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Completed Abstracts should be emailed to arna@arna.com.au by 29 June 2015
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At the AGM last year, an updated constitution for ARNA was adopted. Essentially, a constitution is a set of rules for running an organisation. Because ARNA is an incorporated association in NSW, the specific nature of the content to be included in ARNA’s constitution is spelled out in legislation, regulations and a model constitution in that state.

Review of the old constitution and drafting of the new one involved a lot of discussion and in this editorial I would like to draw your attention to a very specific and possibly most important part of those discussions and consequently the constitution. I am referring to the objective of ARNA. The importance of this part of the constitution is flagged by its positioning at the beginning of the document. The statement of objective spells out the purpose of ARNA and in so doing should inform our mission and activities.

In the new constitution the statement of objective was not only reworded, it was rethought. In the previous constitution, the following nine objectives of ARNA were included:

- To be recognised as a peak body that consults with, makes representation to, and advises government, governing bodies, educators, health care providers and consumers in regard to rehabilitation nursing
- To promote the roles and development of rehabilitation nurses in health services
- To serve as a forum for the exchange of ideas related to rehabilitation nursing and to represent these ideas at appropriate peak bodies.
- To promote the advancement of knowledge and skills in rehabilitation nursing through the promotion and support of education and research activities
- To facilitate the utilisation of new knowledge in the improvement of rehabilitation services
- To develop and maintain collaborative relationships with other specialist nursing- and health-related fields, both nationally and internationally
- To develop and maintain representation on relevant state, national or international associations or groups
- To develop responsible initiatives and strategies to ensure the ongoing financial viability of the Association, and,
- To conduct the business of the Association in a professional and ethical manner (ARNA, 2008, pp. 4–5)

These very specific objectives provided direction for ARNA in its pursuit of recognition as the peak body for rehabilitation nursing in Australia. Establishing credibility as a professional association can be a slow and difficult process, but I believe that these objectives have helped ARNA to successfully navigate that course because they told us what had to be done to be worthy of that status. They have led us to scrutinise who we are and what we do through networking, education and research to better understand our practice and to pursue language to describe our practice. As a result, we have staked our claim that rehabilitation is specialist nursing practice.

In the new constitution these nine objectives have been replaced with one statement, namely:

The objective of the Association is to advance the practice of rehabilitation in nursing (ARNA, 2014, p. 5).
This change represents a significant shift in thinking and in the remainder of this editorial I explore this shift. In making the shift I do not believe any criticism of the earlier objectives is inferred or intended. Instead, the new wording represents our growth. It reflects advancement in our understanding of who we are as an association and our place within the broader nursing landscape. This maturity in thinking is enabled by the earlier inward focus to ‘get our own house in order’ before seeking to influence the practice of others.

Fundamentally, the new objective requires us to move from primarily an inward-looking organisation to one that positions itself within nursing as a whole. This means our focus must shift from rehabilitation as a nursing specialty to positioning rehabilitation as part of all nursing practice.

This positioning of rehabilitation is not new thinking. It is embedded in one of ARNA’s earliest documents, the scope of practice position statement, with words such as “all nurses should be adequately prepared to deliver nursing care that is rehabilitative” (Pryor et al., 1999, p. 14).

Rehabilitation as central to the practice of nursing regardless of setting has been a continuing theme in my own work, from my earliest writing (for example, Pryor, 1999, 2002) to the present (Pryor, 2014). It was also evident in my 2013 conference paper (and subsequent JARNA editorial [Pryor, 2013]) where I spoke about rehabilitation nursing’s yesterday, today and tomorrow. With this new objective, ARNA is well positioned to take up my 2013 call to arms when I said:

I want to see rehabilitation as a primary nursing function across the continuum of care. I want to see function promoting nursing practice (Pryor, 2014) taught in all our schools of nursing. I want this conference to be the start of a campaign to put the R back into nursing! (Pryor, 2013, p. 4).

Such a campaign requires rehabilitation nurses to understand and believe in the potential of their practice to improve health and wellbeing at the individual and collective level. The clearest example of the under-utilisation of this potential is the widespread functional decline experienced by patients in acute hospital wards (Tropea, Amatya, Brand & the expert advisory group, 2011). Rehabilitation nurses have the knowledge and skills to assist in the prevention of hospital-associated deconditioning and functional decline because they understand conserving and restoring function as essentials of nursing care (Pryor, 2014). While most of us have few opportunities to directly influence the practice of nurses outside rehabilitation settings, through our interactions with nursing students on clinical placement we have an opportunity to influence their practice. A good place to start is to explain the continuous nature of rehabilitation and to stress the importance of rehabilitation nursing across the continuum of care. If every ARNA member did this one simple thing they would be actively contributing to the positioning of rehabilitation as both specialty and generic nursing practice.

For anyone who thinks this repositioning of ARNA threatens or in some way diminishes specialty practice, I ask you to think again. It is only through the development of the specialty practice of rehabilitation nursing that we are in a position to influence nursing in this way. Before rehabilitation had specialty status, only individuals could champion the cause. Now a whole specialty nursing organisation is taking it up. This is what the new objective of ARNA tells us to do.

References


Letter to the Editor

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Dear Editor,

I am writing to comment on the guest editorial in the last JARNA written by Brendan Bakes, titled, ‘Acute outliers in rehabilitation beds: Is a bed a bed?’

I was very interested to read the information that was well referenced, and thus implies that this is an ongoing issue for many rehabilitation units around Australia. Bakes listed many reasons against this practice. I have personally experienced having acute outliers in rehabilitation beds when the rehabilitation unit I was working in moved wards and thus ‘inherited’ two reverse cycle air rooms. These rooms were used for people with suspected TB, and other airborne infections, awaiting confirmation of their diagnosis. The beds could be filled at any time in the 24-hour period, even overnight, which meant moving the rehabilitation patients out of the ward temporarily. Although everyone understood the rationale, this was still disruptive for the patients and nurses.

I am writing to comment on the practice of having rehabilitation or geriatric evaluation and management (GEM) outliers in non-rehabilitation/GEM beds. Recently my workplace had GEM patients in a wing of the aged persons acute mental health ward, and currently there are GEM patients in the palliative care ward. Further rehabilitation and GEM beds are being built across the health network so we hope this practice will shortly cease. The challenges for these outliers in non-rehab/GEM beds are many. I am concerned about the accuracy of Functional Independent Measure (FIM) scoring on admission and discharge, and as the admission FIM is linked with funding, scoring accuracy is vital. Staff report spending extra time explaining to the person and family why they are in the palliative care ward. In addition, staff report juggling priorities such as time spent with the person to assist them to complete the activity, verses end-of-life care or complex symptom management. I have observed many missed opportunities that are particular to rehabilitation, such as sitting people out of bed for meals, getting dressing in clothes, goal setting, access to day leave and teaching independence.

I am curious to hear other stories.
Guest editorial

Homelessness in our midst

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In this editorial, I thought I would share my experience of meeting a variety of people experiencing homelessness on the streets of Sydney, New South Wales (NSW), during my six years of travelling into the city on a regular basis to attend PhD candidature meetings. Rehabilitation traditions of respecting the self-determination and autonomy of individuals and groups can be applied more widely to encompass the whole community, including the most underprivileged of citizens. This discussion focuses upon homelessness in the city of Sydney, NSW, and presents information about the complexity of issues in the Australian context.

On that first day in 2009 when I travelled by train to enrol in my degree, I was absolutely stunned by the level of overt, abject poverty which I observed on my relatively short walk between the train and bus stations in the central business district (CBD) of Sydney. The sheer quantity of people begging in the Central tunnel stood out to me. I simply could not believe that this was the reality deep within the metropolitan showcase of the world, in the midst of the beautiful city of Sydney, often considered by visitors to be the epicentre of NSW. Yet, after I stopped and spoke to a women who smiled at me as I found myself staring at her, I continued to stop and talk to people – anyone I passed actually – who were begging on the street and alone. Over the last six years I met some amazing individuals (and consequently, missed a lot of trains). These are some of their stories as told to me between 2009 and 2014 by those who “sleep rough” on the streets of Sydney.

Stories of street dwellers

“Sue” was in her 30s and had a permanent position between Central Station, Sydney, NSW, and the Bus Interchange, a known location for many homeless individuals who live in groups and sleep rough. After being robbed in a shared dwelling, Sue had been left with nothing, apart from what she was wearing. Her social security payments had ceased because she left her dwelling suddenly and therefore she could not provide a forwarding address. She had been unable to find any other accommodation for several months. During the time I knew her (about a year), she was robbed again, until she teamed up with a homeless man, Alex, who kept a watchful eye on her and they started to share “her” space, usually in shifts. Sue was slightly built, vulnerable and often frightened. Just metres away from where she sat, a group of people often stood to hand out pamphlets, yet they had never spoken to her and avoided all eye contact with her, although she was actually facing them directly. The last time I saw Sue, she had found permanent shared accommodation, and she said she was glad to be able to tell me about it. We said goodbye last December, as she and I both knew that she would not be begging on the streets in 2015, and I had handed in my PhD and therefore travelled less frequently to the city. Sue had survived “sleeping rough” for nearly a year, and had come out the other side alive and able to move on, albeit slowly. We had become friends, although I will probably not see her again, and that is a very good thing, considering the circumstances of our meeting each other.

“Danielle” was younger, probably in her 20s, and she always sat with her head bowed forward and a hoodie pulled up over her face and head. She had a cup which she held with one hand extended forward, but not touching the ground. She did not speak much, but sometimes she smiled, and one day she reached out and hugged me tightly as I stopped to chat with her and drop a few dollars in her cup. I went off to get her a drink, as it was a hot day, but she was gone on my return. Homeless people often cannot trust others as their trust has been violated so many times that they...
learn to be cautious of everyone. Australian research has shown that specialist homelessness services provided assistance with accommodation, food, hygiene and information to more than 244,000 people in 2012–13 (Walsh, 2014). Imagine the numbers of people who missed out or who could not locate such services.

“Marion” was a woman in her late 50s who sat on a milk crate close to the shops. She had a small backpack with a broken zipper, which was crammed with a few precious life possessions. She was on the street having lost most of her resources in a nasty divorce. Marion was, in fact, still “in hiding”, having experienced brutal domestic violence during the court proceedings. She wore most of her clothes to prevent them from being stolen, and that also kept her warm. I gave her a coat once and a bigger backpack — my son’s old school bag which was not “in fashion” anymore according to his healthy, 14-year-old reasoning. Homeless older adults experience a distinct health disadvantage because of their lack of safe, consistent and supportive accommodation, and, as a result, premature ageing and the development of chronic illnesses is prevalent in this population (Dunn & Brown, 2008). Middle and older age can be a sad, lonely and isolating experience for people living on the street.

“Don” had a lower back injury and had had surgery. Consequently, he often had to lie down and found it difficult to sit upright and cross-legged on the hard cement around Central Station. While he was in touch with regular mental health services for his (now controlled) schizophrenia, the illness had cost him his family, his job and his home. He was begging for money to renew his most recent script when I met him. Don was an honest, gentle person, and he showed me his script, but had no money or identification, having lost his Medicare card, so was having trouble getting the script filled. When he shook my hand, his own hands were icy cold. He was often approached by the police on foot patrol in the city and in the tunnel. They would ask him to sit up rather than lie down, or instead, to move on. The problem is that he was in severe pain most of the time so moving was hard for him, sitting was hard for him, and he was not allowed to lie down when there were people around, although that was the only time he felt really safe enough to sleep.

“Tom”, another homeless gentleman, used to stand facing the oncoming crowds traversing the Central tunnel towards the Station in peak hour – a particularly dangerous location – which was the reason I stopped to talk to him and to suggest that he move over to the side a little. Where he was standing looked very dangerous to me and people were pushing past, and on occasion, pushing right into him. He moved over a little and “blessed” me for stopping to speak to him. Tom had been a teacher once, and he told me that the “good” homeless refuges in the city offer accommodation and meals for $25.00 a night but the “bad” ones charge $15.00 a night, with no meal offered. By “bad”, he was speaking of refuges or other boarding houses where he had been previously assaulted, robbed or threatened. I later confirmed these facts with the chief executive officer (CEO) of a major not-for-profit charitable institution which assists people who are homeless or without permanent accommodation in the CBD, Sydney. It was true. That is exactly the approximate cost of temporary accommodation in the city of Sydney for one night. Like Sue earlier, Tom had had all of his possessions stolen more than once, and he found it hard to raise the money to afford the better hostels, irrespective of their limited availability. Consequently, Tom had spent many nights on the street.

There are many other individuals I could describe whom I have met in the last few years. I would not have met them had it not been for the fact that they were absolutely destitute. For example, the heavily pregnant woman who had not eaten all day, the 18-year-old girl without shoes in the middle of winter, the young Indigenous woman near St Mary’s Cathedral, the one-armed man near the news stand, the two Aboriginal women elders who stuck close together for safety, and many other nameless, forgotten, Australian citizens. All of them were begging for spare change from strangers to sustain them through the present day. All of them were haunted by societal neglect, but smiled warmly with their eyes and spoke from their hearts.

These are just my personal observations over a few years of travelling into one Australian city on a regular basis. Nationally, however, as evidenced by substantive research, the situation is far worse. The situation of homelessness should be a national priority for action at all levels of government (local, state and federal). Unfortunately, after several years of planning an integrated Australian national policy, which was to be managed through legislation to address key socio-economic determinants, was recently abandoned by the lawmakers who had initially proposed it (Walsh, 2014).

Homelessness in Australia

Homelessness is a complex social phenomenon, particularly considering the concurrent impact of poverty, chronic unemployment, disability and lack of affordable accommodation. Research is now showing the extent of the homelessness problem in Australia and these facts are sobering. According to the Australian Bureau of Statistics (2012, cited in Walsh, 2014)
approximately 105,000 people experience homelessness on any one night in Australia. Proposed legislation [The Homeless Bill, 2013] aimed to incorporate strategies for early intervention and support but lapsed towards the end of 2013 and was not progressed after a change of federal government as mentioned previously (Walsh, 2014). Definitions of homelessness focus on various groups within the populations of people who lack accommodation. These include people who completely lack accommodation as well as those who have unreliable and temporary forms of accommodation, those who experience frequent relocation, and those who live in unsafe, non-accredited boarding houses (Walsh, 2014). These situations can put an ordinary citizen on the street, and occasionally they may have the company of an animal or pet who is homeless too. From my observations, a hidden subculture exists in street life and the conflict between those who had dogs with them, and those who did not, was evident. Affording respect to a homeless person’s dog is one of the most certain ways to afford them a tiny bit of respect in a community often devoid of such. I always asked before I patted a homeless person’s dog. This usually led to a robust discussion and pleasant, friendly interaction.

The number of Indigenous Australians visibly living rough on the streets of Sydney is significant. In 2014, a report by the Australian Council of Social Services (ACOSS) found that Aboriginal and Torres Strait Islander people are increasingly more likely than other Australians to fall below the poverty line (Koori Mail, 2014) and experience homelessness. In Australia, the Northern Territory actually has the highest rate of homelessness, particularly in the city of Darwin where 1,000 people are reported to live in the grasslands surrounding Darwin city each night (Lavery, 2014). Various state government initiatives have developed, despite the lack of co-ordinated federal attention. Queensland, for example, has created multidisciplinary teams that have a primary focus in mental health and drug and alcohol services to outreach to homeless populations (Lloyd & Bassett, 2012) and these initiatives have reported positive outcomes, particularly with regard to assisting younger people. The “Our Backyard – Car to Home project” located in Lake Macquarie, NSW, is a locally based initiative which provides a designated private space for families and single women who are sleeping in their cars to park safely and have access to bathroom and kitchen facilities. Blankets and toiletries are provided, along with referrals to appropriate services if required (Our Backyard, 2014). Despite...
these promising initiatives, other reports emphasise the extent of homelessness among other vulnerable groups, including single men. Asylum seekers and refugees also have a difficult, complex and “long journey” to find sustainable and affordable housing within a strange and unfamiliar community (Power, 2014; Meredith, 2014).

So, what has any of this got to do with rehabilitation or rehabilitation nursing?

Well, the answer is “nothing specifically”, if we see rehabilitation as an activity which occurs only in a clinical setting. In many ways, while essential to care, a clinical setting is an artificial environment which mimics, and prepares for, life outside its walls. Personally, I think we could go a little deeper. If we see rehabilitation nursing as extending to maintaining the wellness of the entire community with all its groups and subgroups, then the fact that illness, injury and chronic conditions are particularly prevalent among those “sleeping rough” (Lloyd & Bassett, 2012) becomes important. Homelessness is a huge problem within our society. That is undeniable. We could do much better as a nation with more equitable distribution of essential resources, regardless of our political persuasions and affiliations. As nurses, clinicians and academics, we need to involve ourselves more in volunteering to assist those who are less fortunate than ourselves, and make a contribution to protecting vulnerable populations, not only on social media (although in our technological age that helps) but also in our everyday worlds where we can. At the very least, we should all be advocating for causes close to our hearts in our professional networks and family settings to raise awareness of issues that affect us all as a nation. Change only happens when we “go out on a limb” and take a risk to contribute to creating a better world in whatever way we can. In writing this sort of guest editorial, I hope I’m taking my own advice.

Conclusion

Many people consider basic or inherent dignity to be fundamental to the human condition. Personal dignity, however, is known to be experienced with reference to the social world and, as such, this depends on the quality of our human interactions (Pullman, 2002). The next time you see someone begging on the street, stop and talk to them if you are not in a hurry. Just ask them how they are going or if they are a bit “down on their luck” at the moment, and ask how they are managing, or if they have anyone to help them out. This way we can acknowledge and nurture another’s sense of personal dignity. Those who have their choices diminished through neglect are often thought to have lost “dignity” (Pullman, 2002); however, it is through nurturing this personal dignity of another that we can act to support and preserve their sense of personhood. Often, such brief interactions are the only uplifting human connection that some individuals will have in their day, and it is this which keeps them going when, otherwise, things are very difficult.

If any member is interested in submitting articles for publication in upcoming issues of JARNA on other social issues which affect some of our rehabilitation clients or vulnerable populations generally, I would be really happy to assist you. We welcome papers from nurses at all levels of practice and rehabilitation experience, including nursing students.

Thanks for reading. I’ll see you all at the next world-class ARNA national conference in sunny Brisbane in October. Remember to put in an abstract! We need to share our clinical expertise, research outcomes, progress, challenges and journeys. That is what keeps us alive as an organisation. Join in and take a leap of faith in yourself, and publish a paper in JARNA after the conference. I’d love to hear what you have to say too.

Acknowledgement

Thank you to Ms Rachel Wayman, who is a BN (Adv) student in the School of Nursing and Midwifery at the University of Western Sydney, for her thoughtful and constructive feedback on this editorial.

References


Meredith, L. (2014). Asylum seekers are the most vulnerable of the homeless Parity, 27(10), 12.


Endnotes

• For the purposes of privacy, pseudonym names have been used in this editorial and some representations of individuals, although completely accurate, have been combined to protect the identity and anonymity of those mentioned herein.

• Laynie Hall Pullin is an accredited volunteer with a small charitable community within NSW.
President’s report

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Welcome to the first edition of JARNA for 2015. Since the ARNA annual general meeting in October 2014 the national committee has been busy. Commencing with a two-day workshop and planning meeting conducted in Melbourne during the first weekend of December and continuing with monthly meetings via teleconference.

During the planning meeting a number of items were discussed, including a review of the 2012–2015 Strategic Plan. This review resulted in the formation of the 2015–2018 Strategic Plan, which will direct ARNA for the next three years. The Strategic Plan aligns with the constitution and incorporates the new focus of rehabilitation being an integral part of all nursing practice. The plan identifies that Leadership and Collaboration is integral to the organisation and is intertwined within all pillars of strategic success, resulting in three overarching pillars of strategic success: Education and Research; Governance; and Membership. The Strategic Plan and accompanying Operation Plan are currently being formatted and will be released and available on the website once completed.

The new website has been well received since coming live online in August. The website allows members to access information about what is happening within their Chapter and at the national level. It allows membership renewal and new members to join online, to name a few benefits. To maintain the accuracy of the information available on the website, we ask a committee member from each Chapter to be responsible for the provision of all Chapter information updates with a national committee member, Kay Stevens, who will take on the coordination of this process.

The proposed new constitution was voted in favour of adoption at the AGM in October. Although there have been amendments made to the constitution in past years, this was the first time that a full review of the constitution had been undertaken. Its adoption brings ARNA in line with relevant legislation and assists the national committee to manage the affairs of the association accordingly.

Discussions about member services during the planning meeting resulted in the development of a national newsletter. The newsletter will be used to publicise general information including Chapter news and events, committee meetings, conference and is planned to be published bimonthly. The first edition of the newsletter was released in February and emailed to all members. All contributions for inclusion within the newsletter are welcomed.

JARNA has long been recognised as a venue for the sharing of information relevant to rehabilitation nursing, practice development activities and research with ARNA membership and beyond. Although a number of members have contributed content to JARNA, with many of these being first-time contributors, articles are being sought. If you have anything of interest you would like to share with your colleagues, please put pen to paper and contribute to this journal. Your contributions will assist in the continual publication of JARNA. JARNA has attracted advertising, which has resulted in some revenue for ARNA, which helps to reduce the cost of publication. Guidelines for submitting articles are available on the website www.arna.com.au.

Planning for the 25th ARNA national conference is well under way, with the organising committee under the leadership of Shaun Matthews. The conference is to be held on 22–23 October 2015 at the Brisbane Convention and Exhibition Centre with a theme of Getting Everyone on Board. A call for abstracts has been sent out and keynote and invited speakers are being approached. Consider submitting an abstract to present at the
conference and I encourage members to attend the conference and make it another successful event.

On a reflective note, ARNA’s 24th annual conference in Darwin last in October was a success. A diverse range of topics were presented. Melissa Noonan, Executive Officer and Founder of Limbs 4 Life, spoke about her own amputation rehabilitation journey and presented an overview of Limbs 4 Life and the services it has to offer people who have undergone a limb amputation. Dr Lucy Madabwe gave a presentation about her research into the measurement of outcome for patients living in the Top End who had a lower limb amputation. Mark Kilpatrick presented conference delegates with an overview of Machado Joseph disease (MJD) describing: the disease, its prevalence in the Northern Territory and supports provided by the MJD Foundation. As with all previous conferences, feedback was sought from the delegates via an attendee survey. The following is some information gained through the survey. Of the number who responded seventy-one per cent were from public sector facilities. The majority were informed about the conference through colleagues, JARNA and the ARNA website. Most (87%) scored the conference program as good to excellent and 93% rated the venue as good to excellent. All respondents rated the catering as satisfactory or above, with 70% giving an excellent rating. Conference highlights for respondents included the conference dinner, the variety of topics, Melissa Noonan, the preconference drinks, the venue, the friendly atmosphere and Darwin, to name a few. The entertainment provided by the Grey Panthers and One Mob Different Country was also well received. All comments expressed through the feedback will be taken into consideration by the 2015 conference organising committee.

The location of the 2016 national conference will be presented during this year’s conference. See you in Brisbane for the 2015 national conference.
Nursing absenteeism following the introduction of the Northwick Park Dependency Scale Hospital Version (NPDS-H) in the rehabilitation setting

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Abstract
The aim of this study was to examine the effect of the introduction of the Northwick Park Dependency Scale Hospital version (NPDS-H) on nursing staff absenteeism at the rehabilitation inpatient unit, Royal Melbourne Hospital. The study sought to investigate if adjusting staffing levels based on the NPDS-H patient dependency scores would result in a change to the personal leave profile of the nursing staff.

The eight-month observational study was conducted over two four-month stages. In Stage One the NPDS-H was introduced into the rehabilitation unit to measure baseline level of patient dependency and the staff absenteeism was recorded. In Stage Two the NPDS-H was used as a trigger for enlisting additional staff to assist with the unit’s workload. The outcome measure utilised in the study was nurses’ personal leave hours.

Results revealed that personal leave significantly decreased from the fourth week of the Stage Two period by an average of 17.4 hours per week (p=0.046) whilst the average NPDS-H score was higher during the same period, indicating that the unit was comparatively busier during this time. Hence, the results of the study suggest that the NPDS-H may be a useful patient dependency measurement instrument and when used to determine and adjust nursing workforce requirements results in a decrease in nursing staff personal leave.

Keywords
Rehabilitation nursing, dependency, absenteeism.

Introduction and background
Patient dependency levels in the rehabilitation setting have a direct relevance for nursing staffing levels, skill mix, satisfaction, stress and absenteeism, costs and, ultimately, patient outcomes. There is little research on the possible interactions between these and other factors in rehabilitation units.

Duffield et al. (2006) suggest that a hospital unit’s safe and positive management and the prediction of its nursing workforce needs rely on understanding of the patients’ nursing dependency levels in the unit. Excessive workload is acknowledged as the major cause of “stress and dissatisfaction” for nursing employees. Similarly, Berry and Curry (2012) note that high patient acuity, resulting in an increased workload, is one of the reasons nurses experience fatigue and that a rise in the levels of patient dependency may also result in a number of causal negative outcomes for a hospital unit, such as a rise in staff absenteeism, leading to an increase in casual staff costs, patients’ length of stay and clinical incidents.

It has been proposed by Ferguson-Pare and Bandurchin (2010) that nursing staff subjectively measure the level of nursing dependency in their patients on a daily basis and they propose...
that many nursing managers use “intuition” to make staffing decisions, rather than by using objective patient dependency measurement tools. A broad range of factors including: levels of experience, team dynamics, patient acuity, individual fatigue levels and the nurse in charge of the shift can affect this subjective approach. Brady et al. (2007) acknowledge the complexity of measuring nursing workload, explaining that the inputs and outcomes of nursing care are not always tangible enough to be measured by a third party. Despite the complexity of quantifying nursing workload, a strong body of literature supports the need to accurately and objectively measure patient dependency. A patient dependency measurement tool/instrument can assist with staff allocation and with matching skill mix accurately to patient requirements (Brady et al. 2007; Stuart et al. 2008). Proponents of such an objective approach emphasise that it allows scope for a more accurate understanding of workforce trends and enables the development of a workforce strategy to address the daily, changing demands of a hospital unit. In a pilot study by Harper (2012), health information technology was used to predict nursing workload, suggesting that health information technology may be helpful in determining staffing levels and decreasing medical errors. Measuring nursing workload is an important function performed by managers to accurately predict the nursing time and skills required for the provision of appropriate and safe nursing care. Indeed, Reid et al. (2008) focus on efficiency and fiscal responsibility, discussing the significance of nursing workload and how nursing managers are required to be accountable for resource allocation. Furthermore, Duffield et al. (2006) note that in Australia, some states and territories have no measure of nursing workload and those states that have introduced measurement methods have an inconsistency in their approach. Cockerill et al. (1993) highlight that nursing is the most expensive element of a patient’s stay in hospital; therefore, replacing staff on sick leave is a costly exercise that should be mitigated. Workforce measurement tools and commercially based software packages have been used across Australia in the acute care setting to generate rosters based on appropriate skill levels, potentially decreasing cost outlays (Duffield et al., 2006). However, there has been little or no research into the potential benefits associated with the adoption of objective workforce measurement systems in the Australian rehabilitation setting.

According to Hatfield, Hunt and Wade (2003) a limited number of instruments have been used to infer dependency on nursing care in the rehabilitation setting and these include the Functional Independence Measure (FIM™) and the Barthel Index (BI). However, both of these measures were developed to measure patient independence and function in relation to activities of daily living, rather than actual dependence on nursing care. The British Society of Rehabilitation Medicine (2008) notes the limitations of these tools to measure the number of nurses and time taken to holistically care for patients, and they express the view that the Northwick Park Dependency Scale – Hospital (NPDS-H) is better at determining patient dependency on nursing care, due to its tripartite assessment method of patient and staff needs, whilst remaining easy to use in a busy rehabilitation setting. Furthermore, Siegert and Turner-Stokes (2010) also noted that applying the NPDS-H in the rehabilitation setting provides a broader scope of information on nursing requirements than other commonly used measures. Another reported advantage of the NPDS-H is its sensitivity to small variations at the high end of the patient dependency scale, otherwise undetectable by the BI (Turner-Stokes et al., 1998), as the NPDS-H was designed specifically to measure the nursing dependency levels in a rehabilitation unit. The NPDS-H was developed by Lynne Turner-Stokes and first published in 1998 (Stokes et al., 2010) and was designed to quantify a patient’s needs for nursing care and support. The NPDS-H takes into account the time required for nurses to supervise patients undertaking tasks for themselves, as well as assisting them and also includes the additional time required to communicate with patients who have language or cognitive issues.

The NDPS-H model generates a score for each patient reflecting the dependency. According to Williams, Harris and Turner-Stokes (2007), the allocation of a dependency category assists nurses to classify the number of patients in each category, evaluate the nursing workload and plan admissions. Hence, the NPDS-H helps to reduce subjectivity in staff workload assessments through providing an objective measure of patient nursing-care requirements.

It has been suggested by Stuart et al. (2008) that using dependency measurement instruments such as the NPDS-H facilitates the holistic articulation of patients’ care needs and moving beyond narrow considerations such as nursing tasks or medical diagnosis. We believe that the NPDS-H is well suited to the Australian rehabilitation setting because of its ability to include in its measurement unique elements of rehabilitation nursing practice. This aspect of the NPDS-H is also consistent with the Australian Rehabilitation Nurses’ Association (2004) competency standards, element 2.3, where it is noted that the rehabilitation nurse “facilitates the development of self-care and independence of the person through teaching and coaching”. Williams et al. (2007) explain how rehabilitation nursing takes a considerable amount of time because of the “stand back approach” the nurse takes to help patients achieve their potential
by teaching and transferring skills to the patient. Importantly, by measuring the time it takes for rehabilitation nurses to teach and assist patients to achieve their goals, the NPDS-H is better able to accurately reflect rehabilitation nursing workload based on patient dependency. The outcome is that the NPDS-H may provide clinical managers with an objective method to determine, and, where required, modify nursing staffing levels.

**Methods**

**Research question**

Does using the NPDS-H scale to manage staffing levels reduce nursing absenteeism in the rehabilitation setting?

The study aimed to establish the point at which the NPDS-H indicated where the demand for additional nursing staff in the rehabilitation unit and if the engagement of additional staff earlier in the process reduced the amount of employee sick leave. Single and multiple (two or three) personal leave days were specifically measured because they contribute to the greatest cost of sick leave and it was thought they could be more easily influenced.

**Design**

The research was conducted as a non-participant, observational study. It was conducted in two stages over an eight-month period in 2013.

**Setting**

The study was conducted in a 40-bed rehabilitation inpatient unit at Royal Melbourne Hospital, Melbourne, Australia. The rehabilitation unit specialises in neurological, amputee, orthopaedic and chronic pain rehabilitation and has a total of 47 nursing staff, comprised of division one registered nurses (60%) and division two registered nurses (enrolled nurses) (40%). There are three shifts across a 24-hour period, an eight-hour morning and afternoon shift and a 10-hour night shift. The morning and afternoon shifts have nine staff rostered and the night shift has four, with a combination of full- and part-time staff.

**Measurement**

**Patient dependency**

The dependency of all patients in the rehabilitation unit was measured using the NPDS-H. This measurement comprised assessing three subscales: (1) Basic care needs; (2) Special nursing needs; and (3) Inpatient nursing needs. Section 1 comprises 12 items associated with activities of daily living that are scored from 0 to 5. Section 2 involves the assessment of the patients’ needs for nursing care and comprises of seven items scored on a dichotomous scale of 0 or 5. Section 3 is the extended hospital version and requires the assessment of eight items specifically related to hospital care and scored on a 0–5 scale. The composite score for the three sections provides the overall NPDS-H dependency level for each patient. There are three levels of dependency produced by the NPDS-H: low (<10), medium (10–15) and high (>25).

Once all patients’ dependency level was determined, the scores were summed to provide an overall unit dependency level. This score was used in the first phase of the study to determine the average NPDS-H dependency level of the unit and to establish the cut point to be used in the second phase of the study to trigger the allocation of additional staffing.

**Staff personal leave**

The rate of personal nursing leave hours was collected monthly. Nursing staff members who took one shift off per month were categorised to have taken single personal leave days, whilst those nurses who had two to three shifts of personal leave per month were categorised to have taken multiple personal leave days. Nurses who took four or more shifts of personal leave per month were not considered in the personal leave totals as it was likely that this personal leave was attributable to matters other than workload-related factors, such as long-term illness. The eligible personal leave was then assigned to the specific weeks in which the leave was taken. Subsequently, personal weekly leave in 2013 was compared with leave taken during the same time period in 2012. Refer to appendix A for the categories of sick leave used in the study.

**Data collection**

**Stage One (February–May, 2013)**

The first stage involved completing a workload measure using the NPDS-H to establish a baseline level of patient dependency. The morning staff completed the NPDS-H for all patients at weekly intervals. The three previously mentioned sections were used to inform the study. The NPDS-H tool took approximately three to five minutes to complete per patient. All collected data was loaded into the UK Rehabilitation Outcomes Collaborative – Clinical tools and Database (UK ROC) to facilitate the NPDS-H data entry. The program generated a NPDS-H total score and categorised the patients into three levels of dependency: low, medium and high. A weekly score was extracted from the data and patients were classified into one of these categories. Additionally, the weekly absenteeism due to sick leave hours was collected from RosterOn: an Australian management software.
system that systematises the key processes of rostering, time and attendance.

**Stage Two (June–September, 2013)**

The second stage of the study used the NPDS-H as a trigger for employing extra staff to assist with the workload. The baseline score of 690 was used as the trigger for rostering additional staff members. This score was based on the average NPDS-H scores observed (687) during the first stage of the study, an additional staff member was rostered on a morning shift (six-hour shift per day and 24 hours total for the week) from Monday to Thursday. The additional staff were booked through the casual staffing pool on the Friday and allocated for the following week. The additional staff member was employed as a “floater” who was allocated to assist other staff members with their allocation of highly dependent patients. During this time nurse–patient ratio remained at one nurse to five patients. Approval for recruitment of extra staff was supported by the unit’s director of nursing. The morning shift was chosen because it was considered the busier shift for nursing staff due to patients’ hygiene requirements and preparation for therapies and appointments.

**Statistical analysis**

Using Auto-Regressive and Integrated Moving Average (ARIMA) time series processes, the trends in personal leave hours and NPDS-H scores were examined weekly to determine if there was any association. ARIMA time series processes enabled a consideration of auto-correlation between consecutive observations (that is, weekly values) that cannot be achieved through simple regression analysis where independence between consecutive observations is assumed. Smoothed, centred moving averages of one month were also considered to remove any short-term variations in the trends of personal leave or NPDS-H, as were different-lagged relationships of up to three weeks. Through the ARIMA modelling process it was identified that auto-correlation was negligible, and thus interrupted time series analyses were undertaken to estimate the impact of the intervention on the trend in personal leave. Descriptive statistics for the two stages were presented, with chi-squared tests used to compare patient and staffing characteristics that were presented in a categorical format. The Shapiro-Wilk test was used to test for normality in each of the continuous variables. For normally distributed (parametric) variables, the students t-test was used.

![Figure 1: Trend in weekly NPDS-H total scores and personal leave (total hours) over duration of the study period](image-url)
to compare Stage One with Stage Two, while the Mann-Whitney (ranksum) test was used for non-normally distributed variables which are presented in the results as Median (and Inter-quartile range). Statistical analyses were conducted using Stata version 12.1 (StataCorp, College Station, Tex, USA). All p-values are two-sided, with statistical significance defined as a p-value of <0.05.

Approval was obtained from the Melbourne Health Human Research Ethics Committee (QA2012092) prior to commencement of the study.

Results

The NPDS-H total weekly score exceeded the nominal threshold of 690 for: Stage Two; 12 of the 17 weeks in comparison to Stage One; 6 of the 18 weeks (Figure 1). Descriptive statistics comparing overall results for Stage One with Stage Two are provided in Table 1. The number of patients was stable across Stages One and Two, with an increased proportion in the number of medium workload patients based on the NPDS-H scale: Stage Two 50%; Stage One 39%. This countered a reduction in the number of light-workload patients: Stage Two 34%; Stage One 45%. The proportion of heavy-workload patients remained steady at 17% during each stage of the study.

When considering time series analysis processes, no direct relationship was found between the weekly NPDS-H score and personal leave, either when considered in its raw format or in a monthly moving average format. However, there is evidence of a significant decrease in personal leave from the week ending 5 July 2013, the fourth week of the Stage Two period, by an average of 17.4 hours per week ($p=0.046$), calculated over the remainder of Stage Two of the study. This reduction in personal leave is further illustrated in Figure 2, showing a significant decrease in weekly personal leave during 2013 when compared to the personal leave trend during 2012. This reduction in personal leave, which is effectively corrected for the likely seasonality profile over the study period, also indicates a significant reduction in personal leave from the end of the fourth week of the intervention stage ($p<0.001$).

When considered at an overall stage level, the mean in weekly personal leave decreased by 12% from 75 hours to 66 hours from Stage One to Stage Two (additional staff intervention period). This compares to an observed increase in mean personal leave of 33% over a similar period in 2012 (that is, 51 hours during equivalent Stage One period to 67 hours during equivalent Stage Two period), although neither of these changes were statistically significant. The proportion of total shifts taken as personal leave decreased slightly from 3.8% to 3.4% following the intervention.
although this change was not statistically significant. The reduction in the proportion of shifts taken as personal leave was consistent across the duration of the study.

Discussion

The study investigated the effect of nursing staff leave following the introduction of the NPDS-H to measure patient dependency and to subsequently decide if additional staff were required in the rehabilitation unit. The results revealed that nursing staff personal leave was reduced approximately four weeks after the Stage Two intervention was introduced, even though patient dependency as measured by the NPDS-H increased. The rise in patient workload in Stage Two was due to an increased proportion of medium dependency patients. Patients in the medium dependency category are defined to require the assistance of one nurse for most activities of daily living (Williams et al. 2007).

The heavier workload and higher NPDS-H scores did not appear to affect nursing absenteeism on a weekly basis prior to the intervention; however, it may be a result of the relatively short period of time (four months) that the intervention was in place. Future research may benefit from observing these effects over a longer period of time.

In Stage Two, when an extra staff member was rostered to help with the heavier workload, a lower rate of sick leave was observed. This finding is consistent with Cohen and Golan’s (2007) strategy of reducing absenteeism and strengthening organisational commitment by increasing job satisfaction. Cohen and Golan (2007) noted that a reliable predictor for the current year’s absenteeism is the prior year’s absenteeism; however, our results suggest that the rate of absenteeism can be reduced through the use of an objective patient-dependency measure to adjust staffing levels.

Similarly the pattern of staff leave (Figure 2) supports the views of Cohen and Golan (2007). The trend in personal leave over Stage Two of 2013 trended down four weeks after the start of the intervention, and was below 2012 personal leave levels for the remainder of this stage of the study. We believe that the observed decrease in personal leave during the intervention period was influenced by using the NPDS-H to manage the nursing workforce. A limitation of comparing 2013 personal leave with 2012 is that we are unaware of the rehabilitation unit’s circumstances and patient-dependency levels in 2012.

Limitations

Our study had several potential limitations, including:

1. The absence of studies that directly link the NPDS-H specifically to the measurement and management of nursing workforce. Therefore, this makes it difficult to compare our findings to other research.

2. There were 11 (23%) morning shifts during the intervention period that an extra staff member could not be rostered on. This was due to higher than normal sick leave across the organisation.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Stage One (February 2013 to May 2013)</th>
<th>Stage Two (June 2013 to September 2013)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPDS-H total score, Mean (SD)</td>
<td>688 (53)</td>
<td>724 (82)</td>
<td>0.14</td>
</tr>
<tr>
<td>Patients, by NPDS-H score, n (%)</td>
<td>674</td>
<td>677</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Light (&lt;10)</td>
<td>301 (45)</td>
<td>229 (34)</td>
<td></td>
</tr>
<tr>
<td>Medium (10–25)</td>
<td>261 (9)</td>
<td>336 (50)</td>
<td></td>
</tr>
<tr>
<td>Heavy (&gt;25)</td>
<td>112 (17)</td>
<td>112 (17)</td>
<td></td>
</tr>
<tr>
<td>Personal leave (ave weekly hrs), Mean (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>75 (19)</td>
<td>66 (24)</td>
<td>0.26</td>
</tr>
<tr>
<td>2012</td>
<td>51 (27)</td>
<td>67 (30)</td>
<td>0.10</td>
</tr>
<tr>
<td>Total number of staff shifts</td>
<td>2,640</td>
<td>2,731</td>
<td></td>
</tr>
<tr>
<td>Incidents of personal leave, n (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 shift</td>
<td>59 (2.2%)</td>
<td>55 (2.0%)</td>
<td>0.57</td>
</tr>
<tr>
<td>2 or 3 shifts</td>
<td>42 (1.6%)</td>
<td>37 (1.4%)</td>
<td>0.47</td>
</tr>
</tbody>
</table>
3. The pre- and post-intervention stages spanned across two different seasonal periods, with the potential for different profiles in personal leave over Stage Two in comparison to Stage One. However, we attempted to mitigate this by the comparison of the personal leave profile over 2012.

4. The study comprised a relatively small sample size and as a consequence may not have captured all effects.

Recommendations
The study suggests that nursing absenteeism can be reduced by accurately measuring patient dependency with the NPDS-H to manage the nursing workforce. To confirm our findings, more data is required to ensure observed declines in absenteeism are not normal annual fluctuations. Also, of value would be studies in multiple rehabilitation settings to explore the strength of relationships between our findings. Should further studies confirm a reduction in absenteeism resulting from using the NPDS-H in workforce management, then cost/benefit analyses would be valuable in quantifying the actual economic benefit of our approach. We are strongly of the view that whilst the reduction of staff absenteeism is a worthwhile goal, the real benefit should be measured through determination of the benefit to the patient and their family. Consequently, there is a need for future research to explore patient outcomes in relation to using the NPDS-H as a dependency measure in the rehabilitation setting.

Conclusion
Patient dependency has a direct effect on nursing staff workload. It is clear that excessive workloads can result in suboptimal patient care and increased staff stress and absenteeism. Our study has detected an indication that by using a reliable, validated, objective patient-dependency measurement instrument like the NPDS-H to adjust staffing levels in the rehabilitation setting, absenteeism can be reduced.

Appendix A
Classifications of personal leave – sick leave
Carer’s leave
Carer’s leave without pay
Personal leave with a medical certificate
Personal leave with a statutory declaration
Personal leave without a medical certificate
Personal leave unauthorised, without a medical certificate, unpaid
Personal leave unpaid, authorised

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References
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An exploration of the post-intensive rehabilitation care of young adults with severe acquired brain injury

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Abstract

Purpose: To explore the process of providing post-intensive rehabilitation care for young adults who are unable to perform or direct their own care following severe acquired brain injury (ABI).

Method: Paid carers who were providing post-intensive rehabilitation care for young adults following severe ABI were interviewed. Five hundred and six minutes of interview data was analysed using grounded theory methods.

Results: This study unveils the inter-relationship of care provided in terms of body, personalising and humanising care and the centrality of compassion in these processes. It reveals that personal care is about more than tasks being completed by one person for another. Furthermore, the ways in which paid carers find out about care recipients and the relationship of these activities to activating the person illustrates the contribution of paid carers in residential aged care to life-long rehabilitation.

Conclusion: By nurturing the efforts of paid carers to have and show compassion there is less chance that complex care will be reduced to a series of tasks which are done by one person to another with little regard for a person’s preferences and individual needs. Discussion of the personal and technical aspects of care recognises and validates the life-long, rehabilitative contribution of paid carers.

Keywords: Acquired brain injury, rehabilitation, nursing, compassion

Introduction

Improvements in medical management following catastrophic neurological injury and illness means there is a higher proportion of people with increased levels of impairment surviving severe neurological injury who previously would have died (Laureys & Boly, 2007; March, 2005). This, in turn, has resulted in an increase in the number of people with acquired brain injury (ABI) living with severe physical and/or cognitive disability (Helps, Henley & Harrison, 2008).

Data indicates there are 432,700 people living with a cognitive or physical disability as a result of ABI, which causes an activity limitation or participation restriction in Australia (Australian Institute of Health & Welfare, 2007). These figures help us to understand the breadth of the issue within the community; however, they do not inform us about: 1) the incidence and prevalence for a subgroup of the ABI population who are young adults unable to perform or direct their own care due to disorders of consciousness from which they may or may not emerge; 2) their care requirements; or 3) where they are living.
Disorders of consciousness identified in the literature include coma, vegetative state, persistent vegetative state, post-coma unresponsiveness, minimally conscious state and, more recently, minimally responsive state (Giacino et al., 1997; NHMRC, 2008). Predicting outcomes for those with any disorder of consciousness is imprecise as identified by the NHMRC (2008). The literature is certainly expanding in relation to assessment of the young adult who has a disorder of consciousness following ABI. However, there remains a scarcity of literature in relation to how care is provided on a day-to-day basis for this small, but potentially growing, number of people. Using interviews with paid carers, the aim of this study was to explore the process of providing post-intensive rehabilitation care for young adults who are unable to perform or direct their own care following severe ABI. Combining the increasing clinical evidence with what we are able to gather from carers will assist with developing a more sophisticated understanding of not only what carers do, but why they do what they do. Such explanations perhaps give insight into contextual factors which impact on the ability or inability to provide appropriate care.

In this study, post-intensive rehabilitation care refers to the care provided after discharge from inpatient rehabilitation and paid carer refers to individuals paid to provide that care. The term young adult refers to adults aged less than 65 years, which is in line with the inclusion criteria for the Younger People with Disability in Residential Aged Care initiative agreed on by the Council of Australian Governments (Australian Institute of Health & Welfare, 2012).

Method

Design

This study used grounded theory methods of coding, comparative analysis, memoing and theoretical sampling (Charmaz, 2009; Strauss & Corbin, 1998) to explore the processes of caring. An understanding of symbolic interactionism as being about interaction and, in particular, the interpretations that occur and thus inform further interactions (Charon, 1979) influenced all aspects of the research. As explained by Charmaz (2009), the interpretation of data which is presented in the findings is a construction of reality developed, in this case, from interactions between paid carers and care recipients as well as interactions between paid carers and the researcher.

Approval for this study was gained from two human ethics committees, one in the clinical setting and the other through Flinders University.

Setting and participants

This study was conducted in a residential aged care facility in a major regional centre in New South Wales, Australia, which provided accommodation and care for a small number of young adults who could not perform or direct their own care following severe ABI. Paid carers who were employed by the residential aged care facility and involved in providing such care were invited to participate by placing an advertisement on the noticeboard within the unit and also attaching participant information sheets to pay slips. Eight (53.3%) of the 15 participants were female and seven (46.6%) were male. The ages of 14 of the 15 participants ranged from 21 to 65 years, with one participant not reporting their age. Six participants were registered nurses, three of whom held management positions, two were enrolled nurses, five were assistants in nursing and two were in non-nursing positions.

Data collection

Conversational interviews conducted with paid carers between March 2010 and March 2011 in a quiet office during work time were digitally recorded and transcribed verbatim. Eight people participated in single interviews, three people participated in two interviews, and four people participated in three interviews; all 26 interviews were conducted by the first author, providing a total of 506 minutes of interview data.

Data analysis

Data analysis involved microanalysis of the data (Strauss & Corbin, 1998). This involved studying and labelling single words and combinations of words within sentences in every line of each transcript. This allowed the researcher to ask questions and develop interpreted meaning from the data (Charmaz, 2009; Strauss & Corbin, 1998). Through questioning the data, participants were asked new questions in an attempt to “make new discoveries and gain a deeper understanding of the empirical world” (Charmaz, 2009, p. 70).

The process of coding was critical to making sense of the data, this included line by line coding, focused coding and axial coding, which helped significant structures and processes to be seen (Charmaz, 2009). Theoretical sampling directed the researcher about which direction to head in more focused interviews (Glaser, 1978).

Data collection, coding and memoing occurred simultaneously. The combination and interplay of these simultaneous activities shaped developing ideas about the data. Memoing in a journal was used extensively, not only as a way to generate, crystallise and develop, but also to refute and discard ideas and concepts which developed through engagement with data (Charmaz, 2009; Charon, 1979; Glaser, 1978; Shreiber, 2001; Strauss...
Life can’t function the way they were prior to that accident. I mean it all changes in a moment. The whole life around them has just changed in a split second. So, you do sometimes feel sad for them (PC 11, Int. 3).

As a result, paid carers were kind and went out of their way to cause as little discomfort to care recipients as possible. They actively attempted to ensure comfort and prevent pain in their daily interactions with care recipients. The feeling of profound sorrow for another person’s misfortune was followed by compassionate responses from paid carers. In this study it was the synergistic relationship between paid carers’ feelings and actions which illustrated having and showing compassion.

Well, as human beings we don’t like to see people suffering. You know, it’s just what it’s like to be human I suppose (PC 10, Int. 2).

Compassion is a feeling of distress, a deep awareness, sorrow or pity for the suffering or misfortune of another, and often includes the desire to help, alleviate or relieve such suffering (McKeown et al., 2008). Given that a person with an ABI may not have established communication systems (Larkins, Worrall & Hickson, 2008; Togher, McDonald, Tate, Power & Rietdijk, 2009) and their social networks are often limited (Sloan et al., 2009), it often may be problematic attaining the person’s story upon which to base their care. Nevertheless, in this study, paid carers did attempt to personalise care, and when care could not be personalised, it was humanised and provided compassionately.

Factors facilitating having and showing compassion

Having and showing compassion was facilitated in the residential aged care environment by two factors: (a) finding out about the person; and (b) caring for the person (see Figure 1). The two factors occurred simultaneously much of the time as the need for care was the fundamental reason why the young people were in that setting. Compensating for lost self-care abilities was the primary opportunity for paid carers to interact with care recipients.
Paid carers accumulated knowledge about the person while caring for the person. They stored this knowledge and integrated it into future interactions, reassessing its appropriateness or correctness in terms of each care recipient’s likes or dislikes. This integration of knowledge and the way in which paid carers adjusted their behaviour on a given day illustrates symbolic interactionism.

Finding out about the person

Finding out about the person refers to paid carers getting to know the person who is the care recipient. Paid carers actively sought information about young adult care recipients, in order to get a sense of them as people. Developing this understanding took time and it was a continual process. Information about the person which may have been acquired individually or through communication with other staff was stored and used at a later time. Participants utilised a range of strategies to find out about care recipients and it was important that they found out about both the person’s past and their present.

Finding out about the person’s past involved paid carers finding out about a young adult care recipient’s life prior to their brain injury. More specifically, they found out about their living situation, relationships, employment and leisure interests.

Strategies paid carers used in this study to gather information about the person’s past were observing the environment in the person’s bedroom, talking with family and reading any clinical notes which were handed over from a previous service. Paid carers found out about the person’s past as they looked at photographs or posters which were on the person’s bedroom wall and they assigned meaning to these visual images. Paid carers interpreted these things as interesting and important to the care recipient. An example from PC 9 shows how paid carers assigned particular meaning to pictures:

Well I can tell you there’s dirt bikes. There's a big picture on the wall from the property with home … Then his posters, there’s pictures of him, with him on his 21st and his brothers. … So that’s on the back wall. Yeah, there’s just lots and lots of family photos. A lot of his brothers, there’s a dog, he’s very passionate about his dog (PC 9, Int. 1).

Talking with family enabled paid carers to find out about the music and films care recipients enjoyed so they could bring this information into conversations with the person or put them on during interactions. PC 2 said, “I ask her mum what she likes and different things, or what music she likes or what DVDs she liked” (PC 2, Int. 1).

PC 8 shows how threads of information from a care recipient’s family, their environment and the person’s reactions are combined to create part of the person’s story and thus inform the actions of paid carers:

Well just through his family. Having photos on the wall and things like that and the way he reacts to it. Because he’s always pretty happy when you put stuff (music, DVDs) like that on (PC 8, Int. 1).

Finding out about the person’s present was an ongoing activity of paid carers in this study. Paid carers found out about care recipients’ current preferences and dislikes for things such as music, positioning and television shows. Additionally, they found out about the person’s current state of health, their abilities, impairments and any appointments they needed to attend on a given day. This was in an attempt to make relevant choices for care recipients and was a way of ensuring the complex health care standards were maintained for young adults who were dependent for all aspects of their care. Study participants reported a variety of strategies for accessing this information.

Spending time interacting with young care recipients was important in finding out about their present. The following excerpt from PC 13 shows the importance of taking time:

You can see with his eyes that when he likes something, he’s more animated. If you, say, talk about a TV program or something and then like his eyes become more animated when it’s something that he likes … He likes football … Anything to do with motor sports … Now, this morning I said to him, what do you want to watch? I went through the programs on the TV and found out what was on and then told him what was on and then it was cartoons. I could tell that he wanted to watch cartoons … I sort of went to each program, told him what was on, and then because I think Sunrise was on one, he just showed no interest in that at all … It’s his eyes again … Yeah, his eyes tell you a lot (PC 13, Int. 1).

Paid carers assigned both positive and negative meanings to different responses and it was through taking the time and observing, that paid carers found out about the person’s present. Furthermore, there was a recognition that the preferences of care recipients were not static and could change from day to day.

Paid carers also found out about the person’s present by trying new things, sometimes intentionally but also sometimes by accident. PC 2 provided a good example of this and how she assigned meaning to what she observed. Bathing rather than showering for this care recipient became the new way in which hygiene was maintained:
PC 2: She laughs or she just, she just gets a different look over her face. When she’s angry she’s either got her fists up like this or then when she’s happy she’s just relaxed like we fill the bath up till she’s floating in it and she just lays there she’s so relaxed.

I: So how did you get to know that she liked the bath so full?

PC 2: We just did it one day and then when I did it flooded, the bathroom had flooded and I had to leave her in there for like half an hour because the bathroom had flooded and I couldn’t get to her and she was just laying in there chuckling the whole time (PC 2, Int. 1).

Participants utilised a range of strategies to find out about a young adult care recipient’s past and present. Given the limitation in verbal communication between paid carers and care recipients, assigning of meaning was essential. Along with finding out about the person, having and showing compassion was also facilitated through the care provided to the person.

Caring for the person

Caring for the person required some fundamental activities, which could be regarded as generic; however, they are critical to caring for all people who are dependent and unable to perform or direct their own care. Analysis of interviews with paid carers in this study showed very deliberate attempts to make caring activities more than prescribed requirements, to be completed by the end of the day. Personalised care was facilitated by using information paid carers had found out about the person when providing that person’s care.

Truly caring for a person in a manner inclusive of the person’s preferences and dislikes required commitment by paid carers to interact and engage with care recipients. Maintaining the physical body by providing personal care and preventing deterioration were background activities for activating the person to get them to respond. In this way, paid carers maintained existing function and promoted functional improvement in young adult care recipients.

Providing personal care refers to paid carers bathing, dressing and grooming care recipients in a way they considered to be personally meaningful to the person. In this study, bathing included showering, dressing included the choice of clothing, and grooming included doing a person’s hair and shaving. Furthermore, the process of providing personal care was much more than just doing the tasks of bathing, grooming and dressing. Rather, it was informed by knowledge of the care recipient’s likes and dislikes as well as by meanings paid carers assigned to the behaviours of care recipients. Subsequently, assigned meanings were integrated into the processes of bathing, grooming and dressing.

Paid carers definitely saw personal care as extending well beyond just physical care. They undertook bathing, dressing and grooming because care recipients were unable to perform these tasks as a consequence of their physical and cognitive impairments. It was evident that personal care included and was informed by a care recipient’s personal interests and preferences. Paid carers developed knowledge about the person through their family and thought about what the person would choose if they were able to, and incorporated this into their daily care routines. If a care recipient’s preferences were not incorporated into these activities, ‘care’ rather than ‘personal care’ was provided.

In the absence of specific information about a care recipient’s likes and preferences, paid carers sometimes used themselves as a point of reference for decision making. One example related to shaving a female care recipient’s legs and underarms. Unable to ascertain what the young woman wanted, female paid carers assumed that given the care recipient was a similar age to them she would like to have her legs and underarms shaved (PC 2, Int. 1). Another example of paid carers using themselves as a point of reference was in choosing a care recipient’s clothing. When unsure what the care recipient would like to wear, paid carers chose clothing which they liked and thought the person “looked good in” (PC 9, Int. 1).

As identified by Watson (1988), engagement and commitment toward the person who is dependent and cannot direct their own care is what differentiates personal care from just a set of tasks to be completed. Although the activities which are required to maintain a person’s body may be essentially the same, without an understanding of an individual’s preferences, dislikes and requirements will differ from one person to another, paid carers are unable to personalise the care that is provided. Personal care for young adult care recipients following ABI, as with the concept of person-centred care, relies on positive interactions, not only with the care recipient but also with families and other paid carers (McCormack & McCance, 2006).

Preventing deterioration refers to activities performed by paid carers with the specific intention of preventing deterioration of the physical body. In this study, preventing deterioration included cleaning a care recipient’s mouth and teeth, managing their incontinence, positioning their body, administering medications, maintaining tracheostomies, and maintaining adequate hydration and nutrition. Such activities were far from one-off or optional. They were repeated at regular intervals, with vigilant monitoring in between times. Collectively, these activities became a program of care that was more fundamental to the existence of young adult care recipients than personal care. Although paid carers did not always articulate an in-depth understanding of how
their activities prevented deterioration, it was clear that at an organisational level preventing deterioration was understood as important. Nevertheless, the importance of activities undertaken by paid carers to prevent deterioration of the body cannot be over-stated.

While paid carers required specific knowledge and skills to provide complex technical care to prevent deterioration in care recipients, listening to and observing care recipient behaviour was important. Preventing deterioration for care recipients who have many needs required paid carers to synthesise their knowledge, experience and assigned meanings, and to integrate this synthesis into the continual process of caring for the person. The complexity of coordination and timing in the process of preventing deterioration is evident in this study as several things such as positioning, nutrition, medication administration and tracheostomy care were taken into account at any given time. The following example illustrates the importance placed on positioning:

Yesterday, they got [care recipient’s name] out of bed and put him in his chair. First thing I did was to go to the end of the chair and I said, he’s not straight, he’s skew-whiff, we need to re-align him in that chair. … Then he’s got his legs out. I said, okay, he might be a quadriplegic but we don’t know whether he can feel discomfort in his muscles… I’ll get the lifter. So I think by explaining to the staff, not just going in and saying, straighten him up. But by explaining why something has to be done for that care need, there is a physiological reason to it, there’s a pain probably reason to it. There’s a comfort thing to it. Then they’re more understanding (PC 6, Int. 1).

Not only does preventing deterioration attempt to maintain the person’s body, but the activities may be rehabilitative in nature as they aim to help the young adult function at their highest potential (Crisp & Taylor, 2001). In this study, paid carers actively and purposefully prevented deterioration, specifically to maintain a person’s current condition, but also with the hope of improvement where possible.

Activating the person refers to paid carers provoking a response in care recipients. In this study, paid carers did this by initiating age-appropriate activities, such as putting on music or DVDs, looking at what was considered age-appropriate material on the internet, using age-appropriate humour and responding to environmental cues, including tattoos, body piercings, posters, photos and bed coverings. They assigned meanings to these cues and integrated these meanings into their interactions with the intention of getting a response thus activating the person, for example:

We always say to her “you would have been a bit of a wild one wouldn’t ya”, cause she’s got tattoos and all of that and she just cracks up laughing (PC 2, Int. 1).

The responses that paid carers were seeking to provoke were very specific, that is, expressions of enjoyment. The activities were initiated with an intention to stimulate the person’s auditory and visual senses and their memory. They were a way of creating a light-hearted atmosphere in the finite time paid carers had with the person before they had to move on to work with other residents.

Knowing about the person’s past and the person’s present informed how paid carers activated the person. Paid carers’ actions brought energy and vibrancy into interactions. They were always specific to that person, spontaneous and intended to brighten the mood. At times, the energy and vibrancy was introduced by stirring up other young residents to make noise. As such, this was indirect activation.

Most importantly, there were also times when paid carers withdrew from activating the person while they were maintaining their bodies. At these times, they interpreted that the care recipient was too fatigued or simply not in the mood to be activated.

In this study, paid carers came into contact with care recipients mostly through providing personal care and preventing deterioration of the body. It was during these activities that paid carers activated the person. Although not explicitly stated by participants, it was evident that while maintaining the body may have been what drew paid carers to care recipients, activating the person was done simultaneously during direct contact with care recipients.

Maintaining the body, providing personal care, preventing deterioration and activating the person were processes which occurred simultaneously in the everyday interactions between paid carers and young adult care recipients. These types of care provided to young adults with ABI in the residential aged care facility were demonstrations of having and showing compassion by paid carers. Fluidity to the process of care provision was illustrated by paid carers responding to the ever-changing factors which were at play while caring for the person, including demands on paid carers, or variables in the family, paid carers and care recipients.

Discussion

Paid carers engage in the process of having and showing compassion as they find out about, and while they provide care to young adult care recipients following ABI. Three aspects of the care literature relevant to this finding will be discussed to extend
the limited understanding of how post-intensive rehabilitation care is provided for the young adult care recipient following ABI, namely providing body care, personalising care and humanising care.

Providing body care

Nursing literature on caring focuses very much on the physical aspects of care and is commonly referred to as “body care” (Lawler, 1991, p. 29; Ray & Street, 2006, p. 35). The aspects of the findings of this study that relate to providing body care are maintaining the body and preventing deterioration. Although identified as a critical component of caring for a person, descriptions of the provision of body care in the literature are vague (Lawler, 1991). This may be because, as Lawler (1991) and Lin and Tsi (2010) note, much of this work is done in private, as it was in this study. It is hidden, and rarely discussed in detail in the literature. In the current study, paid carers, despite being willing, struggled to find the words to talk about these activities. This was probably influenced by the range of educational levels of paid carers and potentially the lack of professional language to assist them to articulate these activities.

In comparison to other aspects of care, such as resuscitation procedures, medication administration and electrocardiograms, which require specific knowledge and skill, providing body care is often described as basic, implying little or no skill is required to provide such care (Lawler, 1991). Paid carers in this study, however, demonstrated that providing body care is far from unskilled. Maintaining the body and preventing deterioration for young adult care recipients following ABI is underpinned by a rehabilitative philosophy, which focuses on maintaining and promoting function (Australasian Faculty of Rehabilitation Medicine, 2008; Australasian Rehabilitation Nurses’ Association, 2003).

Personalising care

Personalising care is discussed in the literature as person-centredness, which is underpinned by the notion that individuals have a right to believe, desire and choose what is important to them (McCance, Slater & McCormack, 2008). Finfgeld-Connett (2008, p. 528) explains that “antecedents to the [care] process include a need for openness to caring on the part of the care recipient”, all of which imply reciprocity. The literature, however, does not explain how to take limitations in reciprocity, as with young adults unable to perform or direct their own care following ABI, into account in relation to person-centredness.

In this study, care providers described care recipients’ responses as limited and variable, which impacted upon care recipients’ ability to express their desires and preferences. Nevertheless, reciprocity was important to paid carers in this study, as demonstrated in the way paid carers incorporated information they had found out about care recipients in their everyday care routines and their very deliberate efforts to activate the person.

This study highlights how paid carers developed understandings of the young adult care recipients as individuals. Care recipients’ responses and non-responses were interpreted by care providers within the context of the relationship they felt they had with each care recipient. McCormack and McCance (2006) note that relationships such as these are a critical component of person-centred care. However, the person with a disorder of consciousness following ABI is unable to reliably express their own beliefs, values and preferences, making it challenging to form a therapeutic relationship as currently defined. Regardless of these challenges, paid carers in this study demonstrated that therapeutic relationships do form, not only with care recipients but between paid carers and families. These other relationships may also become the proxy for those with the disorder of consciousness, as noted by Banja (1990).

The deliberate attempts of paid carers in this study to find out about those for whom they care also demonstrates celebration and solidarity with others, which fits with Fox’s (1979) understanding of compassion. Compassion is about deliberate actions (Heffernan, Griffin, McNulty & Fitzpatrick, 2010; von Dietze & Orb, 2000), which come from a togetherness (Fox, 1979) and solidarity between paid carers and young adult care recipients. This study found that while paid carers did attempt to personalise post-intensive rehabilitation care, it was not always possible. When it was not possible to provide personalised care due to limited information, limited understanding, organisational pressures or when the priority was to maintain standards of care to prevent deterioration, it could be said in these circumstances that care was humanised.

Humanising care

Reference to caring is particularly strong in the professional nursing literature. For example, McCance (2005) identifies Leininger, Watson, Roach, and Boykin and Schoenhofer as nursing theorists who have published on the importance of care and caring as a fundamental aspect of nursing practice. Leininger’s work describes care as activities that are directed at improving a person’s condition; this may be done through physical and emotional means (McCance, 2005). Both Watson and Roach suggest that care is philosophical in nature and the intention to do good is displayed in just acts (McCance, 2005). Boykin and Schoenhofer explain that authenticity is a critical component of the relationships nurses have with those for whom they provide support (McCance, 2005). Respect and listening are also identified as critical components in the preservation of dignity when providing nursing care (Anderberg, Lepp, Berglund, & Segesten, 2007).
These nursing views on care appear to be synonymous with what is described by Todres, Galvin and Holloway (2009) as humanised care, an emerging concept within the literature. Todres et al. (2009, p. 69) state that “to be concerned with humanisation is to uphold a particular view or value of what it means to be human and furthermore to find ways to act on this concern”.

Abjection is a concept of relevance to the humanisation of care for individuals who are unable to perform or direct their own care following ABI. Through exploring abjection one is able to illustrate where health care is not humanised, thus challenging our society’s commitment to such an approach. Abjection describes those who are marginalised or cast off due to disease, impairment and/or disability (Kristeva, 1982). Kristeva (1982) explains that images, which do not fit within our social construct, force the person being faced with impairment or disability to reject and cast away that which challenges one’s mortality and identity. As with the person with late-stage motor neurone disease explored by Ray and Street (2006), the young adult who is unable to perform or direct their own care following ABI may also present with muscle wasting, swallowing problems and urinary and faecal incontinence. All these aspects of the body have been described as dirty (Lawler, 1991).

Marginalisation and isolation for some following ABI is evident within Australia as the lack of suitable, long-term accommodation options shows (Australian Institute of Health & Welfare, 2012). It is evident in this study that paid carers, along with family members, had a key role in activating the person as social opportunities were limited. This study illustrates the reality that we are yet to have a suitable amount and type of accommodation options for young adults following ABI. In recent years, with the ever-increasing pressure on budgets and the tightening of the health care dollar, there is an emphasis on key performance indicators which focus on functional outcomes following ABI (Marshall et al., 2007; Zhu, Poon, Chan & Chan, 2007), length of stay, pressure ulcers, falls and, in the acute sector, readmission rates (Burnell, 2009; Charon, 2006; Maben, Cornwell & Sweeney, 2010; Shantz, 2007). All of these factors have contributed to an impersonal and dehumanised approach to health care, unfortunately often resulting in a distance between care giver and care recipient (Maben et al., 2010; Shantz, 2007).

Paid carers in this study and the health care literature identify the challenges of having and showing compassion within health care (Maben et al., 2009; Meyer, 2009). Barriers identified in the literature include limited time (Meyer, 2009), increased demands on nurses (Maben et al., 2010) and organisational cultures valuing the measurable outcomes more than the human aspects of care (Meyer, 2009; Todres et al., 2009). Although these contextual conditions are recognised by both the literature and paid carers in this study, these findings demonstrate that having and showing compassion is evident in day-to-day interactions which occur, even in the presence of the time limitations. The attempts of paid carers in this study to engage and activate care recipients while preventing deterioration demonstrated that a rehabilitative approach is possible, regardless of the care setting. Paid carers have a valuable contribution to make to a lifelong model of rehabilitation for those who are unable to perform or direct their own care following ABI. Such an approach has been advocated by others (Cameron, Pirozzo & Tooth, 2001; Rees, 2005; Winkler, Farnworth & Sloan, 2006), so the findings of this study add strength to the campaign for such services.

Limitations of the study

Relying solely on paid carers’ reports of how post-intensive rehabilitation care is provided for young adults who are unable to perform or direct their own care following ABI without observation of practice means this study was informed by a limited perspective. Studies of the perspectives of family and friends would provide valuable information in regard to the lifelong rehabilitation and care needs of young adults following ABI. By expanding the paid carer group to include allied health clinicians, future studies could explore if the strategies employed by paid carers in the process of having and showing compassion are similar or different across health disciplines.

Conclusion

The findings of how paid carers have and show compassion is central to providing post-intensive rehabilitation care for young adults who cannot perform or direct their own care following ABI and contributes to the limited literature which is available regarding care for this small but growing population. It also makes a contribution to the limited nursing literature promoting compassionate care and the emerging literature regarding the humanisation of health care.

The findings from this work show the interactive nature of providing care, which is based upon an interpretive process of paid carers assigning and integrating meaning. The commitment and engagement of paid carers and their efforts to activate, stimulate, provoke, and sometimes push, combined with gentleness, humour and solidarity with those for whom they provide care, is evidence that compassionate care exists. Further qualitative research into the area of compassion and the humanisation of health care is essential if we are committed to providing ethical and humane care to those who are vulnerable, which each and every one of us is likely to be at some stage in our lives.

Acknowledgement

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References


Frequently asked questions about FIM

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The Functional Independence Measure (FIM) is the outcome measure used to assess people on admission to, and discharge from, all Australian and New Zealand public and private inpatient rehabilitation and geriatric evaluation and management (GEM) programs. In addition, it is used by some ambulatory and community rehabilitation programs. FIM is an 18-item scale that assesses a person’s burden of care, or need for assistance, in relation to these domains: self-care; sphincter control; transfers; locomotion; communication; social cognition and memory. Individual items are scored from level one, total assistance, to level seven, complete independence. FIM is utilised by rehabilitation facilities worldwide. It was developed in 1987 by the American Academy of Physical Medicine and Rehabilitation, as well as the American Congress of Rehabilitation Medicine. The Australian Rehabilitation Outcomes Centre (AROC) holds the licence for FIM in Australia and New Zealand.

These clinical questions came from FIM users seeking further clarification in FIM scoring. The purpose of this article is to share this information to enable clinicians to accurately score FIM. Here are some frequently asked questions and answers about scoring FIM.

Eating

Question: How do I score a person who has IV therapy (IVT)?
Answer: IVT is not included in FIM scoring.
Rationale: IVT is a medical procedure.

Bladder and bowel management

Question: How do I score a person who requires a helper to flush the toilet?
Answer: Toilet flushing is not included in FIM scoring.
Rationale: Scoring of bladder and bowel management involves assistance from a helper with equipment and devices (part 1) as well as the frequency of accidents (part 2). In addition, raising and lowering the toilet seat is not included in FIM scoring.

Bowel management

Question: How do I score a person who eats prunes regularly and the prunes are listed on the medication chart? They do not require a helper, device or extra time.
Answer: Level 7 — Complete Independence
Rationale: Prunes are considered a natural product and not a drug/medication that requires the supervision of a medical officer.

Transfers – toilet

Question: How do I score a person who uses a toilet roll holder? Is it an assistive device?
Answer: A toilet roll holder is not an assistive device when scoring FIM.
Rationale: Anything in the toilet cubicle that is not a prescribed piece of assistive equipment is not considered an assistive device. For instance, a rail is an assistive device when used for toilet transfers.

Expression

Question: How do I score a person who can accurately blink to communicate “yes” and “no”?
Answer: Level 2 — Maximal Prompting
Rationale: Blinking for “yes” and “no” is regarded as expression of a single word. As the person communicates appropriately and consistently in this way then the score is Level 2 – Maximal Prompting. If a person does not communicate appropriately and consistently in this way then the score is Level 1 – Total Assistance.

Absconding patient

Question: How do I score a person who absconds within the first 24 hours, has stayed overnight and full assessment has not occurred?
Answer: Score Level 1 – Total Assistance
Rationale: The person has not been fully assessed over a 24-hour period and therefore the “score Level 1 if not assessed” rule applies. If scoring in this way the episode will be considered incomplete by AROC and excluded from outcome analysis.

If you have any questions or comments about these or other scenarios, please contact AROC.
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Benchmarking Reports

By the time you read this all AROC members will have received notification that their Calendar Year 2014 Benchmarking Report is available for download. We strongly encourage everyone involved in providing rehabilitation care to access their AROC Benchmarking Reports and spend some time reviewing their units’ outcome achievements over the last year.

As you may be aware, structurally we now present three separate types of reports for Inpatient (Pathway 3):

- the Core Report
- the Outcome Target Reports
- the Impairment Specific Reports

The Core Report includes the standard analysis of all impairments, presenting the facility’s inpatient Pathway 3 data and comparing that to either all public or all private data (whichever is relevant to the facility) and the national data.

The Outcome Target Reports provide a graphical representation of the spread of achievement of the outcome target across all facilities, and where in the continuum of achievement across all facilities the individual facility is situated.

For those facilities that did not have enough data in any impairment category to receive their own outcome target report, or for those that would like to see details on impairments they do not provide care for, a generic report is available for download from the AROC website under the heading Anywhere Hospital Outcome Target Report.

Impairment Specific Reports are generated annually. In 2013 we presented reports for Stroke, Orthopaedic Replacements and Orthopaedic Fractures. In 2014 we will again provide these and also anticipate providing Reconditioning, Brain Injury, and Spinal Cord Injury Impairment Specific reports. This type of report provides greater analysis at an impairment level, and includes analysis of the impairment specific data items that are included in the v4 dataset and detailed FIM item analysis. They present each facility’s data and compare it to the national data.

Again, for those facilities that did not have enough data in any impairment category to receive their own impairment specific report, or for those that would like to see details on impairments they do not provide care for, a generic report is available for download from the AROC website under the heading Anywhere Hospital Impairment Specific Report – [Impairment Name].

Appointment of AROC Clinical Director

AROC is pleased to announce that, after the retirement of A/Prof Ben Marosseky late last year, and the subsequent competitive process to look for a new AROC Clinical Director, AROC has appointed Professor John Olver as the incoming AROC Clinical Director. John’s role with AROC will encompass:

- the provision of regular high-level clinical advice to help guide AROC’s activities and development
- acting as an AROC ambassador, supporting AROC activities within the rehabilitation sector and beyond
- sitting on the AROC Scientific and Clinical Advisory Group (SCAC)

We warmly welcome John to the position and look forward to his input into the ongoing development of outcome benchmarking in the rehabilitation sector. A short summary of John’s background and areas of interest is below.
John Olver, MBBS, MD(Melb), FAFRM (RACP), Consultant Physician in Rehabilitation Medicine, is Professor in Rehabilitation Medicine in the Department of Medicine at Monash University. He is Medical Director of Rehabilitation at Epworth Healthcare, Melbourne, Australia, where he is also Manager of the Epworth Rehabilitation Acquired Brain Injury Programme. In 2008 he was appointed as Chairman of the Clinical Institute of Rehabilitation, Mental Health and Chronic Pain Management at Epworth HealthCare and in 2009 was appointed to the Victor Smorgon Chair of Rehabilitation Medicine, Epworth HealthCare and Monash University. He is Director of the Epworth-Monash Rehabilitation Medicine Research Unit, the medical research arm of Epworth HealthCare Rehabilitation.

Professor Olver’s main research interest and a focus of publication concerns outcomes following traumatic brain injury and treatment of adult spasticity. His doctoral thesis on balance deficits following traumatic brain injury was presented in 2000. He is on the editorial boards of two medical journals, is Past President of the Australasian Faculty of Rehabilitation Medicine, a member of the American Academy of Physical Medicine and Rehabilitation and is a member of the President’s Cabinet (Treasurer) of the International Society of Physical and Rehabilitation Medicine. Professor Olver is on the Scientific Committee of the World Federation for Neurological Rehabilitation (WFNR) and was Convenor of the 2012 Melbourne WFNR Scientific Conference Committee. He is immediate Past President of the Asia Oceanian Society of Physical and Rehabilitation Medicine (AOSPRM).

Nursing staff who are FIM credentialed

Nurses form an important component of the multidisciplinary team providing rehabilitation care. AROC recently undertook an analysis of the proportion of clinicians sitting and passing the FIM exam. The results of our analysis are presented here. Figure 1 shows the growth in FIM exams sat and passed since AFRM brought the FIM tool to Australia and started training here.

Figures 2 and 3 show for the last two calendar years the number, and then the proportion, of passed exams undertaken by profession. Note that some 1,800 nurses sat and passed the FIM exam each year – 40% of the total volume of FIM exams passed.
Meet your national committee

Gillian Garrett
Committee Member

Over the past 20 years I have worked in stroke, traumatic brain injury, neurological and spinal cord injury rehabilitation units. I am currently a CNC (spinal injury) at Royal Rehab in Sydney. I am particularly interested in the attributes required of the nurse in a rehabilitation environment, but it was my enthusiasm for nursing in rehab generally that prompted me to join ARNA. I am a past president of the NSW/ACT Chapter and have joined the national committee hoping to contribute to the association further.

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Rehabilitation nursing is a recognised specialty area of nursing within Australia with a broad and expanding knowledge base. As the official Journal of the Australasian Rehabilitation Nurses’ Association (ARNA), \textit{JARNA} seeks to enhance this expanding knowledge base through the publication of information pertaining to rehabilitation nursing. An equally important purpose of \textit{JARNA} is to facilitate the development of ARNA members as writers for publication by providing constructive feedback to authors.

Prospective authors are asked to follow the following guidelines when compiling a manuscript they wish to submit for consideration for publication in \textit{JARNA}.

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\textit{JARNA} is published three times a year and manuscripts pertaining to rehabilitation nursing are invited. The Editor welcomes manuscripts on research, quality activities, innovative practice, education, management, case studies and any other item of interest to rehabilitation nurses. \textit{JARNA} also invites new and first-time authors, with mentoring provided by the Editorial Board to assist in achieving publication standards.

All work will be sub-edited to the journal’s style. The Editor reserves the right to modify the style and length of any manuscript submitted, so that it conforms to journal format. Major changes to a manuscript will be referred to the author for approval prior to publication.

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All authors must make a substantial contribution to the manuscript and will be required to indicate their contribution. Participation solely in the acquisition of funding, collection of data or supervision of such does not justify authorship. All participating authors must be acknowledged as such: proof of authorship may be requested by the editors. The first-named author is responsible for ensuring that any other authors have seen and approved the manuscript and are fully conversant with its contents. If the author wishes to reproduce material subject to copyright, it is the responsibility of that author to obtain written permission from the copyright holder and to acknowledge this permission within the manuscript.

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Research protocol Approval of protocol by the appropriate ethics committee of the institution within which the research was carried out must be stated within the manuscript.

Human investigations All work must be stated that it conformed to the “National Statement on Ethical Conduct in Research involving Humans” by the National Health and Medical Research Council of Australia, or equivalent in other countries or the Declaration of Helsinki.

Humane animal care All work involving animals must contain a statement that it conformed with the “Statement on Animal Experimentation” by the National Health and Medical Research Council of Australia or equivalent in other countries.

Manuscript types

Submitted work may take any of the following forms:

Original articles These articles should be 1500–4000 words in length and, where appropriate, may include photographs or tables.

Reviews, commentaries and discussion articles These articles should be 1000–3000 words in length.
**Case reports and opinion pieces** These articles should be 1000–1500 words in length and should ensure patient confidentiality is maintained.

**Letters to the editor** Letters will be no longer than 1000 words (but mostly shorter) and typically comment on a topic covered in a recently published edition of JARNA or on matters of key professional or clinical importance to rehabilitation nursing or nurses.

**Book and film reviews** Book or monograph reviews of no more than 500 words may be included depending on the interest to the subscribers. Books or monographs to be reviewed can be sent directly to the Editor. No books will be returned.

**Peer-review process**

JARNA is a peer-reviewed journal. All manuscripts are initially reviewed by the Editor or a member of the Editorial Board and those deemed unsuitable (insufficient originality, serious scientific or methodological flaws, or a message that is of limited interest to the audience of JARNA) are returned to the author/s, usually within four weeks. If the manuscript does not conform to the submission guidelines, the author will be asked to amend prior to peer-review.

All manuscripts are reviewed by peers with rehabilitation nursing experience for relevance, accuracy, currency, construction, flow, style and grammar. All reviewers spend considerable time reviewing manuscripts and providing feedback to authors. The length of time of the review process can vary and depends on the quality of the work submitted. Several revisions may be required to bring the manuscript to a standard acceptable for publication.

Proofs of articles about to be published will be sent to the corresponding author for review. This requires rapid response; if such a response is not forthcoming, the article will be published without the author’s reply. Providing email addresses facilitates with process. This final decision about publication is made by the Editor.

The peer-review process is managed online. Decisions are communicated by email to the corresponding author. Submitted manuscripts are acknowledged by email.

**Preparation of manuscripts**

Manuscripts should use double spacing with Times Roman 12 font and margins 2.5 cm.
two authors, both names should be stated, using an ampersand (Smith & Jones, 2009). In the case of three to five authors, cite all authors the first time (Terrace, Petitto, Sanders & Bever, 1979), then in subsequent citations of this work use the surname of the first author plus et al. For six or more authors, use only the first author’s surname plus et al. If the author is a government agency or corporate organisation, name the organisation in the parenthetical citation (National Health and Medical Research Council, 2001). If the organisation has a familiar acronym then use this in subsequent citations (NH&MRC, 2001).

Use quotation marks for quotations of fewer than 40 words. For quotations of more than 40 words indent the quotation as a block, without quotation marks and always include the page number.

Examples of APA referencing style

**Journal**


**Book**


**Edited book chapter**


**Submissions of manuscripts**

*JARNA*, in conjunction with Cambridge Publishing, now uses the world’s leading manuscript management system – ScholarOne. Manuscripts for peer review will only be accepted via this online program. All tables, figures and photographs, as well as the main document and title page, are to be uploaded separately. Please ensure image files are between 700 kb and 2 MB in size. The manuscript may be accompanied by a Word document with tables, figures and photographs embedded so as to show preferred positioning of such. This separate file can be uploaded at step 4 as a cover letter.


To create an account when using the system for the first time, click on ‘Register here’ under ‘New User?’ in the middle right of the screen, or on ‘Create Account’ in the top right hand side of the screen. Please enter as much information as possible when creating an account.

Once in the system, the steps to submit an article are:

Step 1. Manuscript type, title, running head (abbreviated title) and abstract.

Step 2. Keywords – at least two are required, up to five allowed.

Step 3. Add co-author and edit your details (if necessary).

Step 4. Manuscript information and questions on funding, ethics, conflict of interest and copyright.

Step 5. Upload files.

Step 6. Review and submit.

The *JARNA* ScholarOne website has comprehensive guidelines and online tutorials to assist in using the system. Click on the orange ‘Get Help Now’ in the top right hand corner. A PDF of the Author Quick Start Guide can be downloaded after choosing ‘Author’ as your role.

An email confirming successful submission of the manuscript is sent to the author with details about how to track the progress of the manuscript.
Prevent skin breakdown
Maintain skin integrity with SECURA® skin care
- Cleanse, protect and moisturise
- Formulated with high quality skin friendly ingredients
- Your first line of defence in preventive skin care

Prevent pressure damage
Relieve at-risk areas with DERMAPAD® Polymer Gel Pads
- Specifically designed to help prevent pressure injuries
- Redistributes pressure away from vulnerable body areas
- Washable and re-usable on the same patient
- Available in a wide range of shapes and sizes
- Contributed to a 75% reduction in pressure injuries³

Pressure injuries are one of the five most common causes of harm to patients¹ despite being a largely preventable health problem². Skin protection is paramount to the prevention of skin breakdown and pressure injuries².

References: