Objectives:

- To review the history of rehabilitation
- To explore where the disciplines of nursing and occupational therapy overlap
- To identify our common goals and strategies
- To identify resources to enhance intra- and inter-professional collaboration

History of Nursing

- Has existed for over 2000 years. Has involved tending to the sick and the dying through the preparation and administration of medications, maintaining cleanliness and dignity, and providing empathy.
- Has existed in Canada since 1639 when the Augustine nuns in Quebec developed the first training program in North America.
- Florence Nightingale further refined nursing and developed training programs in the 1850s…as a result of the Crimean War.

History of Occupational Therapy

- Developed in Europe in 1700s incorporating work and leisure activities into hospitals
- Came to the United States in 1800s
- Standardized training programs since early 1900s
- Further refined after WWI including the development of therapy assistant role

Occupational Therapy

- Science and practices of returning injured workers to a level of work activity that is appropriate to their functional and cognitive capacity.
- Help people participate in the things they want and need to do through the therapeutic use of everyday activities.

History of Hospitals

- Initially constructed to
  - Provide hospitality to travelers
  - Treat injured soldiers
  - Isolate disease (measles, smallpox, TB)
  - House the poor
- Hotel Dieu Shaver, Chedoke and Freeport were all TB sanatoriums in the past

History of Rehabilitation (U.S.A.)

- Developed as a result of WWI and WWII
- Became a specialty in 1940s with dedicated funding and programs
- 1970s – legislation preventing the discrimination of people with disabilities in employment
- 1980s – equal access to education for children with special needs
- 1990s – Americans with Disabilities Act supporting equal access in all aspects of living

Evelyn Moore from Alberta

Physiatry

- Developed around 1938
- Role of physiatrist appeared 1946
- Goal of physiatry is restoring function from disabling conditions or diseases for which there is no cure. Optimizing quality of life.
- Evolved as a specialty following the world wars through the treatment of injured soldiers.

Rehabilitation Nursing

- "A creative process that begins with immediate preventive care in the first stage of accident or illness and continues into the restorative phase of care and involves the adaptation of the whole being to a new life" (Stryker, 1977)
  - Prevention of further illness/disability
  - Restoration of function
  - Adaptation to change (physical, psychological)

Key themes in rehab nursing:

- Helping people with a chronic, disabling or developmental condition achieve their potential
  - Preventing further disability
  - Preventing complications
  - Promoting wellness and function
  - Achieving potential
  - Achieving independence in self-care or self-directed care

(Hoeman: Rehabilitation Nursing 1996)

Our common goal

- Ultimate goal is dignity and quality of life
  - Quality in all aspects of life:
    - Physical, Psychological, Cognitive, Social, Financial
- Focus on function
  - Activities of daily living
    - Achieving independence in self-care or self-directed care
    - Being able to manage your own care now and lifelong

Evelyn Moore

Orem's Model of Self-Care (1980)

- Self-care is the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health and well-being.
- Underlying assumption
  - People want to be able to care for themselves
  - We all have self-care activities
    - Universal self-care activities (ie ADLs)
    - Developmental self-care activities (work/roles)
    - Health deviation requisites (eg. Giving own insulin)

Activities of daily living

- Bathing
- Dressing
- Toileting
- Mouth care
- Grooming
- Shaving
- Nail care
- Menstrual management
- Applying cosmetics

➢ Mobility of some type including transfers between surfaces

Orem, 1980 and any OT textbook

Patients with self-care deficits

- Nurses provide compensation for those deficits:
  - Total
  - Partial
  - Supportive/educational
- Nursing methods include:
  - Doing for
  - Guiding and directing
  - Providing physical or psychological support
  - Providing a developmental environment
  - Teaching

Orem, 1980

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA

Doing with vs. doing for

Do it yourself

Give a **man a** fish, and you feed him for a day. Teach a man to fish, and you feed him for a lifetime

Coaching as caring

Mindshift for nurses…and patients/families

- https://www.bing.com/videos/search?q=teaching+a+child+to+put+on+a+coat&&FORM=VDVVXX

FIM

- Developed as a measurement of disability
- Uses a 7 point scale to classify a patient's performance – ranging from 7 (complete independence) to 1 (total assistance)
- Administered within 72 hours of admission and discharge

FIM

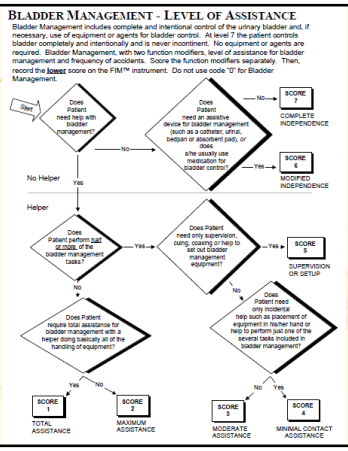
- FIM efficiency is determined by the change in FIM score over the patient's total length of stay
- Hospital funding models consider FIM efficiency
- Awareness of FIM scores may help to drive the focus of a patient's rehabilitation stay

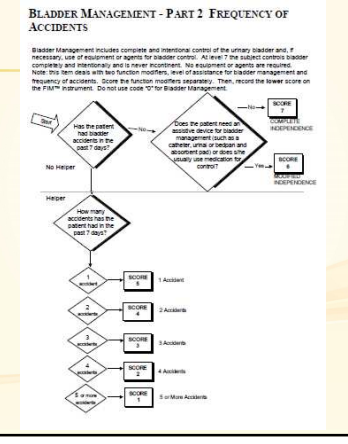
FIM categories

- Eating
- Grooming
- Bathing
- Dressing – upper body
- Dressing – lower body
- Toileting
- Bladder management
- Bowel management
- Transfers – bed/chair/wheelchair
- Transfers – toilet
- Transfers – tub/shower
- Walk/wheelchair
- Stairs
- Comprehension
- Expression
- Social interaction
- Problem solving
- Memory

Case Study – John

- Admission FIM score (related to continence)
  - Toileting – 1 (total assistance)
  - Bladder management – 1 (total assistance)
  - Bowel management – 3 (moderate assistance)
  - Transfers – toilet – 1 (total assistance)
- Total score – 6





- Discharge FIM score (related to continence)
  - Toileting – 5 (supervision/setup)
  - Bladder management – 6 (modified independence)
  - Bowel management – 5 (supervision/setup)
  - Transfers – toilet – 5 (supervision/setup)
- Total score – 21

- Total change in FIM score – 15 points

Interdisciplinary teams

- Overarching goals developed by the patient and team
  - Each team member contributes to achieving the goals
  - Requires clear and continual communication between the team members
  - Works better in program management where staff are committed to the program more than the discipline
  - Encourages collaboration, comprehensive care and a holistic view of the patient

Interdisciplinary teams

Why are professional football players given 40 hours a week to practice for a game that takes 3 hours a week to play, while we have no time to practice and are expected to perform as a team 40 hours a week?

Implementing Interprofessional Care in Ontario (Health Force Ontario, 2010)

- Interprofessional education facilitates interprofessional care.
- Interprofessional core competencies helps build a foundation and clarifies roles.
  - ➢ Stroke core competencies
- Charter of expectations and commitments

Intra-professional Collaborative Practice Among Nurses (RNAO BPG 2016)

- Understanding roles, values, behaviours
- Acquiring and demonstrating attributes of team work
- Collaborative processes, power-sharing, shared decision-making, democratic work practices
- Effective communication

➢ Focus on organizational responsibilities and educational opportunities to promote professional collaboration

Developing and Sustaining Interprofessional Health Care

(RNAO BPG 2013)

- Understanding roles
- Collaborating with colleagues, patients and families
- Developing communication and conflict management skills
- Power sharing - shared leadership and decision-making
- Sharing knowledge

➢ System-based and organizational recommendations

High Functioning Nurse Teams:

Collaborative Decisions for Quality Patient Care
(Baumann et al, 2014)

- Successful high functioning teams were:
  - Fluid
  - Confident
  - Non-hierarchal
  - Patient-focused
  - The right nurse in the right job
- Team members had an intuitive understanding of time and place and an awareness of how they fit within the larger system.
- Team members worked seamlessly to assess patients, analyze problems, negotiate an approach, divide roles and find solutions.

Thoughts from our team

- "Some nurses just get it"… "we are trying to get somewhere here. They look at the schedule and they think to give pain meds before therapy or to have the patient up. It all works much better." (PT)
- "When we can have a conversation about the goals and then we all know what we are working on. Like if I know he is supposed to transfer a certain way I'll do it like that." (RPN)

- "I don't mind helping the nurses with a transfer but I want them to stay and see how it is done so they can do it the same way. It is the difference between helping them and doing it for them." (OT)
- "I like it when the therapists talk to us about the schedule because what if I've got an IV med to give or he's on a tube feed. I can maybe adjust the time. I've got stuff to do with the patient too." (RN)

Optimizing Rehab Teams

- Collaborative assessment with constant communication
- Providing opportunity for practice and physical space

Collaborative assessment with constant communication

- Nurses and physiotherapists should assess patient's transfers on the day of admission
- Nurses and OTs should assess the patients together in first 24hours for ADL planning
- Frequent face-to-face communication (quick give and get)
- Charting should be integrated

Freeport Stroke Rehab Team

- Morning huddle at 08:45 for clinical staff
  - 15 minutes, lead by NP or resource nurse
    - Review discharge target dates with focus on ensuring discharge plans are complete for imminent discharges
- Daily "bullet" rounds at 11:55 for all staff
  - 5 minutes, lead my manager, focus on safety
    - Fall and restraints, things that are broken
    - Special announcements: visits, renovations
- Weekly team meetings for clinical staff
  - 45 minutes per 15 patients, discuss progress
- Family meetings

Setting up for Success

- Consistent therapy teams
  - OT and PT designated teams to each patient
  - Core group of nurses to follow patient from admission to discharge
- Large schedule board central on the unit

Opportunities for practice & physical space

- Therapists and therapy are on the unit
  - Hours
  - Morning ADLs and meal setup
  - Toileting
- Work areas are geographically close
  - Upper extremity group
  - Use of therapy gym/kitchen
  - Extra walks

Challenges

- Rehabilitation philosophy is not embedded in general nursing programs
- Rehabilitation is an entry-level unit for many nursing staff…high turn-over
- Lack of specialized education for RPNs
  - RNs can join the Ontario Association of Rehabilitation Nurses
  - RNs can take the Canadian certification in rehabilitation nursing

Educational opportunities

- Neurological assessment courses
- NDT training courses
- Hemispheres (on-line stroke education)
- Stroke core competencies (on-line stroke education)

- Questions?