treatment into living.

One thing is essential for this: the nurse must keep herself informed of the patient's capabilities. She must either establish regular contact with the physiotherapist and occupational therapist to learn of the patient's progress, or she must observe the patient having formal treatment on the ward. Conversely, if the patient's condition is temporarily affected by something simple like a barium x-ray examination, the nurse can keep the physiotherapist and occupational therapist informed of this minor reduction in the patient's stamina. The nurse also needs to know and to practise some of the practical aspects of physiotherapy, occupational therapy or even speech therapy, in the same way as she needs to know a little medicine. For instance, if the patient is having daily walking training with the physiotherapist, the nurse should not only give short frequent walks on the ward and make these purposive (e.g. walking to the toilet or the meal table) but she must also be sure that she is training the patient correctly and in the same way as the physiotherapist is doing it. She therefore has to know the right way for a patient to get up from a chair and to get her balance before starting to walk and she must know the right way to use each type of walking aid. By the same token she should know how the patient should be dressing herself, and details of the use of dressing, feeding and other aids supplied by the occupational therapy department, and she should know whether a patient with speech difficulty is dysarthric or dysphasic, and the best way to converse with the patient in each case.

The nurse should also make sure that the patient makes proper use of rehabilitation

aids, using her walking aid rather than hanging on to furniture, using the wall-rails provided to get up from the toilet, sitting in the type of chair appropriate to her needs, and she must make sure that each patient has the appropriate walking aid (for her exclusive use) beside her and not left behind her at the other end of the ward. She must ensure that the patient puts on her shoes and keeps them on all day, and that she does not get separated from her glasses, her hearing aid, her dentures, her wig, or any other device which keeps her at ease in her environment. It is the duty of the nurse to see that a patient with a hemiplegia or hemianopia has her bedside locker or table placed on the unaffected side of her, so that she can both see and reach it, thus encouraging independence. The nurse must be careful not to approach a patient with hemianopia from the blind side, she must learn not to support a tottery patient from behind, not to speak to or otherwise distract the patient who is concentrating on walking, and not to do anything which may cause the patient to turn her head sharply, compress a vertebral artery and drop to the floor. It is attention to these and many other details which make a nurse into a good rehabilitator.

It is the duty of the nurse to see that the patient's rectum does not get overloaded and to train the bowel to act regularly, if necessary by introducing a suppository at the same time each day; after an interval it should be possible to discontinue the suppositories and the bowels will still act regularly at the same time. This is very important if the patient is to leave hospital, particularly if she is going to live in a welfare home with other people. The habit of two-hourly bladder emptying with resulting continence can likewise be induced by regular trips to the toilet. To be up and dressed, in nice surroundings, and escorted to a real toilet as opposed to being offered a bedpan will go a long way towards making a good many patients continent.

Contact with the environment

Communication with the patient is vital and apart from the maximum use of hearing aids etc. the nurse must make every effort to "get through to" any patient whose hearing, sight, speech or comprehension is defective. The more environmental stimulation the patient gets the better the rehabilitation response will be, so the nurse should stop and speak to each patient at every available opportunity. Visitors are also helpful in this respect, and in a ward which has open visiting so that visitors are there all day on and off, many of the patients get spoken to not only by their own friends but also by other people's friends. This all helps to give them the stimulation from the environment and the interest in their progress that they need. It is also helpful if while a patient has visitors she can 'show her paces' a bit, preferably, to avoid self-consciousness, without either the patient or the visitor being fully aware that the patient's progress is being demonstrated. The nurse may need to be a little crafty to arrange this. Then when the patient is ready for discharge the nurse should deliberately show and tell the patient's relatives exactly how much the patient may be expected to do, and should warn them against that well-meaning protective helpfulness which can cast so many rehabilitated patients right back into a state of dependency.

Confused or mentally-impaired patients create quite a problem for everyone who is involved in helping them with their rehabilitation. Often they do not respond at all until they have become familiar with their new surroundings and have gained confidence in the nursing staff. A mentall-impaired patient, particularly if she is confused, can become very hostile to those who do not take the trouble to understand her, and a nurse is only likely to make much progress in helping the rehabilitation of such a patient when she has learnt how to soothe her with a cup of tea and a few minutes chatter, or how to distract her when she sets off 'to catch a bus' or to look for her long-dead parents, or how to escort her, when she is found restless and wandering, to the toilet, which usually proves to be what the restless wandering patient is looking for. The nurse should also

bear in mind the importance of keeping the confused patient physically and mentally occupied for as much of the day as possible. The occupational therapist, in addition to her usual treatment, may leave some craftwork on the ward for such a patient, and it is up to the nurse to make sure the patient does it. The nurse should also understand the importance for the confused patient of those things which keep her in touch with the environment e.g. the ward clock and calendar, and of environmental stimulation. I am not suggesting that the nurse should become a TV mechanic, but she is the person who should make sure that the ward television set is maintained in working order, and she should see that the ward goldfish gets its water changed and that the ward budgie gets fed every day, because if she does not understand the importance of these things nobody else will.

Summary

For rehabilitation a nurse must be adaptable and versatile; she must understand the patient's medical condition and be able to adjust the patient's degree of independence on the ward to this. During the acute illness she must try to avoid those complications of inactivity which will prejudice subsequent attempts at rehabilitation. She must understand the psychology of the older patient and be able to gain the patient's confidence and to provide the secure and happy atmosphere and the sense of personal pride and dignity that give the patient a motive for doing her best. She must have the patience of a saint, to encourage and praise the patient's success, to avoid upbraiding failure or lack of co-operation and to stand by and watch the fumbling efforts of a patient to be independent when it would be so much quicker and easier to help. She must keep abreast of the patient's current physical performance and use the patient's capabilities to the full in the everyday life of the ward; she must know and practise some elementary physiotherapy, occupational therapy and speech therapy, paying careful attention to those little details which can make all the difference. She must ensure that the right equipment is in the right place at the right time and put to the right use. She must know how to make incontinent patients continent, or at least less incontinent, and how to integrate the confused patient into the therapeutic community of the rehabilitation ward.

From all this three important corollaries arise.

First, in a rehabilitation ward the need is for good nurses, able, conscientious, and temperamentally suitable. Any old nurse who happens to be available will not do!

Secondly, there must be enough nurses. Supervising a patient's attempts at independence takes far longer than doing everything for the patient, and if the nurses are rushed, harassed, a bit impatient or too busy to talk to the patients, the whole atmosphere of the ward is destroyed. It may seem that these patients are not very ill, and that not much is being done with them, but if the number of nurses on the ward falls too low, everything stops and the whole ward becomes 'chronic sick' in no time. One nurse to 1.4 patients is the desirable ratio for such a ward.

Thirdly, nursing morale must be high. Any gloom among the staff rapidly transmits itself to the patients, but morale stays high if the ward has its fair share of nurses and equipment, and if the nurses are seeing results in the improvement of their patients. This means co-operation on our part in not putting too many doubtful starters into the rehabilitation ward at any one time. The most important factor, however, in maintaining nursing morale on a rehabilitation ward is the interest which we, the doctors, take in the work, its progress and its achievements.