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Multidisciplinary perceptions of the role of nurses and healthcare assistants in rehabilitation of older adults in acute health care

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Aim. This paper describes the perceptions of nurses, healthcare assistants, doctors and therapists of rehabilitation and the role of nurses and healthcare assistants on an acute older adults ward in a London teaching hospital.

Background. The role perception, education and training and attitudes towards the older adults have been identified as barriers that have an impact upon the nurses' role within rehabilitation. However, little is known about the role of nurses and healthcare assistants in rehabilitation of older adults in acute health care.

Design. Action research study.

Method. Twenty-four semi-structured interviews were conducted and audio recorded about healthcare professionals' understanding of rehabilitation, the type of skills needed and their perceptions of the role of nurses and healthcare assistants in rehabilitation. The interview transcripts were analysed using the thematic content analysis.

Results. The findings suggest that the therapists relied on nurses and healthcare assistants for therapy carry-over. Healthcare assistants were perceived as the professional group who could deliver therapy carry-over. There was an evidence of role hierarchy as healthcare assistants perceived that they were not actively involved in decision-making or discharge planning.

Conclusion. This paper suggests that healthcare assistants and nurses are viewed as the professional group best placed to deliver therapy carry-over. However, whilst there is an acknowledgement of their role, there remains a reluctance to acknowledge healthcare assistants as a professional group and to involve them within decision-making and discharge planning

Relevance to clinical practice. Employers must be seen to advocate, support and implement education and training programs for healthcare assistants. However,

whilst nurses and healthcare assistants have an integral role in rehabilitation, there needs to be more research into the how they are supported by therapy professionals.

Key words: nurses, nursing, older people, rehabilitation, therapists

Introduction

Ageing is a process that nurses cannot ignore; globally, there will be 1.2 billion people over the age of 60 by the year 2025. Moreover, by 2050, these figures will have doubled, with 80% of older adults living in developing countries (World Health Organization 2002). However, instead of viewing increasing life expectancy positively, it is commonly viewed negatively and with scepticism.

In the UK, there is still no specific legislation to outlaw age discrimination, although a European Directive may be implemented in 2006. One document, which reflects the ethos of active ageing in the UK, is the *National Service Framework for Older People (NSF)* (Department of Health 2001). This document has helped revolutionize the way the health of older adults is to be managed and the way in which nurses will work for the next 10 years. However, enhancing the health and well-being of older adults cannot be implemented without the skilled and dynamic nurses. Despite successful recruitment drives, there remains a shortage of skilled nurses in the UK (Royal College of Nursing 2003). In the UK, healthcare assistants have been employed to carry out traditional nursing roles making a significant contribution to patient care, carrying out tasks such as personal care, assisting with nutrition, toileting and mobility (Workman 1996, Ramprogus & O'Brien 2002, Fowler 2003). One study found that healthcare assistants were unable to differentiate between their role and the staff nurses' role except in relation to the administration of oral and injectable medications and the administration of i.v. fluids (Thornley 2000).

Background

Rehabilitation is essential to promoting control and independence and is often regarded as the only solution to solve the multiple problems of older adults (Department of Health 2001). In addition, it can significantly influence the outcome of a hospital discharge (Sager *et al.* 1996, Covinsky *et al.* 2003). The complexities of promoting control and interdependence should not be understated and there are high variations in the extent to which individual nurses implement strategies to promote autonomy and independence in older adults (Davies *et al.* 2000). Indeed, the complexity of the problem in the UK is reflected in the vast number of

government (Department of Health 1997, 1998, 2000, 2001) and non-government documents (Audit Commission 1997, Kings Fund 1999, Royal Commission 1999) that continue to discuss and debate the rehabilitation of older adults. The situation is further complicated by the failure of professionals to reach consensus on a definition of rehabilitation (Audit Commission 2000). It is now recognized that definitions of rehabilitation (Wade & de Jong 2000) may refer to structure (the operational characteristics of a rehabilitation service), process (how rehabilitation services work) and outcome (the aims of rehabilitation services).

The Royal College of Nursing (2000) has outlined the nurses' role in rehabilitation as: (i) providing psychosocial and emotional support, enhancing lifestyles and relationships, enabling life review, facilitating self-expression and ensuring cultural sensitivity; (ii) maximizing independence and functional ability; (iii) an educative role such as health promotion, continence promotion; (iv) life-enhancing functions to enhance the daily living experiences of older adults such as nutrition and relieving pain; (v) team functions including the range of administrative and supervisory responsibilities of the Registered Nurse. There is evidence that the contribution of the nurse to the rehabilitation process has not also been valued and or regarded as an equal contribution of the nurse to the rehabilitation process has not always been valued and or been regarded as an equal members of the rehabilitation team. Furthermore, non-nurse professionals were to some extent unaware of the expectations that the nurses held for the nursing role (Benson & Ducanis 1995, Dalley & Sim 2001, Chilvers 2002, Long *et al.* 2002). Furthermore, older adults often do not associate nursing with a rehabilitative role and expect nurses to assist (Audit Commission 1992, Long *et al.* 2002).

Attitudes towards older adults can impact upon rehabilitation and subsequently influence the nursing practice. Pursey and Luker (1995) suggest that nurses' reluctance to work with older people is not solely because of negative attitudes, which nurses hold towards older adults. Their findings suggest that the nurses are reluctant to make the care of the older adults a positive career choice because of the high dependency levels and the structure of nursing work with older adults in hospitals. Negative attitudes can be demonstrated in the way nurses interact with older adults. There is evidence that nurses' social interactions with older adults are

often brief and limited (Armstrong-Esther *et al.* 1994, Nolan *et al.* 1995, Clissett 2001, Lyytinen *et al.* 2003). However, older adults who are the most interesting and socially skilled receive most attention from nurses (Nolan *et al.* 1995). Nurses who placed a higher importance on talking to older adults held a more positive attitude towards them than those nurses who placed a higher importance on nursing tasks such as self-care and bathing (Armstrong-Esther *et al.* 1989); even though older adults rate the importance of providing physical care higher than younger patients receiving care (Chang *et al.* 2003).

The introduction of healthcare assistants into the healthcare arena initially caused some disquiet within the nursing profession and led nurses to the question whether this grade of staff could distort the position of nurses in health care (Redfern 1994, Workman 1996). However, in areas of health care, particularly in the critical care and high dependency units, the role of the healthcare assistant has been extended (Sutton *et al.* 2004). In addition, the Department of Health (2002) has published a target for 27 000 more healthcare assistants in the National Health Service by 2005. Nurses are required to ensure that healthcare assistants are adequately trained and have the required competencies for safe and best practice (Nursing and Midwifery Council 2002). However, there is evidence that nurses who act as mentors and educators to healthcare assistants may not necessarily have the skills needed to ensure best practice. It has been suggested that the nursing of older adults is not covered adequately in pre-registration and postregistration nursing curricula. (Nolan & Nolan 1999, Long *et al.* 2002, McLafferty & Morrison 2004). Likewise, a study by Ramprogus and O'Brien (2002) identified a lack of systematic education and training for the healthcare assistants' role. They in turn felt undervalued and lacked a career structure centred on continuing professional development. Ramprogus and O'Brien (2002) found that in-service training and *ad hoc* learning 'from experience' and colleagues formed additional ways to develop practice-based rehabilitation skills. On a positive note, the *NHS Plan* (Department of Health 2000) recognized that staff without a professional qualification had been previously neglected in terms of investment in their skills. A commitment has been made to provide dedicated training for healthcare assistants.

The study

This study is part of an action research project, located in a large primary care trust in the UK. The project aimed to explore whether healthcare professionals are actively enga-

ging older adults in the rehabilitation programmes. The first stage of the action research project, which is reported in this paper, aimed to ascertain the perceptions of nurses, healthcare assistants, doctors and therapists of rehabilitation on a rehabilitation ward for older adults.

Participants

The lead researcher wrote to all healthcare professionals inviting them to participate in the study. From a total of 40, 24 health professionals responded to the letter, which included 10 nurses, five healthcare assistants, three physiotherapists, two occupational therapists, two therapy assistants and two doctors. Twenty of the participants were female and six were male (two nursing staff, two physiotherapists and two doctors). All of the qualified therapists were employed by locum agencies.

Data collection

The interviews, which lasted between 20 and 40 minutes, were conducted in a consulting room in the therapy centre. All interviews were tape-recorded and transcribed verbatim. The interview schedule was based on the literature and the research teams experience working with the older adults in the acute setting. The following questions were asked:

- What do you understand by the term rehabilitation?
- What is your involvement in rehabilitation?
- Is there a grade or group of staff you feel would benefit most from such training?
- What strengths or barriers do you see in involving nursing staff in carrying out rehabilitation?

Ethical considerations

Ethics approval for the study was obtained from local ethics research committee in March 2004 following the NHS REC application procedures. Participants were informed that the interviews were confidential and information provided would subsequently be anonymous and would be stored securely and destroyed two years after the study was completed.

Data analysis

Thematic content analysis was used to analyse the data (Neuendorf 2001). To become familiar with the data, the interview transcripts were read several times. The transcripts were checked for the errors against the taped version of each interview to ensure that it accurately reflected the content of

the tape. The researcher made comments and notes in the margins. A number of codes emerged and these were then grouped by grouping the data into units of meaning and considering how the codes might be meaningfully clustered together. At this stage, certain cluster themes were eliminated if they did not fit into the cluster themes and or occurred in isolated cases only. Once the relationship between the cluster themes has been determined, the themes were established. Data analysis produced three themes, understanding of rehabilitation, role perception and education, training and competencies.

To enhance the credibility of the research, participants were asked to comment on the accuracy of the interview transcripts and later they were presented with an analysis of the research findings. Two of the researchers compared and discussed the cluster codes and decided whether the codes were reflected accurately within the themes. A high degree of consensus was found.

Findings

Meaning of rehabilitation

Nurses, healthcare assistants and therapists as a means to promoting independence, function and mobility understood the rehabilitation. Only one occupational therapist, one nurse and one doctor emphasized that the rehabilitation was a process that involved the patient. One nurse perceived that the drive for quicker discharges resulted in an older person being discharged before the rehabilitation program had been completed. In contrast, both doctors perceived that it 'was important to ensure that people are not aiming too high' or 'we have to take a realistic approach to the problem rather than an idealism that has been provided by many therapists'. This may account for why the same nurse emphasized the need for nurses to be more assertive because of the pressure on acute hospital beds. She stated:

Most of the time, we discharge people because a bed is needed. We are being pushed from different corners, people need to be taught how to say no with reasons.... We should be given more support.

Psychosocial factors were not cited as being a part of the rehabilitative process. Although one healthcare assistant did state that if she had some free time, then she would speak with the patient to find out more about the patient. However, this could be an important factor in discharge planning as one occupational therapist was of the opinion that care and services were often not started or involved within the discharge process, 'just little things get missed like restarting carers and meals on wheels'.

Nurses and healthcare assistant's role in rehabilitation and other perceptions

Only one staff nurse perceived that she had not received adequate training in the skills of rehabilitation. There was a general consensus that healthcare assistants were best placed to delivery therapy carry-over and were actively involved in occupations of daily living and had the most direct patient contact. Healthcare assistants also shared this view. However, they empathized that that they were not actively involved in multidisciplinary meetings and or within discharge planning. One healthcare assistant stated:

We are the closest of the staff to the patient so we assess them and we can tell, even though we haven't a part to tell anybody else,...we know what they are capable of doing. They don't ask us, they ask the people who are far from them.... Therefore the assessment is really faulty.

Nurses identified two key roles, therapy carry-over and co-ordination of the patient. In relation to therapy, therapists and healthcare assistants regarded the patients' independence in functional tasks as a key role. Both nurses and healthcare assistants emphasized how they mobilized patients after liaison with physiotherapists. Interestingly, there was no mention of carry-over therapy instructions from occupational therapists. Only one healthcare assistant and one nurse emphasized that nurses continued to monitor the progress of the patient in the absence of therapy staff.

In relation to co-ordination, nurses perceived that their key role was to refer patients to persons or departments that specialized in rehabilitation. Furthermore, the fact that the nurses were on the ward 24 hours a day was regarded as an important component of the rehabilitation process by doctors, physiotherapists and occupational therapists. The main advantage is for information exchange and for therapy carry-over. One doctor emphasized the importance of therapy carry-over, 'nursing staff need to know how to carry through what's been suggested so that the therapists don't just give hour an hour and then leave the next twenty-three-and-half hours static with nothing happening'.

There was a belief from therapists that nurses did not have time to incorporate rehabilitation into their role as they needed to focus their time on basic nursing tasks. Furthermore, therapists emphasized the fact that they were not 'trying to get nurses to do their job'. Although it could be perceived that the nurses are performing a physiotherapist and occupational therapist role. Therapists felt that they did not carry out rehabilitation but only assessed the patient. One doctor perceived that nurses spent more time carrying out the rehabilitation than physiotherapists and occupational

therapists. Indeed, therapists emphasized that their role in the rehabilitation process was to carry out the assessments. One occupational therapist stated, 'we might assess personal care and then reassess again in three days time.... Try and see that the patient has therapy carry-over...but then again it's all within limits, as to what we can do.'

Interestingly, when it came to therapists carrying over nursing tasks such as finding slippers for patients or toileting, the therapists appeared to be resentful that they may need to perform this role. All of the healthcare assistants emphasized that their role in rehabilitation was to encourage the patient. One healthcare assistant stated:

My involvement, to encourage more than anything, to encourage more than help. In contrast, only two nurses perceived this as an important aspect of the rehabilitation process.

In contrast, one staff nurses felt that healthcare assistants were not promoting independence:

I don't mean to sound derogatory, but I think because they want to get their work carried out, they've got a straight line...if they veer off that line you know they don't like it.... Instead on observing them to see how they can manage themselves, they're tending to do it all for them.

A shortage of therapy and nursing staff and time constraints was identified as factors that had an impact upon staff roles communication and multidisciplinary teamwork. One staff nurses stated, 'sometime we are busy that's why we don't get the chance to walk the patient to the toilet, like we're short of staff'. Likewise, one occupational therapist stated, 'it would be nice to leave the nurses a few things they could do, but they don't have the time to give someone the opportunity; its quicker if they do it for them, which is a bit of a shame. 'One physiotherapist was of the opinion that therapy carry-over occurred 50% of the time', 'by the end of the week.... You've had a person who can get out of a chair'. Go home for the weekend and come back, and they don't even know how to get out of a chair and you think here we go back to square once again'.

One doctor emphasized how poor quality rehabilitation impacted on a patient's well-being. The therapists say, 'we don't avail proper rehabilitation on this ward, they just do what geriatricians called rehabilitation is the best of a bad job.... There's not a lot going on between the therapy sessions; they're sitting, getting demotivated and depressed; we loose potential for them improving'. Although one healthcare assistant emphasized the importance of an activity nurse, 'one staff nurses used to come in so many days a week and she would show them video films from years ago, how they did ironing and cooking and all of that, and they really loved

it...she used to bring them books from the library to read'. Boredom was a factor reiterated by two other staff nurses one of which commented on the importance of day rooms on a ward to enhance communication and elevate boredom.

Staff shortages were perceived as limiting the rehabilitation process with regard to the quality of basic nursing care, the carry-over of therapy and on teamwork. Continuity of care was also influenced by the frequent use of locum and agency therapists and nurses. Both doctors and nurses commented that time constraints had an impact upon nurses attending multidisciplinary team meeting. One staff nurse stated:

There's no teamwork; there's no feeling on the ward, as much as we would like it, as people would like to work as a team. If you call me when I'm in the middle of everything...I was willing but there was no time.

This view was also shared by one doctor, 'The nurses attending the MDMs you get the impression sometimes they're too busy and it's very difficult to get them to come to the whole thing'. In contrast, occupational therapists and physiotherapists commented on their close working relationship, which they felt was an indication of successful teamwork.

Discussion

The findings from this study suggest that lack of time and staffing issues identified by all the participants as having an impact upon the nurses' role within the rehabilitation process and team working. Consequently, older adults may be unable to reach their optimal level of functioning because of the limited rehabilitation. There is also evidence that older adults are likely to develop new functional deficits during hospitalization (Sager *et al.* 1996, Covinsky *et al.* 2003). Team working is an essential part of the rehabilitation process. Nurses in a multidisciplinary team are perceived to know about the individual's level of function (Johnson 1995). However, this study suggests that a healthcare assistant had the most patient contact. Consequently, healthcare assistants should be actively encouraged to participate in team meetings. This in turn could allow nurses to continue with other tasks. A study that investigated nurses perceptions of the discharge process within an acute hospital found that lack of time was reported to be the biggest barrier that affected interprofessional working and hence the co-ordination of assessments (Atwal 2002). Therapists appeared to accept their assessment role within the rehabilitation process and did not appear to demonstrate a desire to actually carry out the rehabilitation programmes. Consequently, it is suggested that older adults are not receiving adequate therapy from professionals trained in specific rehabilitation techniques.

Whilst appearing to value the 24-hour approach to nursing, therapists thought that the opinion that nurses did not have the time to carry out basic nursing tasks let alone the therapy carry-over. Indeed, the findings from this study support the view the non-nurse professionals were unaware of the expectations that the nurses held for the nursing role (Dalley & Sim 2001, Chilvers 2002, Long *et al.* 2003).

In addition there appears to be different perceptions between the professional groups about the purpose of rehabilitation. This supports the notion for a definition of rehabilitation to be agreed by all professional groups (Audit Commission 2000) but also recognizes the complexities of achieving this. Iwarsson *et al.* (1999) suggest that a distinction should be made between rehabilitation carried out by specialists in rehabilitation (therapists) and general rehabilitation, which is carried out by nurses. The findings from this study suggest that a distinction should not be made between therapy and nurse rehabilitation as therapists perceived that they were only performing assessments.

The roles of the nurse and healthcare assistant were regarded in very physical terms, for example promoting mobility as opposed to enhancing psychosocial issues. Only two staff nurses state that this was part of their role. Allen and Turner (1991) suggest that even if staffing levels were enhanced, then more time would be spent on physical care. Furthermore, interaction was not cited as an important aspect of the role of staff within the rehabilitation process. Although, in nursing, there has been an acknowledgement that nurses' social interactions with older adults are often brief and limited (Armstrong-Esther *et al.* 1994, Nolan *et al.* 1995, Clissett 2001, Lyytinen *et al.* 2003). The therapy professions have not yet researched this area.

Nurses had a very narrow perception of their role within the rehabilitation process when compared with the Royal College of Nursing (2000) in relation to the promotion of health and well-being and psychosocial issues. This is consistent with the work of Nolan *et al.* (1995), Clissett 2001 and Lyytinen *et al.* (2003) who found that nurses' social interactions with older adults are often brief and limited. Similar findings have been reported in the cancer nursing (Gill *et al.* 2000). Healthcare assistants had a similar role but with a further emphasis on the importance of encouragement within the rehabilitation process. Encouragement has been identified as a factor, which motivated older women who were labelled as unmotivated by the rehabilitation team (Resnick 1996). The findings from this research suggest that nurses' role be perceived in relation to therapy carry-over. Whilst nurses highlighted co-ordination as a part of their role, these were not related specifically to the multidisciplinary team but rather to the co-ordination of rehabilitation staff and services.

Findings from this study suggest that further research be conducted into the use of older adults' rehabilitation wards. For if therapists and nurses do not have the time to carry out rehabilitation, how is the patient's day occupied? Observational studies carried out in UK hospitals looking at the activity levels of older patients show that therapeutic activities only occupy a minimal proportion of their time, and that most of the day is unoccupied (Nolan *et al.* 1995, Birchall & Waters 1996, Perrin 1997, Clissett 2001). Furthermore, there is need for therapists to demonstrate actively the type and amount of therapy that is needed to meet the older adults' goals. Indeed, the Royal College of Physicians (1994) suggests that rehabilitation wards require more intensive occupational therapy and physiotherapy and different types of nursing skills than is available on general wards.

It is suggested that the role of the healthcare assistant in the rehabilitation process of older adults needs further exploration. There appears to be a reliance on them as a staff group to perform basic nursing tasks fundamental to the rehabilitation process but a reluctance to acknowledge them as a professional group and or involve them within the decision-making and discharge planning. Workman (1996) has suggested that the role ambiguity occurred between nurses and healthcare assistants because of nurses' lack of clarity about their role, which in turn affects their expectations of the healthcare assistant's role. Indeed, this research has highlighted that healthcare assistant's perceive themselves as being essential to the information exchange process but they are not used in an effective manner. All the participants in this study perceived that healthcare assistants were in the best position to carry out the rehabilitation programmes with older person. It would be in the nurses' professional interest to ensure that healthcare assistants are trained adequately. In this study, only one nurse perceived that her training had not given her the skills necessary to carry out the rehabilitation, which contradicts the findings of Nolan and Nolan (1999), Joy *et al.* (2000) and Long *et al.* (2002).

Methodological considerations

This study explored the perceptions of nurses, healthcare assistants, doctors and therapist in relation to the rehabilitation process and therefore the findings cannot be generalized to all other older person's rehabilitation wards.

Recommendations and conclusion

It could be suggested that this study highlights the need for there to be discussion between the different professional bodies regarding the role of therapists, nurses and healthcare

assistants in older adult acute rehabilitation services. This research has highlighted that older members of the multidisciplinary team including nurses perceived that healthcare assistants are best placed to deliver therapy carry-over. More research is needed into the role of the healthcare assistant and in particular how they can be incorporated into the multidisciplinary team as a professional within their own right. Indeed, Thornley (2000) argues that nurses should welcome a more progressive role for healthcare assistant within healthcare team. Interprofessional education programmes should consider that how support workers could be incorporated.

Contributions

Study design: AA, KT; data collection and analysis: KT and manuscript preparation: AA, KT, KC, CC.

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