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Position Statement

UNDERGRADUATE NURSING CURRICULA

1 PREAMBLE

The purpose of this document is to set out the content of undergraduate nursing curricula that is deemed appropriate to ensure that all registered nurses are adequately prepared to provide nursing care that is rehabilitative by the completion of an undergraduate nursing degree.

This Position Statement is informed by the second edition of the ARNA Rehabilitation Nursing Scope of Practice Position Statement (Pryor, Lever, McNally & Draper, 2002) that states - each nurse should possess a repertoire of approaches to client care. This includes the ability to promote self-care and independence, as well as to actively participate in the prevention of unnecessary dependence of clients upon nursing care.

It is recommended that undergraduate nursing curricula include rehabilitation in both the theoretical and practice components of the program. Furthermore, rehabilitation should feature across the entire three years of the program as a philosophy that informs client centred care, rather than a practice setting or a phase of health care (Pryor, 1999a).

2 THEORETICAL CONTENT

The following should be included in the theoretical content of the program:

- The rehabilitation philosophy;
- International Classification of Functioning, Disability and Health (World Health Organisation, 2001a);
- The principles of rehabilitation nursing and their application across the health care continuum;
- The goals and focus of rehabilitation nursing (Pryor, 1999b; Pryor et al., 2002);
- The multidisciplinary team approach;
- Cure versus wellness model of health care;
- The social construction of disability; and
- The lived experience of chronic illness and disability.

To ensure appropriate coverage of this content, it should be taught by specialist rehabilitation nurses. The ARNA State Chapter Presidents would be able to recommend appropriately qualified persons.

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2.1 THE REHABILITATION PHILOSOPHY

Rehabilitation nurses believe that the rehabilitation philosophy should inform nursing practice across all practice settings. The rehabilitation philosophy is based on the belief that every human being has the right to determine their own thoughts, beliefs and actions (Pryor, 1999b). In terms of rehabilitation nursing practice, this philosophy is about each client's right to choose their goals, actions and priorities including their optimum level of functioning (Pryor, 1999b).

Whilst the ability to be independent is valued within rehabilitation settings, for many clients independence in the physical care of one's own body is not a realistic goal (Pryor, 1999b). The ability for clients, however, to make decisions about that care is frequently possible and is a principle that guides the actions of rehabilitation nurses. Through participation in making decisions about their rehabilitation, clients are enabled to live "...with as much freedom and autonomy as possible..." (McEachron, 1986 cited by Dittmar 1989, p.8).

The rehabilitation philosophy is reflected in the rehabilitative approach described by Pryor and Smith (2000) as follows:

The rehabilitative approach relates to the manner in which nursing activities are performed, adopting a wellness model of care with the specific intent of facilitating the patient's rehabilitation and discharge from the service. Adopting this approach nurses focus on the person's abilities, to see possibilities rather than focusing on disabilities. To contribute effectively to the facilitation of a person's rehabilitation, nurses must possess a repertoire of interpersonal skills and techniques, from which to choose when approaching each nurse-patient interaction. The choice of specific skills and techniques is based upon an assessment of the patient in his/her context at that point in time, being mindful of the patient's long term and short term goals. It also encompasses particular nursing activities that facilitate rehabilitation through the development of therapeutic relationships with individuals, and the creation of a rehabilitation milieu. Generally, the rehabilitative approach is associated with the nurse's ability to see 'the big picture', to possess 'a sense of that person' or to possess 'a sense of the whole' (p.20).

The rehabilitation philosophy includes not 'doing for' the client because of their disability, but focuses on enabling clients to be empowered and to take control over what is happening to them within the limits of safety (Davis, 1999; Pryor, 1999a). When the philosophy of rehabilitation does not commence as soon as the client enters the healthcare system, rehabilitation nurses believe a disservice is being done to the client. Whilst 'doing for' the client is quicker, it may result in increased dependency, poor self worth and poor self esteem (Davis, 1999; Pryor, 2001). Furthermore, there is adequate evidence to support the belief that rehabilitation should be an essential aspect of all nursing (Davis, 1999; Nolan & Nolan, 1998, 1999; Pryor, 1999a).

2.2 INTERNATIONAL CLASSIFICATION OF FUNCTIONING, DISABILITY AND HEALTH

The World Health Organisation (WHO) International Classification of Functioning, Disability and Health (ICF) aims "to provide a unified and standard language and framework for the description of health and health-related states" (WHO 2001b, p.3). It describes body functions and structures, activities and participation. The domains are classified from body, individual and societal perspective's.

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2.8 THE LIVED EXPERIENCE OF CHRONIC ILLNESS AND DISABILITY

An understanding of the lived experience of chronic illness and disability can enhance health care professionals' abilities to provide appropriate and timely care. Exposing students to the growing biographical and autobiographical resources written about and by people who have experienced chronic illness and disability provides the student with an insider's perspective, a perspective that is not well represented in the formal nursing literature.

3 CLINICAL PLACEMENTS

Designated rehabilitation settings are a rich environment for undergraduate clinical placements. In these settings, students will be exposed to the rehabilitation philosophy and the principles of rehabilitation in action. The clients are usually physiologically stable allowing the main emphasis to be rehabilitative nursing care. A wide variety of diagnostic groups and ages are common in rehabilitation inpatient, outpatient and community services.

All undergraduate nursing students should complete a minimum of one week's clinical placement in a designated rehabilitation setting. Ideally, this placement would be undertaken in the second year of the program.

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ICF also includes a list of environmental factors as an individual's functioning and disability occurs in a context. This is illustrated in the following example from W.H.O. (2001b):

When a person with a serious disability finds it difficult to work in a particular building because it does not provide ramps or elevators, the ICF identifies the needed focus of an intervention, ie. that the building should include those facilities and not that the person be forced out of a job because of an inability to work (p. 1).

Unlike traditional health indicators based on the mortality rates of populations, the ICF shifts focus to "life". The ICF also changes mainstream understanding of disability, takes into account the social aspects of disability and puts all disease and health conditions on an equal footing irrespective of their cause (WHO, 2001b).

In addition to understanding and measuring health outcomes, ICF can be used in clinical settings, health services or surveys at the individual or population level. For example, the ICF classification establishes a common language for describing health and health related states in order to improve communication between different users such as health care workers, researchers and people with disabilities (WHO, 2001b). Furthermore, ICF provides a useful framework for ensuring that nursing interventions are focused on the individual person and their particular situation.

2.3 THE PRINCIPLES OF REHABILITATION NURSING AND THEIR APPLICATION ACROSS THE HEALTH CARE CONTINUUM

Rehabilitation nursing is informed by several principles and any one nursing action could reflect several principles. To aid understanding, the following principles of rehabilitation nursing have been artificially separated.

- Health care should be client centred. This begins with providing clients with the information and permission to drive their care. To be successful, client centred care should take into account the developmental level of the client, the type of impairment, the significance of that impairment for the client and cultural aspects of the client.
- Health care should adopt a whole person approach and this includes addressing the physical, psychological, social and spiritual dimensions of being human.
- Health care professionals should move towards and enable an equal partnership in care with clients, their families and significant others. Partnership in care incorporates health professionals sharing information with clients to facilitate client-informed decision making and education. It includes elements such as relationship, reciprocity, sharing, equality, friendship and participation (Wade, 1995). In addition to being consistent with consumerism, partnership in care also leads to client empowerment, autonomy and client centred care (Wade, 1995). Without partnership, the aims and functions of healthcare professionals become meaningless in rehabilitation (Whitelock, 1999).
- Mutual goal setting informs the rehabilitation plan and allows the goals to be focused on the client rather than just health professionals. It also acts as a motivator for client performance since clients are more likely to be motivated to achieve their own goals. It entails informing clients of all the available options in an unbiased manner and health care professionals being open to choices generated by the client. Skills in communication, negotiation and conflict resolution are required to effectively break down client long term goals to achievable, realistic and measurable, short-term goals. Mutual goal setting facilitates client responsibility for goal achievement, avoids lack of assistance from health care professionals being misconstrued as a lack of care and enables the client to see

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improvement. Mutual goal setting may also enable the healthcare professional to identify where the client and their family are in their thinking regarding their rehabilitation program and whether they are focusing on realistic goals or not (Davis, 1999).

- Health care should be based on getting to know the individual person. This incorporates identifying the person's abilities, roles, likes, dislikes, preferred activities and social networks (Pryor, 1999b). Central to getting to know the person are the core activities of client observation, assessment and interpretation (Pryor & Smith, 2000, 2002). These activities are a continual process and should not be viewed as limited to the assessment undertaken on admission (Pryor, 1999b). Whilst getting to know the person takes time, it facilitates the setting of meaningful goals and formulation of the plan of care including discharge planning (Pryor & Smith, 2000, 2002).
- Maximisation of self-determination is central to the success of the rehabilitation program. This principle reflects the value that the right to decide goals, actions and priorities rests with the client. "Importantly, this must include the determination **by** the client of what **is** the optimum level of function" (Pryor, 1999b, p.83). Whilst a fundamental principle that should guide the action of all health professionals, it is not always straight forward. For many clients, autonomy of action and/or autonomy of decision-making is frequently impacted upon by physical and/or cognitive impairment (Sim, 1998 in Pryor, 1999b). In addition, self-determination does not and cannot readily answer ethical dilemmas that arise due to psychological and spiritual distress such as when the client claims death over life to be the preferred option. In such situations, self-determination by proxy, that is via family or significant others, may be the best alternate option available (Pryor, 1999b).
- Involvement of the family, significant others and carers can enhance the rehabilitation process. Family and significant others should be viewed by health care professionals as an extension of the client since chronic, disabling or developmental disorders do not occur in isolation from the family and significant others. Involvement should not be viewed as limited to family conferences. It should include assessment of knowledge of the client's condition and understanding of the rehabilitation process, preparation for potentially changed and increased roles and assessment of family and significant others adaptation.

2.4 THE GOALS AND FOCUS OF REHABILITATION NURSING

The goals of rehabilitation nursing are:

- the maximisation of self determination,
- the restoration of function, and
- the optimisation of lifestyle choices for their clients (Pryor et al., 2002).

To achieve these goals, rehabilitation nurses focus on:

- the maintenance of existing abilities and roles;
- the promotion of health;
- the prevention of further impairment of body structures and function;
- the prevention and reduction of activity limitations;
- the restoration of body function and social roles; and
- the minimisation of participation restrictions (Pryor et al., 2002).

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2.5 THE MULTIDISCIPLINARY TEAM APPROACH

Rehabilitation is enhanced by a multidisciplinary team approach. Because of the complexity of rehabilitation, it is unlikely that any one discipline would possess all the expertise required.

Building a successful multidisciplinary team requires effort in the working environment. This should result in improved efficiency and effectiveness in achieving the overall goals of the client, team members and organisation (Whitelock, 1999). With team building strategies, problems such as communication, coordination of effort and role overlap may be overcome (Davis, 1999).

2.6 CURE VERSUS WELLNESS MODEL OF HEALTH CARE

Rehabilitation is delivered adopting a wellness model of health care rather than the cure model. The wellness model approach focuses on the person's abilities to see possibilities rather than focusing on disabilities (Pryor & Smith, 2000, 2002). It is also an approach that involves clients in their care and enables them to be empowered (Armentrout, 1993; Davis, 1999). In comparison, the cure model approach is focused on 'fixing' the client, 'doing for' the client and/or 'telling' the client what to do. Whilst the cure approach may on occasions be the most appropriate model of care in acute health care settings, this approach is rarely appropriate in rehabilitation. Furthermore, most people with chronic illness and long term impairment 'live with' their condition and therefore require a wellness approach to assist them to adapt to lifestyle changes.

2.7 THE SOCIAL CONSTRUCTION OF DISABILITY

The consequences of disability have up until now been largely thought of in terms of the physical, sensory and intellectual 'inadequacies' likely to accompany the disability. The dominance of the 'medical model', with its curative approach based on deficiency, has highlighted an individual's inability to function in certain aspects of life. The impact of the social climate in which an individual with a disability lives, is often overlooked.

Fortunately, in recent years there has been a shift in conceptualisation of the nature of disability, towards a 'rights' model, where disability is viewed largely as a failure of the general community to accommodate diversity and difference. This change has been associated with initiatives such as:

- a heightened awareness within the general community that people with disabilities have the same rights as others;
- an expectation that disability services should be accountable to the users of the services;
- the introduction of legislation to protect the rights of people with disabilities; and
- the ability of people with disabilities and their advocates to lobby effectively for meaningful change in the arena of disability services.

Missing from these developments are the consequences of disability such as social and economic issues, acceptance by others, personal autonomy, income, vocational options, social status and labelling. These concepts are difficult to measure and quantify but none the less important. By considering all these aspects, it is possible to challenge traditional views of disability and establish a paradigm shift away from traditional perspectives such as the medical or pathological models.