Spring 1958

The Responsibility Toward Rehabilitation Of The Nurse In A General Hospital

Jean Lind
Carroll College

Follow this and additional works at: https://scholars.carroll.edu/nursing_theses

Part of the Nursing Commons

Recommended Citation
Lind, Jean, "The Responsibility Toward Rehabilitation Of The Nurse In A General Hospital" (1958). Nursing Undergraduate Theses. 68.
https://scholars.carroll.edu/nursing_theses/68

This Thesis is brought to you for free and open access by the Nursing at Carroll Scholars. It has been accepted for inclusion in Nursing Undergraduate Theses by an authorized administrator of Carroll Scholars. For more information, please contact tkratz@carroll.edu.
THE RESPONSIBILITY TOWARD REHABILITATION
OF THE NURSE IN A GENERAL HOSPITAL

SISTER JEAN REGIS LIND, S.C.L.

SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR
THE DEGREE OF BACHELOR OF SCIENCE

TO THE
DEPARTMENT OF NURSING EDUCATION
CARROLL COLLEGE

1958
This Thesis for the Degree of Bachelor of Science by Sister Jean Regis Lind, S.C.L.

Has Been Approved for the Department of Nursing Education by

__________________________

__________________________

__________________________

Date ______________________
Because rehabilitation is an area of growing importance in total patient care and because nurses commonly make the misjudgment that rehabilitation includes only vocational aspects, the purpose of this paper is to show the true concept of rehabilitation and the responsibility of the nurse in a general hospital to include this concept in all her nursing care.

For the information, direction and encouragement they have given, I acknowledge my appreciation to Reverend James R. DeGroat; Miss Frances Saylor of the State Department of Public Health; Sister Ann Raymond, Administrator of St. Vincent Hospital, Billings, Montana; Sister Agnes Eugenia of the Carroll College Department of English; Sister Mary Damien, O.P.; Sister del Rey, who typed the final draft of this paper; and Sister Eugene Teresa, Director of the Department of Nursing Education, Carroll College.

(S.J.R.)
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LIST OF CHARTS</td>
<td>v</td>
</tr>
<tr>
<td></td>
<td>LIST OF FIGURES</td>
<td>vi</td>
</tr>
<tr>
<td>I</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>II</td>
<td>What is Rehabilitation</td>
<td>4</td>
</tr>
<tr>
<td>III</td>
<td>The Need for Rehabilitation</td>
<td>11</td>
</tr>
<tr>
<td>IV</td>
<td>When Does Rehabilitation Begin</td>
<td>17</td>
</tr>
<tr>
<td>V</td>
<td>Attitudes for Rehabilitation in Nursing Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educational Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychological Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical Needs</td>
<td>22</td>
</tr>
<tr>
<td>VI</td>
<td>Summary and Conclusion</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Bibliography</td>
<td>43</td>
</tr>
</tbody>
</table>

iv
<table>
<thead>
<tr>
<th>Chart</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient Needs and Resources</td>
<td>10</td>
</tr>
<tr>
<td>2. Causes of Death: 1900 and 1948</td>
<td>13</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Normal Range of Motion</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Normal Range of Motion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Foot and Ankle</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Knee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hip</td>
<td>32</td>
</tr>
<tr>
<td>2.</td>
<td>Normal Range of Motion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shoulder</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Wrist</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Normal Range of Motion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Spine</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elbow</td>
<td>34</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

The last half-century has been called the age of preventive medicine. Medical science, in improving and broadening the field of curative medicine, has realized the importance of controlling what precedes the actual advent of the disease process, in fighting the disease itself. Naturally, a glance before will tend to produce a glance after, and that is where the third phase of medicine, rehabilitation, begins. Rehabilitation deals with the patient after the acute stage of the disease until he has resumed a normal, or as near normal as possible, role in society. With prevention, cure, and rehabilitation, we move into the age of total medicine.1

The aging population and the upsurge of chronic disease are problems which have become increasingly apparent in the last half-century. New therapies have done much to conquer acute disease and thus lengthen the life span, but little has been accomplished to alleviate chronic disease or to make desirable the life of our aged people. Handicaps and disabilities brought about by wars and the accidents of our techno-

logical way of life have increased. Along with the growth of hospitals and elective hospitalization has come the change in the role of medical personnel, both of doctors and nurses. Formerly, medical care was family-centered, personalized, and naturally concerned with the total needs of the patient because of its intimacy and limited scope. Today, care is specialized and institutionalized, and since its scope is broad and highly technical, a conscious effort must be made to meet total patient needs. All these factors have highlighted the need for and progress in rehabilitation.

Organized efforts in rehabilitation in the United States date back to 1920. In 1925 the National Rehabilitation Association was organized in Cleveland. Until 1942 membership in the organization was limited, but in that year membership was opened to anyone interested in the field and has now grown from 2,000 to 18,000. With this increased interest, centers for rehabilitation have grown up in many parts of the country and are responsible for the return of thousands to productive, full and happy lives.

Although many who are seriously incapacitated are treated at rehabilitation centers and in local rehabilitation programs during their convalescent period, the acute and early convalescent periods are spent in a general hospital. It is recognized that a serious deterrent

---


to rehabilitation is a lack of preparation, both physical and psychological, for rehabilitation; and yet it is during these very periods of acute illness and early convalescence that the patient's attitudes are formed to meet the future, and the needed muscles are allowed to atrophy or are strengthened.

But in a general hospital rehabilitation is not only concerned with those having more serious incapacities which would need intense and often prolonged programs of vocational rehabilitation, but also with every hospitalized patient from a simple surgical patient to a patient with an advanced cardiac condition. Each, in varying degrees, needs to make the transition from a dependent diseased condition back to a normal, or a modified way of life.

Thus we see that the nurse in a general hospital has a responsibility toward rehabilitation not only of physical and psychological preparation but also, most notably, of developing in herself an attitude of rehabilitation consciousness.
CHAPTER II

WHAT IS REHABILITATION

The National Conference on Rehabilitation defines rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." But to get a fuller picture of modern rehabilitation we add other concepts that have become apparent:

The total rehabilitation of the handicapped, therefore, includes what had been called "medical" rehabilitation. This is usually thought of as the curative or therapeutic phase. The second phase has been called the "conditioning" phase of rehabilitation where the patient's assets are evaluated, and he is studied, motivated and helped to make the transition from hospital to home. This may mean more activity in the rehabilitation department of the hospital. It may mean being discharged from the hospital, where he was during the acute period of illness, to a convalescent home or rehabilitation center, or it may mean being discharged directly to his home where supervision is continued, perhaps through an out-patient department, perhaps through a visiting nurse or other health supervisory agency. In any one of these ways, he is guided and supervised to continue strengthening his assets. He develops increasing responsibility for his own care and for the activities of his daily living. Thus, he is restored to his place in the home and to his status in the family group. Gradually he participates in group life in the community, becomes ready for vocational guidance and education, and finally becomes financially self-sufficient. The third phase in rehabilitation

---

is often referred to as the "vocational." It may be that the disability is of such a nature and the patient's background, education, and vocational experience is such that when the acute phase is over, he can return to his accustomed position. In many instances, however, a period of retraining is necessary when the individual's handicap limits him so that he cannot pursue the type of economic activity that he was accustomed to before the disease, injury, or accident. It is in these areas that vocational counselors can be of greatest help, first of all, in evaluating the patient and finding out what his educational and vocational assets are, and second, in determining what parts of his training, education and experience in the past can be utilized. A study is also made to find out what centers exist in the community where he can get the desired training, and finally, what employment centers exist that will help place him in profitable work when he has completed his training.

Thus we see that rehabilitation is a broad and complex field, involving not only the entire health team but also utilizing and relating to hospital, community, state and national resources. In realizing her role in the program of rehabilitation, the nurse in a general hospital must see it in relation to the other personnel and to the other circumstances that function in the process of rehabilitation. In this broader picture, the nurse must not lose sight of the analogous use of the term rehabilitation and its special implication in the hospital situation. Where organized rehabilitation associations are mainly concerned with the handicapped, the paralyzed, or the crippled, the nurse must think of rehabilitation in terms of the need of assistance for every patient in planning for his return to ordinary home life after his stay in the hospital. Thus the simple technique of early ambulation for a surgical patient in order to keep muscle tone and to speed recovery is as

---

5 Jensen, op. cit., pp. 16-17.
6 Ibid., p. 49.
important a tool to the nurse as prostheses, self-help devices and wheelchairs are to the therapist in a rehabilitation center.

In recent years the emphasis on the "whole patient" has pointed up the need for rehabilitation in the nursing program. We are made to see the patient as an individual and a member of society, not as a disease with a hospital room number, but as a person with personal rights and needs and as a part of a family which is vitally affected personally, emotionally and economically by his sickness. He comes to the hospital with needs in every area, physical, spiritual and emotional, which the nurse must be prepared to meet. It must not be forgotten, however, that the patient will leave the hospital with needs that have been modified and perhaps are less urgent but that must be met by himself, his family and the community. Rehabilitation aims to prepare the patient and his family to meet the future. (Chart 1, Page 10)

The phase of rehabilitation usually found in the general hospital is that which has been called the second or "conditioning" phase in which the patient and the health team first evaluate the patient's assets and problems, then make plans for the transition from hospital to home life. These plans may include an intensive and prolonged program in a vocational rehabilitation center or may simply necessitate instructions such as not to lift any heavy objects or to rest for two hours in the afternoon for a week.

One of the most challenging problems of the hospital rehabilitation program is that of working with the chronically diseased and the
Rehabilitation nursing can never approximate the drama of surgery, the emergency room, or obstetrics; the charm of pediatrics or the nursery; or even the thrill of helping a medical patient in his battle through an acute illness. In rehabilitation, progress is slow and satisfaction is usually in distant and often poorly achieved goals. With the aged, distant goals are impossible to a large extent and even immediate goals are frequently fraught with the irritability, slowness and lack of interest of the patients.

When sudden illness strikes, it reaches into the hearts and moves the hands of friends and neighbors - even strangers. Lingering illness lacks the drama that demands immediate voluntary assistance. But the chronically ill patient's needs are like his disease - lingering, trying, continuous. 7

Only a sincere belief in the dignity of the human person and the duty to augment and sustain each person's existence can motivate the nurse in the work of rehabilitation, particularly that of the aged.

Because of the growing number of older people in our population, we know that both the number of cases of chronic disease and the problems associated with these diseases are certain to increase. There is little hope that the problem of chronic illness will decrease unless we find some means of improving the health standards of our older population. 8

Actually it is felt that the general hospital is not always the best place psychologically for the long-term patient. For one thing, the high cost of hospital care is prohibitive to a prolonged stay for most patients and besides, these patients frequently do not require the tech-


8 Ibid., p.22.
nical care which the hospital staff is geared to give. Again, the pa-
tient is constantly interrupted by the many tests, treatments and proce-
dures conducted in the care of the acutely ill. He may be annoyed by the
distractions and interruptions of his rest or he may feel that the acutely
ill are getting more service from the doctors and nurses and may think
he must compete for their attention by constant demands. But the great-
est obstacle to the good of the chronically ill patient in a general hos-
pital is the fact that the atmosphere of the hospital is one of sickness.9

The emphasis is on taking care of the patient, doing things for
him. For the patient with a long-term illness, this type of care is
no longer considered to be the best; instead, the emphasis has shift-
ed to encouraging the patient to do more things for himself. Many
times these patients are bedridden for long periods of time, and
because of this there is grave danger of them becoming increasingly
helpless unless encouraged to do some things for themselves. The
routine of the general hospital is not geared to these patients. All
too often the personnel are inclined to think it is easier and quick-
er to do things for the patient than to have him help himself. As a
result, the patient may become increasingly dependent and lose all
incentive to do things for himself.10

Despite the realization that the general hospital is not the
most desirable environment for the chronically ill, the fact remains that
the number of long-term patients filling beds in these hospitals is high.
Studies show that five out of six hospital beds are occupied by the
chronically ill.11 This figure is not so unreasonable considering that

9 Ibid., p.51.
10 Ibid., p.52.
11 Federal Security Agency, Public Health Service, Chronic Disease,
it includes as chronic the mentally ill (who fill 55 per cent of all the hospital beds in the United States today) and the large number of tubercular patients in sanatoriums. None the less, it is a terrifically high figure and is one that warrants the consideration of the need for care of these patients.

With the instability of family life caused by high divorce rates, with the socially accepted reluctance to keep sick and aged people in the home, and because of insufficient and poorly run nursing homes, the majority of chronic patients simply have no other place to go than to the general hospital. 12

In conjunction with the attempted development of more numerous and more desirable nursing homes, an alleviation of the problem is being sought within the hospital by the creation of special units for the chronically ill. These units are designed to meet the special needs of patients requiring long-term care during periods of diagnosis, study and acute episodes. Just as it is undesirable for the patient to continue to stay indefinitely in the general hospital, it is also undesirable for him to stay in the special unit after establishment of a routine toward rehabilitation. He should be taken home or to a home substitute in order to provide space for those who need the special services he no longer requires. 13

---

12 The Teacher's Page, "Care of the Chronically Ill," Davis Nursing Survey, XX (February, 1956), 53.
13 Waterman and Lang, op. cit., p.50.
PATIENT NEEDS AND RESOURCES

NEEDS
- Spiritual
- Medical
- Financial
- Psychological
- Educational
- Physical

PATIENT

RESOURCES
- Community
  - Family
  - Friends
  - Clergymen
  - Public Health
  - Social Workers
  - Welfare Agencies
  - Church Groups
  - Public Agencies
- National
  - Office of Vocational Rehabilitation
  - Commission on Chronic Diseases
  - U.S. Public Health Service
  - Rehabilitation Association
  - National Disease Societies
  - Veteran's Administration
  - Professional Societies
  - Children's Welfare

Hospital
- Nurse
- Physician
- Dietitian
- Psychiatrist
- Physiotherapist
- X-ray Technician
- Laboratory Technician
- Medico-social Consultant
CHAPTER III

THE NEED FOR REHABILITATION

To carry out the implication of nursing the "whole patient" to its logical conclusion, the nurse's responsibility toward patient health does not end as the hospital doors swing shut behind the newly discharged patient. The patient enters the hospital as a person with a certain position in society and will return to live, play, pray and work as a person in society. Yet it would be foolish to suppose that the nurse employed in a hospital would be able to keep a check on a patient after he had left the institution. It will be her preparation of the patient to return to a normal life that will assist him in the time after discharge. A survey of the Hospital Council of Greater New York showed that 5 per cent of general surgical patients, 15 per cent of medical patients, 30 per cent of all clinic patients and 85 per cent of orthopedic patients did not need further medical care but did need rehabilitation and retraining in order to go back to work.11 While the patient is in the hospital, the nurse carries out her duty toward patient health after his discharge from the hospital through rehabili-

11 Howard A. Rusk M.D., "Implications for Nursing in Rehabilitation," American Journal of Nursing, XXXVIII (February, 1938), 2.
tation and preparation for his further rehabilitation.

Beside those patients who need help only with the adjustment from hospital to home, is the increasing number of patients who must be prepared for further rehabilitation.

Today, the United States is faced with a growing tide of chronic diseases with their concomitant disability, which threatens to engulf our national life medically, socially and economically. Paradoxically, we in medicine have caused much of this inundation through the scientific advances made in reducing the incidence of death from infectious and communicable diseases, through a reduction in infant mortality, and through improved public health measures, thereby producing an aging population.\(^{15}\)

Two thousand years ago, the average length of life was 25 years; at the turn of the century, \(h_9\); and today it is 67. In 1900, one person in 25 was 65 years of age or older. It is estimated that in 1980, the ratio of persons over 65 years will be one in 10. As people become older, they require more medical services. In 1940, one-fourth of the nation's population was over 45 and required over half of the nation's medical services, and by 1980, it is estimated that those over 45 will constitute nearly half of the population.\(^{16}\)

Better maternal and child care, immunization programs, sanitation, education, treatment and higher standards of living have brought about a change in the incidence of the causes of death from 1900 to 1948. The decrease in deaths from acute infectious diseases, and the increase in those diseases more closely associated with older age.


\(^{16}\) Ibid., p.2.
<table>
<thead>
<tr>
<th></th>
<th>1900</th>
<th>1948</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pneumonia and influenza</td>
<td>Cardiovascular diseases</td>
</tr>
<tr>
<td>2</td>
<td>Tuberculosis</td>
<td>Cancer</td>
</tr>
<tr>
<td>3</td>
<td>Diarrhea and enteritis</td>
<td>Brain hemorrhage</td>
</tr>
<tr>
<td>4</td>
<td>Cardiovascular diseases</td>
<td>Accidents</td>
</tr>
<tr>
<td>5</td>
<td>Senility (unknown)</td>
<td>Nephritis</td>
</tr>
<tr>
<td>6</td>
<td>Brain hemorrhage</td>
<td>Pneumonia and influenza</td>
</tr>
<tr>
<td>7</td>
<td>Nephritis</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>8</td>
<td>Accidents</td>
<td>Premature birth</td>
</tr>
<tr>
<td>9</td>
<td>Cancer</td>
<td>Diabetes</td>
</tr>
<tr>
<td>10</td>
<td>Diphtheria</td>
<td>Senility (unknown)</td>
</tr>
</tbody>
</table>

groups, have raised the mortality age and given us a higher percentage of old people.

Hearing defects, multiple sclerosis, epilepsy, arthritis, diabetes, nephritis, tuberculosis, cancer, cardiovascular diseases, syphilis, blindness, spasticity and mental disorders are the main disease conditions into which the 28,000,000 persons with chronic disease in the United States can be divided. Disability from illness or some other condition prevents 5.4 per cent of the population from doing anything but occasional part-time work. Not only is the problem of chronic disease confined to the old; one half of the chronically ill are under 45 years of age. (Chart 2, Page 13)

Though their numbers are large, disabled war veterans constitute but a fraction of the population in need of rehabilitation. During the war there were 19,000 amputees in the military services, but during the same period, over 120,000 civilians suffered major amputations resulting from disease and accidents. The number of men blinded in military service during the war totaled about 1,500, but 60,000 civilians lost their sight during the war years. Approximately 260,000 service men were permanently disabled in combat duty; some 1,250,000 civilians were crippled by accident and disease during those four


19 Ibid., p.1.
The economic loss from illness and accident is such that industry is spending large sums annually in health programs, studies, research, and insurance plans. Every year approximately one billion work days are lost. Yet 75 per cent of chronic diseases are partially or completely controllable. The average cost to maintain one dependent disabled person is $350 to $600 annually, while the single cost of $450 would provide individual vocational rehabilitation that would last for life. In 1951, 63,000 successful rehabilitations resulted in a net gain of $98,000,000 in salaries for the trainees after the first year of rehabilitation, and although the economic figures are more tangible, the psychological effects of the return to productivity and usefulness indicated, must have far outweighed the financial returns.

Although the growing necessity of rehabilitation is partially evident from the economic pressure and health needs of society, these do not give an adequate reason for carrying on the tedious work of rehabilitation. The patient's renewed productivity and the increased national spending power due to his financial returns are impelling motives to foster a rehabilitation program, but these motives fall far short of a truly basic reason for rehabilitation.

22 Waterman Lang, op. cit., p.294.
Neither is the entire answer in the duty of society to provide for its ailing members, or the family to care for its own. If it were, then the problem of a disabled older person without family or kin could be solved properly by providing palliative care for his needs and not necessarily by expending the time and effort of retraining, particularly when his life span will probably be short. The true need for rehabilitation is founded on the concept of the dignity of the human individual. Each person has a right not only to life, but to as full a life as he can achieve. "The goodness of the thing consists not only in its mere being, but in all the things needed for its perfection." We attempt to assist the person to gain as much independence in his life as possible, even if this independence may consist only in his ability to care for a few of his personal needs.

It would be incorrect to take the stand that because man is destined for eternity, what happens to him in time outside the direct scope of his eternal end is inconsequential. All other things considered, man grows spiritually most easily in an atmosphere of psychological and, to a lesser extent, physical, well-being. It is well to be aware that caring for the person's temporal needs may help to remove obstacles which could prevent his spiritual growth.

CHAPTER IV

WHEN DOES REHABILITATION BEGIN

The misconception that rehabilitation begins when the patient is well into convalescence or when he is about to be discharged to a rehabilitation center, may well be responsible for the failure of some patients to return to a state of usefulness and self-respect.

Rehabilitation is an innate element of adequate care and properly begins with diagnosis. It is applicable alike to persons who may become employable and to those whose only realistic hope may be a higher level of self-care. Not only must formal rehabilitation services be supplied as needed, but programs, institutions, and personnel must be aggressively rehabilitation-minded.24

Perhaps the best approach to rehabilitating the patient was proposed by John Galsworthy in an address in 1919 to a conference on the care of the disabled:

Restoration is at least as much a matter of spirit as of body and must have as its central truth that body and spirit are inextricably conjoined. To consider either one without the other is impossible. If a man's mind, courage and interest be enlisted in the cause of his own salvation, healing goes on space, the sufferer is remade. If not, no mere surgical wonder, no careful nursing will avail to make a man of him again. Therefore, I would say: "From the moment

---

24 The Teacher's Page, "Long-term Illness and Chronic Disease," Davis Nursing Survey, XXI (March, 1957), 64.
he enters the hospital, look after his mind and his will; give him food; nourish him in subtle ways; increase that nourishment as his strength increases. Give him interest in his future. Light a star for him to fix his eyes on so that when he steps out of the hospital you shall not have to begin to train one who for months, perhaps years, has been living mindless and will-less the life of a half-dead creature."

That this is a hard task, and none who knows hospital life can doubt, that it needs special qualities and special effort quite other than the average range of hospital devotion is obvious, but it saves time in the end and without it success is more than doubtful. The crucial period is the time spent in the hospital. Use that period to re-create not only the body but mind and will power and all shall come out right. Neglect to use it thus and the heart of many a sufferer and of many a would-be healer will break from sheer discouragement. A niche of usefulness and self-respect must be found for him. To carry the process of restoration to a point short of this is to leave the cathedral without a spire. To restore him and with him the future of our countries, that is the sacred work.25

As rehabilitation, to be effective, must begin at the earliest possible moment after acute illness, patient motivation must be started by the bedside nurse.26 But until the nurse realizes the psychological problems that confront many of the patients who need rehabilitation, she will never be an effective instrument of motivation.

In man's natural striving for happiness, several basic drives are discernible. They are grouped and classified differently by various persons but generally can be divided into the needs of preservation of life, of love, of esteem or worth as an individual and of self-realization or productivity.27 Rehabilitation strives to meet these needs but the disabled

26 Howard A. Rusk, "Implications for Nursing in Rehabilitation," American Journal of Nursing, XXXVIII, (February, 1948), 2.
person may be so emotionally upset and confused that he does not accept
the means of help that rehabilitation can give.

Some leaders in the field (of rehabilitation) have come to the
conclusion that more than 50 per cent of physical disability is due
to emotional problems. One careful study indicated that 20 per cent
of the 200 cerebral palsied studied were unemployable because of
emotional maladjustment.28

The acceptance of physical disability must extend to three as-
pects: the physical, in which the patient has a concrete awareness of
the origin and nature of his disability, the complications that may ensue
and the prognosis that may be expected; the social, in which the patient
has a realistic attitude toward his job of the type of work he will be
able to do and toward his family and friends; and the psychological, in
which the patient is showing no serious emotional symptoms in handling
the idea of his disability.29

An attempt to achieve an attitude of acceptance poses problems
that are both social and personal in nature. In looking at things real-
istically, we are aware of the fact that society on the whole reacts det-
rimentally to the disabled, but we cannot speak of real acceptance unless
the patient is capable of integrating himself into society, whether
society's reaction to him is detrimental or not. The disabled person
who complains of or fears that employers hesitate to hire disabled
persons, that he will be "looked at" or that his marital prospects will

28 Jayne Shover, "Estimating Long-range Potentials for the Center," Re-

29 Morris Grayson, M.D., "The Concept of Acceptance," Journal of the
American Medical Association, (March, 1951, p.1)
be very dim, expresses situations that, unfortunately, are only too true. To a great extent he must realize them and attempt to overcome his reaction against them.  

The solution of social problems is facilitated by personal, or inner, realization, and it is a painful struggle for the patient to recognize his disability as a part of himself. "In working with disabled persons one is frequently impressed, not with their depression, as one would imagine, but more with their complete inability to understand what the disability is all about." As in the case of any emotional problem, the person handles it in the manner of his own personality pattern. Some patients may feel that the disability represents a punishment and may deny the disability by hostility toward any measures of alleviating it, or by a withdrawal into himself, a feeling of unreality, or depersonalization, or perhaps he may attempt to blame others for it. Other patients may show evidence that conscious or unconscious guilt feelings are assuaged by the disability and move with a certain gratitude into a dependent and untaxed role. Still other patients may see their disability as God's will and receive it as such, even though emotionally it may be difficult to realize as part of themselves.

Although the burden of acceptance falls mainly on the patient, the health team must provide an atmosphere in which the patient is able to achieve it. This must be effected through the staff understanding

30 Ibid., p.5.
31 Grayson, op. cit., p.3.
the patient and his disability. The patient will look to the staff as the measure of the social acceptance he will find in the future and the inner acceptance he himself can achieve. He will unconsciously use the staff to test out his own understanding of his disability in terms of himself and society. This testing may manifest itself in many ways and may range in varying degrees from the extreme of marked affection and dependence to that of hostility and negativism. Thus, all the personnel must be aware of these psychological needs and reactions in order to accept the patient as he is, so that the patient in turn will learn to accept himself.

In dealing with these patients, one must not forget that if the patient is going to benefit by rehabilitation, his acceptance must be active. This means that while on one hand the individual will have to acknowledge certain limitations, on the other hand he will move forward to develop the capabilities he has left.  

CHAPTER V

ATTITUDES FOR REHABILITATION IN NURSING CARE

From her beginning days in the hospital, the nurse is imbued with the nobility of doing everything possible for the patient. In rehabilitation, it is necessary for the nurse to broaden and make her concept of nursing more flexible. She must realize that there comes a time in the patient's convalescence when the best thing she can do for him is to teach him to do as much as possible for himself. For some patients, dependence is the most comfortable and the easiest way of meeting needs, especially if the nurses are all too eager to spare the patients any effort. For others, dependence brings irritation and resentment although they have not been trained to effectively help themselves, and they must grudgingly accept the assistance of the nurses. This does not mean that the nurse concerned with rehabilitation will leave the patient to fare for himself and be spared the effort of care. On the contrary, planning, teaching and patient practice will be as taxing and time-consuming as if she were to do everything for the patient. Anyone who has ever had experience teaching a child to do a

task knows how much easier it is to do the job oneself and get it done correctly than wait for the painstaking and bungling efforts the child will make. Gradually the nurse de-emphasizes her part in meeting the patient's physical needs and finally begins to withhold her support in his psychological needs, leading him to be able to rely on himself and his local community.

The busy nurse of today may be tempted to regard proposals of planning, psychological care and instructing, with scepticism if not with real irritation. She has been made responsible for a multiplicity of technical functions and, because of rapid advances in medical therapeutics and intricate surgical procedures, finds herself with a high percentage of patients who need intensive nursing care. In many cases, personnel, particularly professional personnel, are insufficient and the weight of the technical functions falls to the staff nurse, head nurse and supervisor. The nurse is expected to perform all the modern nursing procedures skillfully and at the same time retain the calm personal approach of a more circumscribed era of nursing. With the acceptance of new procedures there has been no displacement of the old ones, but nursing has come to the stage in which there must be some re-evaluation and displacement before any more new ideas can be absorbed. The conscientious nurse already feels keenly her inability in many instances to carry out the comprehensive care she realizes patients could receive, and any proposals for improved patient care which would make a further demand of time are viewed as idealistic and although perhaps desirable,
nevertheless impractical in nursing as it is today.

Fortunately, the concepts of rehabilitation nursing accomplish a large part of this re-evaluation and revision. The time for care and planning is not increased but modified. The patient is not cared for and trained but cared for by training. Rehabilitation has found that doing everything for the patient is unnecessary and actually detrimental. In establishing a program of rehabilitation, the nurse should realize that to be effective it does not take extra time but takes an integration of care, instruction and planning throughout all nursing procedures.

An awareness of rehabilitation needs must permeate the entire staff and this awareness, or rehabilitation atmosphere, rests largely on the attitude of the head nurse and supervisor. Work assignments and nursing care plans, made with the view of the patient's gradual assumption of partial responsibility for his own needs, as well as emphasis on body alignment, exercise and reflex re-training, will do much to foster a rehabilitation atmosphere. In guiding the personnel toward acceptance of the patients as they are, it is well to remember that the staff, particularly the semi-professional staff, will quickly sense the attitude of the head nurse and supervisor toward patients, particularly those patients going through a period of emotional adjustment. Passing remarks, innuendoes, and even tale bearing, may reveal a judgmental

34. Jensen, op. cit., p.49
attitude and set the tone of the department accordingly.

The first step in planning nursing care with a rehabilitation consciousness is to determine the rehabilitation goal of each individual patient. This may be done by simple observation and interpretation on the part of the nurse or it may involve discussion of the prognosis with the doctor and the physiotherapist. The rehabilitation goal will vary among patients as to the length of time necessary to return to a normal state of health and to the limitations that the patient can expect. Although the plan must be optimistic, it must be characterized by realism. It would be unjustifiable to hold out the hope of complete return to normal function to a patient suffering a severe disability when his efforts would be spent more fruitfully in learning a few measures of personal care with the functions he does have left. On the other hand, it would be equally as unjustifiable not to motivate a patient to strive for a high degree of independence simply because the struggle to achieve it will be long and arduous.

After the rehabilitation goal has been determined, the nurse should work out a plan through which the patient’s particular educational, psychological and physical rehabilitation needs can be met through the hospital routine. Modifications in the rehabilitation goal may come about as convalescence progresses and either accelerated recovery occurs or hoped-for-gains are not made, but these modifications can usually be easily fitted into the original plan. To insure that the plan is carried out regularly and included in the daily routine of care,
the main points should be noted in the patient treatment file. For formal teaching needs, such as diet instruction, insulin instruction, etc., space should be allowed to record and check their completion before plans for dismissal are begun.

Educational care consists of planning with the patient for the future. The nurse and patient must discuss necessary modification in the patient's activities for the future concerning his work, diet, home conditions and recreation. This usually can be accomplished most easily and effectively through informal and incidental teaching while giving routine care, during ward rounds, and in the various contacts the nurse has with the patient during the day. Formal teaching, in which the nurse sets aside a definite time in which she approaches the patient only for the purpose of instruction, should not be relied on too heavily. This does not mean, however, that teaching should not be planned. Even in incidental and informal teaching, the nurse must have in mind the patient's educational needs and make use of opportunities for instruction during their conversation. But as the patient's condition involves all the people in his environment, his family must be made aware of the way they can help the patient while he is still in the hospital and when he returns home.

An attempt also should be made to indicate to the patient the

community resources from which he can get necessary assistance after his dismissal. Financial aid may be obtained in various cases from Unemployment Compensation, the Department of Welfare, insurance policies, State Support for the Disabled, or any local agency. Nursing and medical problems are usually handled through the Public Health Service, county or city physician, or the Child Health and Welfare Department. Arrangements for further rehabilitation are often made through the State Office of Vocational Rehabilitation, the Veteran's Administration, or rehabilitation centers in hospitals or other related agencies. 36

Last, but by no means least, the patient should be discharged with the knowledge that there are people to whom he can turn. His own physician heads the list and if indicated, the local Visiting Nurse Association may be asked to visit him once or twice to help him over the transition period from hospital to home. If the patient is to return to the clinic, it should be made clear to him that this visit is very important, even though he may be doing very well. 37

Inclusion of both formal and informal teaching needs in the daily assignment will encourage students and staff nurses to correlate health teaching in their daily care plan.

As we have seen, psychological care centers mainly about helping the patient toward attitudes of acceptance. Beside the important aspect of the staff itself accepting the patient as he is, other techniques in the psychological rehabilitation of the patient are helpful. 36

36 Jensen, op. cit., pp.57-61

Discussing future rehabilitation plans and goals will assist the patient toward better and more complete understanding. This should be done realistically and must be fitted to the personality of the patient. The same explanation that would suit a ten-year old child would not be very effective for a bio-chemist, a 60 year-old widow or a coal miner. In any case, tendencies toward a patronizing attitude, affectation, or cold efficiency should be avoided.

Another highly important aspect of psychological rehabilitation is that of diversional activity. Radio, television, books, and magazines are probably the most easily provided forms of recreation, especially for the bedridden or sub-acutely ill patient. Variety and more self-activity such as in knitting, crocheting, and leather work should also be encouraged. Ambulatory patients enjoy visiting one another or playing cards and there is usually some little-used corner that could be provided with a few chairs and a table so the patients can chat or play. For long-term ambulatory patients, going outside for short walks around the hospital grounds or even sitting out in the fresh air is often a great boon to morale. Perhaps the diversional activity of the most help and importance to the patient is that of the visits with his family. This is the tie that links the patient to life outside the hospital environment and often serves to stimulate his interests and motivate his efforts toward recovery. In the case of long-term or disabling illnesses, the family should become thoroughly familiar with

38 Waterman and Lang, op. cit., p.41.
the patient's condition, care and rehabilitation needs. In this way, when the patient returns to his home, a great deal of the adjustment, strangeness and fear on the part of both the patient and the family will be alleviated. Visitors should be welcomed with cordiality and arrangements made, if possible, so that nursing procedures will not disrupt the time set aside for visiting. If children are not allowed on the hospital wards, some method should be provided to permit the long-term patient to visit his family either by sending the patient to an area in which children are permitted or, if that is not feasible, permitting the entrance of children to a restricted ward.

Remembering occasions special to the patient such as a birthday or the accomplishment of a rehabilitation goal, by a small token such as a card or an afternoon treat for the group of immediate patients is an effective way of maintaining good spirits because it recognizes the patient as a person.

In motivating the patient toward acceptance and sublimation of his disabilities, the nurse should use his family ties and natural desires for happiness and independence as compelling forces but must remember that true acceptance is in the realization that the illness is God's will for him and is directed by His Providence. This leads to the desire to utilize fully whatever capacity is left to him. On a bronze tablet in the lobby of the Institute of Physical Medicine and Rehabilitation in New York is inscribed as an inspiration to all, this concept of acceptance by an unknown Confederate soldier:
I asked God for strength, that I might achieve
I was made weak, that I might humbly learn to obey...

I asked for health, that I might do greater things
I was given infirmity, that I might do better things...

I asked for riches, that I might be happy
I was given poverty, that I might be wise...

I asked for power, that I might have the praise of men
I was given weakness, that I might feel the need of God...

I asked for all things, that I might enjoy life
I was given life, that I might enjoy all things...

I got nothing that I asked for — but everything I had hoped for
Almost despite myself, my unspoken prayers were answered
I am among all men, most richly blessed!

Physical care is centered about achieving the best possible condition of the patient for return to his home or to a rehabilitation center. The first and most obvious aspect is that of good general nursing care. The patient must be watched for the development of untoward symptoms of secondary infection or the exacerbation of the disease process even after he is apparently convalescing. The possibility of developing hypostatic pneumonia must be lessened by encouraging movement and deep breathing, and circulation to the extremities should be stimulated by some exercise during all stages of the disease. Frequent back care and maintenance of dry linen assists in preventing decubitus ulcers. The patient also must be protected against resuming activities too.

rapidly and over-tiring himself, and against falls and accidents because of lack of assistance and supervision.

Keeping good body alignment, applying supportive measures to prevent deformity, and maintaining muscle tone and range of joint motion are vital techniques in physical rehabilitation. Many cases of muscle imbalance and contractures result because of lack of adequate exercise when the patient was bed-ridden or even when he was in a wheelchair. The proper treatment of these conditions is prevention. Active exercises are those the patient performs aided only by instruction from the nurse or therapist, while passive exercises are those in which the nurse moves the patient’s joints through a range of motion without assistance from the patient. See Figures 1-3. For patients who will be using crutches or for those who will need the arm and shoulder muscles strengthened for helping themselves in and out of a wheelchair, these exercises may be started when the patient is still confined to bed:

1. Flexion and extension of arms.
2. Coming to sitting position by bending the elbows and pushing the hands onto the bed in such a way as to raise the body by straightening the elbows.
3. Pushing the body off the bed by pushing down on the hands and straightening the elbows.
4. Squeezing grippers.
5. Raising the head and shoulders from bed; reaching forward with the hands as far as possible.

---

40 Jensen, op. cit., p.85
41 Ibid., p.109
NORMAL RANGE OF JOINT MOTION

FOOT AND ANKLE

![Diagram of joint motions](image)

Dorsal flexion 45°
Plantar extension 35°
Eversion 25°
Inversion

Knee

Extension 10°
Flexion 45°

Hip

Flexion 125°
Hyperextension
Abduction 50°

Adduction 45°
Internal rotation 30°
External rotation 60°

Figure 1. (Cited in Jensen, op. cit., pp. 77-78, from Air Forces Manual no. 23. New York: Training Aids Division, Army Air Force.)
33. NORMAL RANGE OF JOINT MOTION

Shoulder

Flexion  Hyperextension  Abduction  Adduction

External rotation  Upward rotation  Internal rotation  Elevation

Wrist

Radial flexion  Flexion  Ulnar flexion

Figure 2. (Cited in Jensen, op. cit., pp. 78-79, from Air Forces Manual, No. 23, New York: Training Aids Division, Army Air Force.)
NORMAL RANGE OF MOTION

Spine

Flexion  | Lateral flexion  | Hyperextension

Neck

Flexion  | Extension  | Rotation  | Lateral Flexion

Elbow

Flexion  | Extension  | Supination  | Pronation

Figure 3. (Cited in Jensen, op. cit., p. 79, from Air Forces Manual, no. 23, New York: Training Aids Division, Army Air Forces.)
If possible the patient using a wheelchair should not be lifted bodily from the bed to be placed in the chair, but should help himself in moving into the chair. This can be accomplished if the wheelchair is placed next to the bed. The patient moves parallel to the edge of the bed, grasps the far arm of the wheelchair with one hand, then lowers himself gradually from the side of the bed, to the inner chair arm, then into the seat while two nurses partially support his weight or guide an injured extremity with a drawsheet or by hand. The procedure should be thought out and explained carefully to the patient beforehand.

Because many hospitals are without the services of a physiotherapist, the nurse should be familiar with the correct use of crutches. Most people are familiar with crutch gaits from observation but these points should be kept in mind when instructing the patient in crutch-walking:

1. Crutches must be individually measured and adjusted for correct length. Measurement is made from the armpit to the ankle bone to determine the right length.

2. The hand piece should be placed to allow a 30 degree angle at the elbow.

3. The shoulder pieces should be protected with rubber pads but the weight should be borne on the hands, not the armpits.

4. Soft rubber suction tips prevent slipping of the crutches.

5. Crutches should be placed from three to four inches to the
side of the patient to provide a broad base for balance.

6. The patient should never stop with the crutch tips behind him, or he may easily be thrown off balance.

7. Crutch walking is very tiring to the beginner. Until the patient has had some practice and is sure of his balance on the crutches, he should practice in a supervised area.

Dietary needs are important in rehabilitation of patients, especially of the aged patients and those with chronic illness. The two major nutritional disturbances encountered among the chronically diseased are malnutrition and obesity. In a recent study of 431 patients with chronic illness, 138 were suffering malnutrition and in nine patients the sole disability was starvation. Some of the physical characteristics of malnutrition such as hepatomegaly, pallor, psychiatric aberrations, skin changes, weakness, muscle atrophy and decubitus ulcers are enough in themselves to recommend specifically an adequate dietary program as an important adjunct to rehabilitation.

Obesity, with its resultant overtaxing of the heart, poor circulation, and repression of exercise, is equally detrimental to rehabilitation. As most dietary problems are due to faulty eating habits, food idiosyncrasies, anorexia due to disease, and emotional problems, at least partial control of nutritional needs can be accomplished in the hospital.

---

by evaluation of the patient and regulating the diet, as well as instructing and gradually orientating the patient to good food habits. Foods that are well chosen and attractively served, that are offered with a certain amount of concern for the patient's likes and dislikes, and that are prepared to meet the patient's chewing ability, are paramount to building better nutritional habits.

The hospitalized patient is predisposed to problems of elimination because of several factors. Inactivity, disruption of eating habits, dehydration and abdominal surgery account for many of the problems which are cared for by the doctor through ordering treatment and medication, but in cases of incontinence due to trauma or disease, the ingenuity of the nurse is frequently more tried than that of the doctor. With traumatic injury to the spinal cord, there may be partial or complete loss of bowel and bladder control and rehabilitation must begin in the hospital as soon as possible, to train the reflexes of these organs to empty at specific times. Incontinence produces an embarrassed, uncomfortable patient, the development of decubitus ulcers and a tendency for the patient to withdraw within himself. As the odor and irritating action of body wastes are due to a urea-splitting bacteria which produces ammonia, a new antiseptic in the form of a powder which prevents urea-splitting is now being used over the skin surface, along

43. An excellent review of bowel and bladder training can be found in Alice B. Morrissey, R.N., "The Procedures of Bowel and Bladder Training," American Journal of Nursing, (March, 1951), pp.194-197
with the usual measures of extra attention to cleanliness and frequent turning and massage.

As soon as a patient has passed the acute stage of illness, his care should gradually be increased in self-activity. In making out care assignments, the head nurse must be aware not only of the patient's rehabilitation goal, but also of his maximum progress in recovery and, at the same time avoid routine advancement in self-help unrelated to the patient's capacity. Emphasis should be placed on caring for personal needs. Responsibility for his oral hygiene and part of his own bedbath as well as turning in bed, and leg and breathing exercises with a minimum of assistance are primary measures in progress. The application of overhead bars, side-rails or half-rails to the bed frequently facilitates turning and positioning for the patient particularly in the case of an older, obese patient or one with lower neurological damage. A patient who requires prolonged treatment such as an irrigation or dressing, which may still be necessary after dismissal, should be taught the procedure involved soon enough in his convalescence to insure the opportunity for sufficient repetition with supervision to gain skill and confidence.

In administering a plan of gradually increased patient independence, the head nurse must constantly be aware of two tendencies which could vitiate the entire program; the use of patients' self-help as

---

The term "head nurse" is used here to designate whichever member of the staff make(s) out daily care assignments.
a means of avoiding work by the personnel and indiscriminate decisions by anyone on the ward as to the degree of independence of which the patient is capable. In this day of overtaxed hospital facilities, high percentage of briefly trained auxiliary personnel and shortage of professional nurses, these tendencies have to be closely guarded against, or a method that is designed to improve care will actually cause decline in the quality of patient care. In order to insure that the patient is trained to meet his own needs as a means of gradual rehabilitation to home life, close, helpful supervision must accompany patient activity. If the program does happen to free the personnel of some of their duties, it will only free them to devote their time to some area of patient care they were unable to perform before because of lack of time. In teaching the patient procedures in which asepsis is an important part, the nurse particularly must repeat the demonstration and supervise practice by the patient until she is sure that the patient grasps the underlying techniques, and yet she must exercise enough prudence not to lead the patient to fear or scrupulosity. Rehabilitative measures should be included in the daily care assignment by the head nurse who is fully aware of the implications of the patient's condition and needs. This is done to avoid advancing the patient beyond therapeutic limits in order to expedite a heavy work assignment.
CHAPTER VI

SUMMARY AND CONCLUSION

Summary

With realization of the need of total patient care and the upsurge of chronic disease and disability, rehabilitation is becoming an increasingly important phase of medicine, but one of the greatest deterring factors to rehabilitation is improper physical and psychological preparation for it. It is during the time of acute illness and early convalescence when attitudes are formed and the body recovers, that preparation for rehabilitation must be effected and it is this period that is most frequently spent in a general hospital.

Rehabilitation is concerned with the restoration of the whole person who has been handicapped by disease or accident to as full a life as possible. Included in this number are not only those patients who are permanently disabled or crippled but also the patients who need help adjusting to normal home life after being temporarily handicapped by illness. Increased medical skill and the successful fight against acute disease have produced an aging population and a high percentage of persons affected with chronic illnesses who need assistance in achieving a happy, fairly independent life.
Since the three phases of rehabilitation are curative, conditioning and vocational, it is apparent that rehabilitation must begin as soon as the patient is diagnosed and must be aimed at understanding and providing for the psychological drives of the patient as well as for his physical needs.

To achieve rehabilitation in a general hospital, the nurse must realize that rehabilitation is not an extra, time-consuming treatment, but the integration of the concept of restoration to a fuller life, in all care, instruction and planning. She must discard the idea of over-assistance of the patient and by her attitude, influence all the personnel toward rehabilitation consciousness.

Educational, psychological and physical aspects of rehabilitation are planned by the head nurse and included in the daily care assignment. After the rehabilitation goal for the patient is set, the nurse discusses and instructs the patient and his family in the accomplishment of his modified living pattern. She proposes motivation for acceptance and sublimation of his disabilities and guides him along realistic lines of adjustment. The physical care of the patient purposes to achieve the best possible condition for the patient's return home or for future rehabilitation and centers around good general nursing care, attention to dietary needs, elimination and adequate restorative exercises, and advancement toward independence through gradually increased self-help.
Conclusion

Total rehabilitation is a broad and complex field involving several aspects and concepts and including, along with many medical and community facilities, all the members of the health team. Every member of the team has a specific role in rehabilitation, and the nurse in a general hospital has a responsibility for providing physical and psychological preparation by developing a rehabilitation consciousness in all her nursing care.

This thesis has attempted to formulate a simple program emphasising the role of the health team and the individual nurse in the accomplishment of rehabilitative nursing care in a general hospital.

Beginning with the basic concepts of rehabilitation, the nurse learns the importance of a rehabilitation consciousness and advances to a practical plan of achieving this consciousness throughout her nursing care in meeting educational, psychological and physical needs.
BIBLIOGRAPHY


