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A study to determine the contributions of a nurse to an out-patient rehabilitation center.

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A STUDY TO DETERMINE THE CONTRIBUTIONS
OF A NURSE TO AN OUT-PATIENT
REHABILITATION CENTER

by

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A field study submitted in partial
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CHAPTER I
THE PROBLEM

Introduction and Overview

During the past few years, a great deal of emphasis has been placed on the word "rehabilitation". Since 1940 as many as forty five rehabilitation centers have sprung up in all parts of the country. The advent of these centers is one of the truly significant developments in rehabilitation, making rehabilitation possible for thousands for whom it had been denied. The centers combine varied specialized services to meet the needs of the handicapped individual. They focus their efforts on teamwork by bringing together and utilizing people of various disciplines. In this way maximum rehabilitation can be achieved.

Mary E. Switzer and Howard A. Rusk have noted a number of characteristics of a rehabilitation center which are useful in constructing a definition.

"They combine within one organization the facilities and processes for moving the disabled persons as far as possible along the road from the hospital bed to productive employment.

"They provide a coordinated approach in the evaluation of the patient's condition and the prognosis of the degree and character of his physical and vocational restoration.

"They are not hospitals, schools, or industries, but partake of the characteristics of all these.
"They are a tool for use by all social agencies, by the medical profession, and by the representatives of groups who are interested in the fullest possible rehabilitation of its citizens.

"They are patient-centered in that, around the problems and prospects of the patient, there is formed a program in which each of the services---such as medical care, physical therapy, occupational therapy, speech therapy, social work, adult education, vocational counseling, and psychological services---function simultaneously.

"The rehabilitation center supplements rather than supplants the physical medicine and rehabilitation activities and programs of hospitals and other agencies within the community. Centers by themselves cannot meet the entire community need for rehabilitation services, but by their existence they increase the quality and quantity of the work performed by other rehabilitation agencies which focus on special aspects of the entire problem."

Henry Redkey, a consultant on rehabilitation centers in the Office of Vocational Rehabilitation, United States Department of Health, Education and Welfare, defines a rehabilitation center as follows:

"A rehabilitation center is a facility in which there is a concentration of services, including at least one each from the medical, psychosocial, and vocational areas, which are furnished according to need, are intensive and substantial in nature, and are integrated with each other and with other services in the community to provide a unified evaluation and rehabilitation service to disabled people."

In December of 1952, the National Society for Crippled Children and Adults Inc. and the Office of Vocational Rehabilitation

1 Switzer, Mary E. and Rusk, Howard A. "Doing Something for the Disabled." Public Affairs Pamphlet, No 197, 1953.

compiled information submitted by thirty nine rehabilitation centers for the purpose of obtaining detailed descriptions of the program and facilities of these centers. It was necessary for clarification purposes to classify these centers into five categories.

- Teaching and research centers operated by medical schools and hospitals.
- Community centers with beds.
- Community out-patient centers.
- Insurance centers.
- Vocational rehabilitation centers.

The study showed that today many communities are interested in establishing a rehabilitation center. However, they are at a loss as how to begin organizing it. Much information is asked about staffing, equipment, space, cost, etc. The National Society for Crippled Children and Adults, Inc. and the Office of Vocational Rehabilitation conducted a survey of rehabilitation centers to help answer such questions. The committee that wrote the report recognized the necessity of presenting several basic ideas regarding staffing within a rehabilitation center. This was attempted on several occasions. No results were achieved because of lack of definition of the type of centers for which the patterning was attempted. Results of the government survey implied that staffing be based on consideration of the patient's needs rather than on services and facilities that might be available in the community. The survey also showed that "nurses were seldom used to advantage". Because of this the investigator

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has attempted to demonstrate the contributions of a nurse to an out-
patient rehabilitation center.

Statement of the Problem

In the present study, attempts will be made to evaluate
the role of a nurse in a specific out-patient rehabilitation center.
Further attempts will also be made to determine her function in this
type of setting.

Purposes

1. To evaluate the role of a nurse in a rehabilitation out-patient
center.
2. To ascertain the need for nursing service, if any, as ex-
pressed by patients in an out-patient rehabilitation center.
3. To ascertain the need for a nurse, if any, not recognized
by patients.
4. To ascertain the need for a nurse, if any, as expressed by
   team members.
5. To determine nursing activities being done
   a. by nurses
   b. by non-nurses
Statement of Methodology

A total of forty hours was spent at the rehabilitation center in observing incidents, interviewing personnel and patients and reviewing case records.

The first step was to ascertain the attitudes of the rehabilitation team and the patients in regard to the contributions of a nurse to the center.

The second step was to interview selected cases to ascertain problems which were encountered during their rehabilitation period.

The third step was to observe incidents which would reveal whether or not a nurse served as an important member on the rehabilitation team.

The fourth step was to ascertain how team members communicated with each other. Direct observations were made at staff conferences and in day to day interdisciplinary contacts.

The fifth step was to review two case records. These were concerned with patients recently discharged from the rehabilitation center. The results obtained from these case records are presented in the findings.
Sequence of Presentation

In Chapter II the philosophy underlying the study will be presented. This chapter will also include a survey of literature.

Chapter III will include a detailed description of the methodology including the selection and description of sample, the tools used, and the procurement of data.

Chapter IV will be concerned with the presentation and analysis of the data.

Chapter V will include a summary of the conclusions reached and recommendations derived from the findings as well as recommendations for further study.

Scope and Limitations of the Study

At the outset it was necessary to choose an out-patient type of rehabilitation center which would be available for study. The center chosen has a rehabilitation team but does not employ a nurse per se. The medical rehabilitation team consists of one physician-internist, three orthopedic surgeons, one vocational counselor, five physical therapists, four occupational therapists and two prosthetists. It is an interesting fact to note, however, that the vocational counselor is a registered nurse but was hired specifically for counseling and job placement and not for administering nursing functions.

All types of injuries resulting from industrial accidents are treated at this center. These usually include severe and multiple
fractures, hand injuries, amputations, severe lacerations, burns and spinal cord injuries.

Because there are many similar out-patient rehabilitation centers springing up in all parts of the country, it is probable that problems similar to those at this center will arise elsewhere in regard to staffing.

This study has certain implications for these centers because it attempts to demonstrate the role and contributions of one member of the team, namely, the nurse.

Limitations

This study has certain limitations. The center chosen is not necessarily typical of all rehabilitation centers with out-patients. In fact it would be difficult to choose one that was representative. The many rehabilitation centers in the United States are set up individually to meet their own particular needs. Obviously they differ greatly and therefore if this study determines there is or is not a role for the nurse in this setting, it will not substantiate whether there is or is not a role for a nurse in all out-patient rehabilitation centers.

In recent years a study was undertaken by the center being studied which statistically proved that the average patient was not admitted to the rehabilitation center before a period of seven months from the time of initial injury. The center requires that all open wounds be completely healed before admission is contemplated. Another limitation is due to the fact that the center has at its disposal
an industrial clinic which is readily accessible for any emergency and is staffed by a full time physician and nurse. These facts could limit the applicability of this study to other centers.

Definition of Terms

Rehabilitation: Restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable.

Rehabilitation team: Highly skilled group of professional workers closely integrated and coordinated to achieve the most effective results in a minimum of time in restoring the patient to his optimum functional capacity within the limits of his disabilities and capabilities. Various members are the physician, nurse, physical therapist, occupational therapist, vocational counselor and prosthetist.

Discipline: A highly skilled group of professional workers.

Example: the nurse, the social worker, the vocational counselor.

Prosthetist: One skillfully trained in the art of fitting and applying artificial parts to the human body and supervising training in the use of such appliances.

Example: leg, arm, eye, hand.

Vocational counselor: One who screens and evaluates abilities and interests of patient, arranges for patient attendance at vocational
schools or on the job training and who serves as a link between employer and patient.

Physical therapist: One who treats disease and injuries by physical means such as light, water, electricity, massage and therapeutic exercises consisting of progressive relaxation, assistive, active, resistive and passive movements.

Occupational therapist: One who conducts programs for patients confined in hospitals and other institutions to provide them with directed activity and to assist in their rehabilitation. She plans and organizes work projects for patients according to medical prescription.

Example: printing, painting, rug making, sewing, woodworking and recreational therapy.
CHAPTER II
PHILOSOPHY

Today's concept of nursing is not strictly one of bedside nursing. The role of the nurse is complex. In the past there was a tendency in nursing care to treat the disease rather than the patient and the trouble rather than the troubled. For instance, a patient who had a gangrenous leg was interesting to nurses because a life was at stake. Saving of lives has always been the greatest motivating force behind the nurse's choice of profession. Often, much time and energy was spent in treating the leg---by soaks, dressings, pre-operative care, post-operative care, and in the special care of the stump so necessary to promote healing by primary union. When the immediate problems concerning the diseased leg were resolved, the patient was labeled "cured" and then sent home. But did this fulfill the patient's total needs? What was done to assist him to face the vexing problems that arose upon his discharge from the hospital? He might have been weak and unable to walk. Instead of possessing a symmetrical body, his was now misshapen. His job prospects were poor. Worried about the future, he strongly felt that his social problems were enormous. Yet this patient was called "cured". True, his life was saved, but there was something lacking in the total care of the whole patient.

Until complete rehabilitation has taken place through the combined efforts of doctors, nurses, therapists, and others, based on an intelligent understanding of the needs of the whole man and by
application of the principles and procedures of rehabilitation, there can be no real cure, for the terms "cure" and "rehabilitation" are synonymous.

Hartigan says: "The nurse is the person who has the greatest opportunity to help a patient make the early adjustment to his illness which means so much in his total recovery. She is the one to whom the patient looks for not only personal care, but also information, encouragement, motivation, guidance and assistance. No one can doubt that meeting these needs is the nurse's responsibility. It is equally obvious that this is a major contribution to the patient's rehabilitation." 4

The nurse in rehabilitation must possess many skills. The following are factors and skills which directly pertain to the rehabilitation nurse as determined by nursing authorities.

1. Knowledge and application of good general nutrition and nutrition pertaining to individual needs.

2. Knowledge and application of good general nursing care, e.g., general health measures, skin care, elimination, bladder and bowel training, etc.

3. Recognition, promotion and maintenance of maximum health of the patient and the family.

4. Understanding of the individual as a person, as a member of a family and the community.

5. Understanding of the emotional factors in long-term illnesses and disabilities in regard to patient, family, society and influence on motivation.

6. Understanding and evaluation of hospital and home environment as related to patient's needs and ultimate recovery.

7. Counseling and guidance of patient and family in regard to social, economic, recreational, vocational, and educational needs through referrals to appropriate community resources.

8. Teaching the patient, his family and others so that the rehabilitation process will progress as rapidly as possible within the patient's maximum capacity.

9. Knowledge of physical aspects of rehabilitation.
   a. knowledge of physical growth and development.
   b. recognition of deviation from the normal.

10. Knowledge of skills and techniques in rehabilitation.
    a. understanding and application of supportive measures in the prevention of deformity.
    b. maintenance of muscle tone and range of joint motion.
    c. encouraging functional activities within the patient's maximum capacity.
    d. participating in activity programs as prescribed by the physician, i.e., bed sitting, and ambulatory exercises, crutch walking, etc.

11. Knowledge of equipment needs in rehabilitation.
    a. knowledge and application of special devices and equip-
11. The nurse as a member of the rehabilitation team.
   a. emotionally accepts the individual with a disability.
   b. intelligently understands the functions and skills of all members of the team.
   c. works effectively with other services and team members.
   d. promotes, stimulates and coordinates plans for team care programs.
   e. utilizes community resources for continuity of care in the promotion of maximum health and welfare of the patient and his family. e.g. in regard to social, economic, recreational, vocational, and educational aspects.

13. The nurse as a member of the team recognizes rehabilitation potential as dependent upon individual and his environment.  

   The foregoing definitely points out the many areas in which the nurse of today is expected to function. Unfortunately many people are

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not familiar with the concept of nursing care which is every person's right today. They do not realize that much of the rehabilitative process is implicit in good nursing care. They regard rehabilitation nursing as something that begins when the patient goes to the physical therapy department or when he begins occupational therapy. Therefore, it would seem worthwhile for all rehabilitation personnel to look at the skills and knowledge that are developed and available in rehabilitation nursing.

It is extremely important that the nurse be recognized as a teacher, coordinator and counselor. It is the belief of the investigator that only when the public and allied professions are made aware of this will the nurse be able to assume her rightful place on the rehabilitation team, whether it be in an in-patient or out-patient setting.

Survey of Literature

Due to the fact that rehabilitation, now known as the third phase of medicine, is considered one of the newer forms of medicine, literature concerning the role of the nurse in rehabilitation is limited.

Hartigan says: "Rehabilitation of the ill and disabled is as old as nursing and what we now call rehabilitation is an old idea brought up to date to meet present day needs." She further states: "Rehabilitation nursing is not confined to the convalescent period alone. It begins at the onset of illness when the patient is required to make his first adjustment to a new condition. It is a continuous process and extends to the end of the patient's period of disability or until he is restored to his highest
attainable skill and gainful employment. No other worker has the opportunity which is afforded the nurse. To her falls the unique responsibility of helping the patient achieve and maintain that degree of health which will permit other members of the health team to add their special skills to his total recovery. Even then, much of the responsibility for integrating and correlating these special services depends on how well she performs her role."

She continues: "We nurses have been slow to realize and acknowledge what we have to offer in rehabilitation. It is quite remarkable that frequently the nurse has been omitted from the list of members of the rehabilitation team and that often she has been willing to be omitted. It is noticeable, also, that when the special service personnel are not always available, the nurse directs and supervises the care of the patient and frequently gets the same results which might have been obtained if all special service personnel were available. Nursing is an accepted fact while the other services—such as physical therapy and occupational therapy, which are of more recent origin—are not so well known and so widely used and we are still pretty much in awe of their accomplishments. I urge all nurses not to look afar for interpretation of the nursing role in rehabilitation, but rather to study what is being done in nursing now, and what can be done further with the knowledge and skills that are presently available. I suggest that instructors and supervisors encourage in their students and co-workers a sense of responsibility and strength in rehabilitation nursing. I urge that all of us become more vocal in stating our role in the rehabilitation
movement, be more positive in proffering what we know we have to offer, and that we step forward and take our rightful place on the rehabilitation team. As we begin to think of ourselves as major contributors on this team, we shall find that our patients receive better nursing care from the beginning, that their convalescence is shorter and much less expensive, and that their limitations will be much more acceptable to themselves, to their families, and to their communities."

Dock says: "Nursing will become less a matter of caring for bedfast patients, and more a problem of supervising physiological rest, restoring courage and strength, and training patients how to live more comfortably with chronic disabilities."

Ward says: "Where many varieties of services are available, such as occupational therapy, physical therapy, vocational guidance and others, the nurse will act more or less as a coordinator. It is the nurse who sees that the patient applies to his daily activities the principles of treatment, therapy and exercise prescribed for him."

Knocche says: "Even though a major share of the specific reconditioning exercises is assumed by functional re-educational specialists, there is still a great deal in the prevention of deformity and in teaching and encouraging self-help measures which we nurses can do, without infringing upon the work of the occupational therapist, or the physical

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therapist. There is far more work to be done in the area of convalescent reconditioning than there are hands to do it. The role of nursing on the rehabilitation team is a vital one. Let nursing not be the weakest link in the chain. It is time for us to re-evaluate the nursing given in the light of the rehabilitation viewpoint.  

From these readings one can detect that a nurse does not function solely at the bedside. She is a person of varied abilities and assumes responsibilities of a nurse, teacher, counselor and coordinator.

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CHAPTER III

METHODOLOGY

The Rehabilitation Center

The study was done in an out-patient rehabilitation center operated by an insurance company and located in a city of approximately 800,000 population. Its doors were first opened in June, 1943, its purpose being to assist the medical profession in restoring injured workers to maximum usefulness. The center is the natural outgrowth of several common aims and ideals developed under the American system of compensation insurance—by insurance beneficiaries, insurance buyers, insurance companies and the medical profession. This insurance company was a pioneer in providing a second great service—loss prevention. It has been a leader in preventing industrial accident losses. It is now meeting a third vital need—restoration from loss. This is the function of the rehabilitation center. It has brought greater well-being and security within the reach of men and women who are employed by Workmen's Compensation policyholders. Rehabilitation, like prevention, reduces insurance costs and thus benefits the people who buy and sell insurance. But the greatest beneficiaries are those men and women whose self confidence, industrial skill and earning ability are restored to their families, to their employers and to their country.
Realizing the vital importance of having more trained personnel in rehabilitation work, the center has become affiliated with a well-known large university and a school of occupational therapy for the training of occupational therapy students. Facilities are also provided for clinical teaching of physical therapy students from two other universities. The personnel of the rehabilitation center feel that this work of instruction constitutes a valuable service to the medical profession.

The center is located on a busy metropolitan thoroughfare. The ground floor consists of the switchboard, prosthetist's office, vocational counselor's office, manager's office, conference and examination room and a large area for various exercises (mat, bicycle, rowing). On the second floor is a physical therapy department where accepted modalities for heat, exercise and massage, together with standard exercising devices are given. The woodworking shop is located below the ground level where the patient selects his own project and builds it with hand and foot operated tools under the skilled guidance of trained therapists. The recreation room and occupational therapy shop are also found below street level.

In the recreational therapy program relaxing but practical games provide further use of the injured part. Work tolerances are carefully observed and developed until actual work ability has been attained. All patients are on a full, daily program which permits a more rapid progress toward the desired end result.

The prosthetic service is directed by physicians experienced in the problems of the amputee. Under their guidance, full-time
trained prosthetists work closely with the amputee in his daily routine. When the problems of stump shrinkage, flexion deformities and muscle weakness have been adequately solved, guidance is given by the prosthetists in the selection of an artificial limb that will best suit the patient's circumstances and the kind of employment which is contemplated for him. Once the selection is made, careful measurements are taken and the limb is then made by certified limb manufacturers to suit the size, weight, posture and point of amputation of the individual. The completed limbs are carefully fitted and the amputees are then taught to use their limbs correctly. This is carried out in such precise fashion that, even in the case of bilateral arm and leg amputees, they can be taught to be entirely self-sufficient. This includes the ability to put on their limbs, dress themselves, eat, travel on public conveyances, drive cars, and use the tools of their future employment. Virtually all discharged patients who have used these services wear their devices successfully, and more than three-fourths of those who have completed training have returned to remunerative employment. These include men who have lost both legs above the knees and men who have lost both arms above the elbows.

"Counseling plays an important part in the patient program. Following admittance, it is used as a means of orientation to provide understanding and gain cooperation. However, its more important function lies in the area of preparation for return to work and vocational testing and guidance. Personnel, trained and experienced in the techniques of practical counseling, work with the patient, his employer
or other placement potentials to return him to a safe and productive job. Outside agencies, both public and private, are used for aptitude testing or retraining for a different type of work.

The entire rehabilitation program is keyed to the need of the medical profession for a post-surgical complement in the case involving traumatic industrial injury. Its practical accomplishments are based upon patient motivation and interest, restoration of confidence, a hardening to work ability and the psychological 'lift' which comes from group participation in a common interest and aim.\(^\text{10}\)

The Patients

The patients treated at the rehabilitation center are those who have sustained injuries resulting from industrial accidents. Among the various cases are found severe multiple fractures, hand injuries, amputations, severe lacerations, burns and spinal cord injuries.

Approximately 250 patients are admitted yearly. The average patient stay is considered to be forty two days. In a statistical study done in January, 1954 on 2614 cases, 2210 or eighty five percent of the cases were improved by treatment. Of these 1857 or eighty four percent were returned to work.

The patients interviewed in this study were chosen at

\(^{10}\) Liberty Mutual Insurance Company. "The Rehabilitation Centers." Boston.
random and typify the usual cases found at the center in the course of one month. Both men and women were studied by the investigator. The patients chosen range in age from the early twenties to the late sixties. All suffered injuries at their place of employment.

The Methods

During the data collecting period, the investigator spent approximately forty hours in interviewing, observing, and reviewing case records.

The interviews were not scheduled but were impromptu. The investigator was free to go from one department to another while patients were receiving treatments or merely sitting around. At this time conversations were instigated by the investigator. The patient was told of the study being done and was encouraged to talk freely about the subject. A great willingness to discuss the issue was shown by all the patients interviewed. Three main questions were always asked of the patient. They are as follows:

1. Have you ever felt the need for a nurse at this center?
2. Why or why not?
3. How would you see her functioning?

Notes were taken of the interview immediately after conversation with the patient. The investigator then discussed the patient's case with the vocational counselor to ascertain if she could add any pertinent information regarding patient-nurse relationships. The case record
was then reviewed by the investigator in order to better acquaint her with the patient’s background and present physical and mental status.

The team members were also contacted. The interviews were usually held when the therapists had free time to discuss the problem with the investigator. They all showed an eagerness to participate in the study. The before-mentioned questions were asked of them. They too were encouraged to give their views of the contributions of a nurse to the center. Notes and quotations were written as the therapists spoke to the investigator.

During the investigator’s stay at the center, incidents were observed which appeared to have bearing on the study. These incidents either occurred while the investigator was interviewing patients and personnel or they were told to the nurse by a member of the team. In no way were these incidents planned. They are reported in this study by the investigator in order to demonstrate the contributions offered by the nurse on these occasions.

Staff conferences were attended in order to determine how the team members communicated among themselves. Observations were made regarding the people who participated in the conferences and the material presented.

The investigator also attended doctors’ rounds in the morning and observed interaction between nurse, doctor, team members and patient. Particular attention was focused on the conversations between the doctor and nurse and between the doctor and the patient. Direct quotes and relevant material pertaining to the nurse’s contribu-
tions in these situations were noted.

The investigator also observed many direct contacts the team members had with the vocational counselor. These incidents are described and evaluated to determine how the vocational counselor and other team members interacted. These day to day communications were observed while interviewing other patients, at conferences or at any opportune moment.

Finally, several case records were reviewed. These cases were chosen at random. Pertinent facts concerning the contributions of a nurse were copied and presented in the findings.

The methodology used has been discussed in detail. However, the investigator, in attempting to determine what the contributions of a nurse are in an out-patient center, was fortunate in being helped to demonstrate these contributions because the vocational counselor is also a nurse. Although she is not hired primarily for nursing service and is not regarded or referred to as a nurse in any rehabilitation center publication, she was in fact using many of her nursing skills in her work at the center. If she had not been a nurse, this study would have necessarily had to be undertaken differently. This, then, is a natural experiment, in that, since we find that nursing skills are used at the center, we can argue that they are needed at the center.
CHAPTER IV

PRESENTATION OF FINDINGS

Attitudes of the Staff

Interviews were held with four physical therapists. To each of them the following questions were posed.

1. Have you ever felt the need for a nurse in this center?
2. Why or why not?
3. How would you see her functioning?

These were their responses.

1. Three definitely stated they had often felt the need for a nurse. One felt that a nurse was not necessary in this particular setting.

2. Three stated they had come across problems which they felt could have been handled better by a nurse.
   a. "We haven't the medical background the nurse has."
   b. "Even though I see the patients every day, there are certain problems and changes I would like to discuss with a nurse."
   c. "The patients usually seem freer to discuss their problems with a nurse."

3. Three mentioned small accidents that have happened in the past.
a. "My patient fainted and I felt very helpless. I called Mrs. Wright, the vocational counselor because I know she is also a nurse."

b. "My patient fell downstairs and cut his knee. I called for Mrs. Wright because she's a nurse."

c. "One of my patients fell off the bicycle while doing his exercises. I was glad the vocational counselor was around."

4. Two stated that they saw the vocational counselor, the nurse, functioning as a nurse.

   a. "We need her to take occasional blood pressures."
   b. "She often is needed to give a liver or insulin injection."

5. Three mentioned they saw her functioning as a teacher.

   a. "She has shown some of the patients how to measure and give their own insulin."
   b. "I've sent patients in to see Mrs. Wright so she can explain their diet to them."
   c. "One of my patients went in to ask advice about his newborn baby."

6. One stated she saw the nurse as a coordinator.

   "We automatically ask Mrs. Wright to lead our discussions and attend the conferences. She knows more about what goes on in all disciplines than we do. She keeps in touch with the patient and brings back information to all of us."
7. All saw Mrs. Wright as a counselor.
   a. "The patients don't mind talking to a nurse. Somehow she seems to understand."
   b. "I send the patient in to see Mrs. Wright if I notice he is having a problem adjusting to the center. She can usually calm his fears."
   c. "I know Mrs. Wright has helped many to go back out into civilian life. She has had training in counseling and job placement."

Similarly in interviews with three occupational therapists, the same questions were asked.

1. All felt the need for a nurse.
   a. "She knows more about sickness than we do."
   b. "We need someone we can rely on for medical advice."
   c. "When I have a problem about a patient, I know I can go to her."

2. All stated they could see Mrs. Wright functioning as a nurse.
   a. "One of my patients developed a puffiness about the eyes, so I sent him up to see Mrs. Wright. She's a nurse."
   b. "Mr. L. cut his finger on one of the machines and Mrs. Wright took care of it for me."
   c. "John T. did a great deal of coughing, so I spoke to Mrs. Wright about it. She arranged for an X-ray.

3. Two mentioned Mrs. Wright as leader of the conferences.
   a. "She gets to know more about the patients in all various
forms of treatment."

b. "We seem to get more information about the patient from Mrs. Wright than from anyone else."

4. One mentioned the fact that she thought the nurse was a teacher.

"She often brings various medical and non-medical groups around and explains the functions and set-up of the center.

5. Two felt that the nurse is a counselor.

a. "She knows how to relieve the patients of worry, especially about problems at home."

b. "She can arrange for ability tests and can help the patient find a suitable job."

In interviews with both groups, it was apparent that the majority felt that someone with a nursing background was able to take over many duties that they felt unqualified to handle. It is interesting to note that both disciplines were acutely aware of the fact that the vocational counselor, Mrs. Wright, was a nurse. "I called Mrs. Wright, the counselor, because I know she is also a nurse."

One member of the group had good understanding of the overall picture the nurse had of the patient. "She knows more about what goes on in all disciplines than we do. She keeps in touch with the patient and brings back information to all of us."

Both disciplines saw Mrs. Wright functioning as a nurse when she took blood pressures and gave injections or did dressings. One occupational therapist indicated her awareness of Mrs. Wright as a teacher even while conducting tours through the center. The failure
on the part of some physical therapists and occupational therapists to recognize the nurse as a teacher indicates the need for better interdisciplinary orientation.

The physical and occupational therapists had a clear understanding of the role of the nurse as counselor. The observations by both disciplines that "the patients don't mind talking to a nurse. Somehow she seems to understand" illustrates the deep rooted knowledge that the nurse is often called upon to be the "confidant".

Studies of Selected Patients

The Case of Mr. Winslow

Mr. Winslow, a thirty-four-year-old married white man with four children under twelve years of age, suffered a below-the-knee amputation as a young child. He was successfully fitted to a prosthesis and was employed as a route salesman for a bakery concern when his truck struck a tree on August 2, 1955 causing multiple fractures of the left lower arm and a severe hematoma of the left buttocks.

After weeks of hospitalization he was admitted to the rehabilitation center on February 1, 1956. On admission he complained of severe pain on walking and had to use a cane. His old prosthesis was inadequate and therefore the insurance company agreed to replace it with a new one. The jaw, areas involving the arm and hematoma of the buttocks had healed satisfactorily. His main complaint consisted of difficulty in walking due to a deep necrotic ulcer of the left leg just above the ankle which had been discovered at the time of removal of cast.
At the rehabilitation center, a thorough medical evaluation by the medical team ensued. Physical and occupational therapy was prescribed. There was profuse drainage at site of ulceration which necessitated constant sterile dressings. It was at this point that the physical therapist referred Mr. Winslow to the vocational counselor. When questioned about this incident Mr. Winslow said:

"I was really worried about the drainage and I didn't know who to ask about it. The physical therapist told me to see Mrs. Wright who was a nurse, so I asked her to look at it. Mrs. Wright taught me how to keep the ulcer clean and how to apply the dressings. This sure made me feel better."

On further examination the doctor prescribed an elastic stocking for the left leg. Mr. Winslow said to the investigator:

"I thought elastic stockings were used for varicose veins. I haven't that kind of trouble too, I hope."

It was at this time that Mrs. Wright intervened and explained the use of elastic stockings; i.e., for prevention of swelling and for maintenance of proper circulation in the extremities. Mr. Winslow was noticeably relieved.

On one occasion while working in the woodworking shop, Mr. Winslow developed a severe headache. The occupational therapist sent him to Mrs. Wright. Mr. Winslow said:

"I get these all the time. Can you give me something?"

Mrs. Wright arranged for the patient to see the doctor. No definite pathology was noted. Aspirin was prescribed which was administered by the nurse and which afforded temporary relief.
Mr. Winslow spoke freely about his family to Mrs. Wright. He showed his deep concern about their future as he felt he could not return to his former job as route salesman.

"I at least had one good leg before and I could hop in and out of the truck pretty well. Look at me now. I'm no good for any job which keeps me on my feet. What am I going to do?"

Here is the point at which Mrs. Wright functioned as vocational counselor, the position for which she had been hired. Previously in all contacts with Mr. Winslow, Mrs. Wright was called upon strictly because of her nursing background.

The vocational counselor wrote to Mr. Winslow's employer, the bakery concern, enlarging in detail the physical aspects of Mr. Winslow's case, and denoting his progress at the center. Emphasis was placed on the fact that Mr. Winslow had been evaluated and that it was thought improbable and hazardous for him to return to his former work as route salesman because the job necessitated too much walking. A sincere appraisal of a patient's condition to the employer is extremely essential for the welfare of the patient. Within a few weeks the bakery concern answered Mrs. Wright's letter and pointed out that due to Mr. Winslow's previous excellent record with the company, they were sure they could use him in the office where he would not have to be on his feet all day.

However, no stone was left unturned. Mr. Winslow had expressed interest in sheet metal working as he had previously had some experience in that line. Mrs. Wright arranged for Mr. Winslow to gain more experience in the field during his rehabilitation period.
Mr. Winslow said to the investigator:

"I don't know what I would have done without Mrs. Wright. She sure has been a godsend for me. Somehow I don't think I could have made the grade unless I had someone cheering for me."

When again seen by the investigator Mr. Winslow showed concern about the ulcer on his leg. He had been told by the doctor that he was to see a plastic surgeon who would determine whether or not he needed a full thickness graft. Mr. Winslow said to the investigator:

"Who is this guy anyway? What do you think he'll do? I'm afraid he'll fool around with my tendons and I won't be able to walk at all. At least I can bend my foot a little. My wife just wrote to me and told me to come home. She feels I'm better off the way I am. Honestly nurse, I'm sick about all this."

It is interesting to note that this patient conveyed his feelings to the investigator, a nurse. Upon further inquiry it was established by the investigator that no one was aware of the feelings and frustrations of the patient. No one had assumed the responsibility of explaining what was planned for him. Again Mrs. Wright played a major role in nurse teaching for it was she who interpreted and explained to the patient just what the orthopedic and plastic surgeons were contemplating. She reassured him that no tendons would need transplanting, for his ulcer did not warrant such drastic plastic surgery. She impressed upon the patient that if at any time he had worries about his condition that he should feel free to discuss them frankly and openly. What is often a great source of concern and worry for patients can often be resolved by intelligent discussion and appraisal of the problem. When Mr. Winslow was being seen by the plastic surgeon, he questioned
him in detail about the possible outcome of plastic surgery. He discussed the question of tendon transplant which had concerned him so deeply previously. It was only after the doctor sat down and appraised the situation squarely that the patient felt a sense of relief.

Three days later Mr. Winslow was admitted to the hospital where a full thickness graft to the leg was done. Upon discharge from the hospital Mr. Winslow returned to the rehabilitation center for further treatment. It was at this time that he expressed a desire to study business management. Prevocational testing had clearly shown marked ability on the part of the patient in this field. Plans were completed by Mrs. Wright for Mr. Winslow to attend a business school. It is expected that this patient will gain enough from this experience to seek a position in a sheet metal business office and in this way return to civilian life and the competitive world as a rehabilitated person.

Discussion

In analyzing Mr. Winslow's case, it is noted that throughout his stay at the center, Mr. Winslow communicated often with Mrs. Wright. These communications were not always in relation to vocational counseling or job placement, the position for which she was hired. Four incidents regarding Mr. Winslow's attempts to seek a nurse's help and advice are noted. The reasons for these attempts seem clear. Mr. Winslow was aware of the fact that a nurse could adequately treat his minor symptoms and reassure him regarding his eventual recovery.
Although it is a policy of the rehabilitation center that no persons with draining or unhealed wounds are to be admitted, this does not preclude the possibility that wounds may become infected after admission. Mr. Winslow's case clearly demonstrates this possibility. Here is an incident of an open draining infected wound which needed expert aseptic dressing care. It does not fall within the realm of the physical and occupational therapists to care for such problems. The physical therapist showed astute judgment in delegating this procedure to one who had been trained in aseptic techniques. In this case the only person available was Mrs. Wright, the vocational counselor with the nursing background.

The doctor prescribed elastic stockings for the patient. No explanation was given for the need of them, nor did Mr. Winslow realize that elastic stockings could be used for reasons other than for varicose veins. Although the public gains a great deal of information and education from what they read and from advertisements, another source is from qualified trained personnel. Here again the nurse's responsibility and role are clear. She is basically a teacher. It is obvious that Mr. Winslow's concern about the use of his elastic stocking was allayed because he received satisfactory reasons for its use.

The occupational therapist realized the importance of consulting Mrs. Wright when Mr. Winslow complained of headaches. It is clear that even the so called "common headache" can be an early symptom of a serious condition. When referred to the doctor by the
nurse, Mr. Winslow was suffering from:

1. Pain: This was relieved by aspirin which was administered by the vocational counselor, again because of her previous nursing experience.

2. Apprehension regarding recovery: It was pointed out that the patient was a "worrier". Here is an area where the nurse counselor could function beautifully. Often frank and open discussions can solve more problems and relieve more pain than most medications.

3. Anxiety regarding plastic surgery: It was determined later that Mr. Winslow suffered from headaches because he was concerned about what the plastic surgeon was planning in regard to his leg. For some unknown reason he was under the impression that a tendon transplant was contemplated and that he never would be able to flex his foot again, thus making walking extremely difficult.

This case study showed that the patient spoke freely of this to the investigator who he knew was a nurse, again demonstrating that patients feel free to confide in nursing personnel. However, no one was aware and no one made any attempts to discover the reasons behind Mr. Winslow's apprehension. Only when the patient himself spoke of his concern to the nurse was this particular problem resolved.

Mr. Winslow also had family problems. He was slowly realizing that he could not return to work as bakery route salesman because he was not able to walk for extended periods of time. He was faced with
knowledge that he would have to seek other gainful employment to support his wife and four children. Here again Mrs. Wright's role cannot be disputed. She is hired as a vocational counselor and in this respect she was able to counsel the patient in planning a program whereby he would be trained to return to gainful employment regardless of his handicap.

In this case one observes Mrs. Wright as a nurse standing squarely in the middle of the team. Each professional person, the doctor, the physical therapist, and the occupational therapist and the patient himself turned to the nurse for help, advice and guidance.

There is every indication that the nurse's role in this case study was very important towards Mr. Winslow's rehabilitation.

There is an apparent need for clarification of Mrs. Wright's role in the rehabilitation center. Her ability to assume nursing responsibilities and her actual performance of nursing services would indicate that her job description should also include performance of nursing activities, even though she is primarily hired as a vocational counselor.

All formal organizations hire titled personnel for specific duties. When there is a tendency towards inclusion of other specific skilled duties, then this is a sign that the job description should also include these specific skilled duties. The presentation of Mr. Winslow's case shows clearly that Mrs. Wright functions both as a vocational counselor and as a registered nurse.
The Case of Mr. Holcomb

Mr. Holcomb, a forty-five-year-old male, was injured July 13, 1955 in North Carolina. He had been a foreman for a woodworking and veneer concern for three and one half years when he became involved in an accident with a buzz saw which resulted in an above-elbow amputation, left, and a massive laceration involving the twelfth rib to the lower third of the left buttocks with resulting empyema. He was hospitalized immediately. Upon discharge a few weeks later, he returned to his home where his wife was suffering from cancer. Although contacted by the insurance company for admission to the rehabilitation center, Mr. Holcomb declined immediate therapy. He remained at home caring for his wife as best he could until she died.

On February 2, 1956 he was admitted to the rehabilitation center where he was thoroughly evaluated by the rehabilitation team. At the time of admission there was very slight drainage oozing from the lower third of the left buttocks. The doctor noted this on the chart and told the physical therapist who happened to be with him at the time to cleanse the wound with alcohol and apply a dry dressing. This was done every day for a period of weeks. At the time of the investigator's interview with Mr. Holcomb, he was most vehement about the manner in which his wound had been cared for. When questioned he responded as follows:
"I thought the physical therapist was a nurse. I never would have let her touch me if I had known she wasn't. I only found out the other day from another patient that she isn't a nurse. I don't think the sore is healing properly. It's all closed up now, but it's real red and puffy underneath. I think there's pus forming under there and I'm afraid it's going to open up again. A nurse would watch the wound and wouldn't let it heal too fast."

This incident was brought to Mrs. Wright's attention. She was not aware that the wound had been draining. However, she did look at it, assured the patient that the wound was not infected, and referred the patient to the doctor the next day for examination. The physician reported that the wound had healed properly and that the patient had no cause for concern about its being re-infected.

During the period of rehabilitation Mr. Holcomb was prepared for a fitting of a prosthesis. It was while working with the prosthetist that he complained of headaches and eye strain. This was immediately brought to Mrs. Wright's attention. She arranged for Mr. Holcomb to see an ophthalmologist. Mr. Holcomb was prescribed new glasses. These were ordered by Mrs. Wright.

Later, a routine microfilm X-ray was done on Mr. Holcomb. Because of questionable findings the doctor asked Mr. Holcomb to report to the clinic on a designated day for a twelve by fourteen, six foot chest plate. No further explanation was given. At the time of the interview with the investigator, Mr. Holcomb expressed fear of having an additional chest plate taken. When questioned further, he told the investigator that he thought he had tuberculosis. No one on the team knew of Mr. Holcomb's fears. When the investigator
referred the patient to Mrs. Wright, Mr. Holcomb was told that because he had previously had empyema, certain shadows were prominent on the microfilm and could not be diagnosed because of the small size of the film. She further explained that a larger film was ordered to rule out complications and that most likely the shadows on the microfilm were nothing but residual symptoms caused by the empyema and of no clinical significance. After this discussion Mr. Holcomb was X-rayed with less apprehension. The results were negative.

Discussion

In analyzing the case of Mr. Holcomb it is still evident that the nurse played a major role in his rehabilitation. Much of the communication between Mrs. Wright and Mr. Holcomb was a strictly patient-nurse relationship. Three incidents are noted which demonstrate the nurse's role in this setting.

Mr. Holcomb felt insecure in the knowledge that he had had repeated dressings done by a physical therapist. He harbored secret thoughts that the wound was infected and that this was due to lack of proper observation by what he considered qualified personnel. Only when Mrs. Wright had examined the wound, assured him that it was healing properly and referred him to the physician for confirmation did the patient feel reassured. Here is a typical example of the confidence and trust that patients place in nurses. The wound had healed beautifully but still Mr. Holcomb was apprehensive simply
because a therapist and not a nurse had cared for and dressed his wound.

The second incident typifies the need for nurse consultation by members of the rehabilitation team, in this case, the prosthetist. When Mr. Holcomb complained of eyestrain and headaches, he immediately sent Mr. Holcomb to the nurse. Upon evaluation of symptoms, she in turn referred Mr. Holcomb to an eye specialist who recommended a change of glasses. The eyestrain and headaches were relieved immediately. Here again, the nurse became a valuable member of the rehabilitation team. She served as the important link between doctor, patient, and prosthetist for she was entrusted with the responsibility of evaluating the patient's complaints and symptoms.

In analyzing the third incident, it is apparent that the medical rehabilitation team had failed in interpreting to the patient the purpose for re-examination of the chest. For days prior to the second examination Mr. Holcomb worried about the possible outcome of the repeat chest plate. He had magnified his worries to the point where he believed he had contracted tuberculosis. It is only when he was interviewed by the investigator, known to him as a nurse, that he spelled out his fears. The role of the nurse is apparent in this situation. As a teacher she was called upon to explain to Mr. Holcomb the various uses of X-rays, the different sizes of plates and the meaning of shadows. Furthermore, she had to discuss and relate the previous findings of empyema to the probable cause for further recheck chest X-rays. Most of all she had to allay his fears regarding tuberculosis.
by reassuring him that the recheck was ordered simply to rule out residual complications from empyema and that tuberculosis was not even under consideration.

In this case one observes the effect on Mr. Holcomb of uncoordinated, professional effort. He could have been spared a great deal of anxiety and frustration if he had known at time of admission that Mrs. Wright was a nurse. Since her job description consists of vocational counseling and job placement and does not include nursing functions, it is well understood why many patients are unaware of her ancillary duties as a nurse. It is obvious in this case presentation that Mrs. Wright's duties included nursing, teaching and coordinating of services.
Mrs. Renson, a forty-seven-year-old white female, suffered a severe left hand injury while working as a machine operator, a position she had held for nine years. Her hand became jammed in a chain and she was so severely mangled that it took fifteen minutes to free her. She was hospitalized for three weeks at which time it was determined that two major nerves and seven tendons had been severed. She also had fractured three metacarpal bones and amputated the tip of her left thumb.

In reviewing her history it was learned that her husband had died several years before leaving her with a son to support. For this reason Mrs. Renson took a part-time evening job as a nurse's aide.

She was admitted to the rehabilitation center on December 6, 1955. Every three weeks she was seen by the physician and her progress was evaluated. In the meantime she was receiving intensive physical and occupational therapy treatments, the goal being maximum usefulness of the injured hand. When receiving one of her daily hand massages, the patient suddenly complained to the physical therapist that she "felt something give". She became hysterical and exclaimed that she knew her "hand had been broken again". She threatened to leave the rehabilitation center because her condition had not improved but had been aggravated. The physical therapist immediately called Mrs. Wright. She in turn arranged for a stat X-ray of the hand with
the request that she be given a wet reading. The roentgenologist re­ported negative findings. It is assumed that what Mrs. Renson "felt give" was merely an adhesion that had given way. Mrs. Wright then explained to Mrs. Renson what had happened and assured her that there was no new fracture. She then persuaded her to continue the rehabilitation therapy. In the meantime Mrs. Wright called the home town surgeon and gave him all the details.

During the course of rehabilitation Mrs. Renson complained of diarrhea. When interviewed by the investigator, she said:

"I hate to go to a doctor. I'd just as soon discuss this problem with the nurse. Probably all I need is a little paregoric."

In an interview with Mrs. Wright, it was learned that what was really troubling Mrs. Renson were conditions at home. In discussing them with the counselor, plans were made to ameliorate these conditions. The diarrhea improved.

Mrs. Renson's hand, at the time of her discharge, was eighty percent improved, and it was expected that she would soon return to her former employ.

Discussion

In analyzing Mrs. Renson's case, it is again ascertained that the nurse played an important role on the rehabilitation team. Her services were required by:

1. The physical therapist.

When Mrs. Renson complained that she "felt something give", the therapist immediately relieved herself of all
further responsibility by referring the patient to the nurse for evaluation. It is apparent that the physical therapist felt inadequate in dealing with a problem that did not strictly consist of physical therapy. Mrs. Wright dealt with the problem by examining the hand, ordering an X-ray and comforting the patient. No other member of the team took the full responsibility of determining the extent of Mrs. Renson's injury. Here again the talents of a nurse were required.

2. The patient:

Mrs. Renson became hysterical because she feared the therapist had seriously injured her hand. Only when she was sent to the nurse did she calm herself sufficiently to listen to reason. Mrs. Renson received an explanation of the reasons for an X-ray and the interpretation of the results. She also sought professional advice about her diarrhea.

3. The referring physician:

Mrs. Wright established good relations with the referring physician by notifying him immediately of the details concerning Mrs. Renson's complaint, the course of action taken and the results achieved. The physician was most grateful for such prompt and efficient handling of the situation.
It is evident that the nurse played a major part in cementing and fostering good relations between the rehabilitation center personnel and the referring physician. In this case one again observes the nurse:

1. As a teacher (interpretation to the patient of X-ray findings.)
2. As a coordinator (establishing good relationship with referring physician.)
3. As a nurse (evaluating and caring for hand injury.)
4. As a counselor (helping and encouraging the patient concerning family problems.)
Observations of Incidents

Incident Number One

Mr. Lally was a patient well known to all members on the rehabilitation team. He had been referred to the center for intensive treatment of a left ankle injury sustained while working on a steam shovel. At the time of the following incident, his ankle had healed sufficiently so that he was able to ambulate without assistance. Because of some degree of stiffness of the left leg and because of a slight contracture, he was receiving daily physical and occupational therapy.

The investigator noted a four-by-four dressing on the back of his neck. When questioned about this, the patient stated:

"I don't know what I've got, but it sure is sore. I've had it a week now. I've seen my private doctor and he thinks it's a carbuncle. He told me to keep a dressing on it and go back to see him next week."

Upon further questioning the patient revealed that no one at the center had questioned the reason for the dressing and that even though the sore was becoming increasingly painful, he only planned to see the doctor the following week. When asked why he hadn't brought it to Mrs. Wright's attention, he said:

"This stuff is not her job. I'd rather see a nurse, not a counselor. What could she do for me?"

In analyzing this incident it is apparent that a nurse could have alleviated some of this patient's symptomatology if she had been told
about it. Mr. Lally had no way of knowing Mrs. Wright was a nurse or he would have spoken to her about the increasing soreness of the carbuncle. When Mrs. Wright did learn of Mr. Lally's plight, she immediately took a look at the carbuncle and called the private physician to report its status. Constant hot soaks were ordered and were applied to the carbuncle by the nurse. In two days the patient's condition was greatly improved. Here again, the nurse is seen functioning as an important member of the team.

Incident Number Two

Mr. Abbott, a sixty-two-year-old white man fell down a flight of stairs at the mill and suffered a fractured right tibia. He was referred to the center for rehabilitation therapy.

On admission Mr. Abbott was evaluated by the rehabilitation team at which time it was revealed that he was a severe diabetic. When asked about his insulin injections, Mr. Abbott said:

"I've been giving them to myself for years. The only thing I'm worried about is my diet. If I go off it, I usually get into trouble. Where will I be able to get the right foods?"

At dinner time, Mrs. Wright took Mr. Abbott to two restaurants which were situated just a few blocks from the rehabilitation center. She explained to him that during his stay at the center he was to eat at either of these two places. Mr. Abbott said:

"Do you think they'll be able to serve me the proper calories? I'm not used to eating in a restaurant."

Mrs. Wright assured the patient that she had gone over the
diet carefully with both chefs and that they understood what Mr. Abbott could and could not eat.

Mrs. Wright was well known to both chefs for she had previously discussed several special diets with them regarding several other patients who were receiving therapy at the center.

In analyzing this incident it is apparent that once again Mrs. Wright's duties extended beyond those of vocational counselor. She was called upon to perform functions which were chiefly associated with her nursing background and which demonstrate clearly that the nurse is also a teacher.

Incident Number Three

Mrs. Wright was seated at her desk one morning when the telephone rang and the investigator heard her say:

"Do you think the group could come over Thursday, the seventeenth? I think that would probably be more satisfactory for all of us."

When questioned about this incident, Mrs. Wright stated that people in various medical professions are interested in the work done at the rehabilitation center. They are encouraged to visit in groups. She said:

"I usually take them around, explain the various treatments, show them our physical set-up and discuss our aims and purposes. We don't want the patients to feel they're in a goldfish bowl, but we do want the public to be more rehabilitation conscious. I often go out and speak to student nurses or interested lay groups."
Mrs. Wright also pointed out that she had met many nursing leaders at conventions and professional meetings and that these contacts were important in establishing good relationships between nursing groups and the rehabilitation center.

In this incident it is again evident that Mrs. Wright's duties are not strictly those of a vocational counselor. Because she is also a nurse, she is given responsibilities that no other team member can undertake. In this incident she is seen as:

A teacher: (speaking to various groups about the functions of the rehabilitation center.)

A coordinator: (Making the aims and functions of the rehabilitation center known to the public, thus establishing good relationships with outside groups.)

Incident Number Four

Mr. Paulson was a twenty-four-year-old white male who served as maintenance man in a newspaper office. He was admitted to the rehabilitation center because of complications following a fracture at the head of the radius. At the time of the incident, he had walked up the ten stairs to the physical therapy department for his daily treatment when he suddenly felt very weak, became cyanotic and extremely dyspneic. Mrs. Wright was summoned immediately. She propped him up on several pillows to facilitate his breathing, took his pulse, and then called the doctor. It was thought that the patient had
suffered a heart attack. Mrs. Wright arranged for a medical examination and hospitalization. She did not leave the patient's side but stayed with him until he had arrived safely at the hospital. Mrs. Wright later told the investigator that she accompanies all severely ill patients to the hospital.

Mr. Paulson was examined by the clinic physician. A chest X-ray was taken after which a definite diagnosis of spontaneous pneumothorax was made. No definite reason for this could be established. Mrs. Wright spoke to Mr. Paulson's mother and explained what had happened to her son. She clearly made it understood that he had not had a heart attack and that he soon would be well.

Before Mr. Paulson returned to work, Mrs. Wright contacted his employer and gave him all the details regarding the case. She assured the employer that Mr. Paulson had not suffered a heart attack and could return to work as long as he did not have to do any heavy lifting.

In analyzing this incident Mrs. Wright is again seen functioning

As a nurse:

1. Emergency care of seriously ill patient.
2. Interpretation of symptoms to doctor.
3. Transportation of ill patient to hospital.

As a teacher:

1. Explanation of pneumothorax to mother.
2. Explanation of patient's condition to employer.
Incident Number Five

Mr. Crouse, a middle-aged white male and a recently diagnosed diabetic, had been a patient at the rehabilitation center for twelve days. He had been sent to the center from Connecticut for treatment of contractures of the left hand. Because of the great distance involved in traveling to and from the center for daily therapy, arrangements were made for the patient to remain at a nearby hotel for the remainder of his rehabilitation period.

One Monday morning, Mr. Crouse did not keep an appointment with the occupational therapist, nor did he make an appearance in the physical therapy department. Grave concern was expressed about his whereabouts particularly since it was known that he had been receiving insulin daily. It was assumed that Mr. Crouse was not well and therefore Mrs. Wright was sent to the hotel to check on his condition and his whereabouts.

Mrs. Wright found Mr. Crouse in his room. He explained to her that he was not feeling well and that he had decided to forego treatment so that he could stay in bed until he felt better. Mrs. Wright noted that he was perspiring profusely, felt cold and clammy and complained of dizziness. She immediately called the attending physician who examined the patient. A blood sugar was done. It was determined that the patient was going into insulin shock. He was treated for it and returned to the center the following day none the worse for his ordeal.
For the remainder of his stay at the center, Mr. Crouse was watched closely for signs of insulin shock or diabetic coma. He was instructed by Mrs. Wright regarding the signs and symptoms of both and was told to notify her or the doctor if he felt any untoward symptoms. There were no further complications.

In this incident it appears evident that a nurse is necessary in evaluating a patient's complaints and symptoms. She functioned as a valuable member of the medical team in interpreting symptoms to the physician and in securing proper medical attention for the patient. She also functioned as teacher in interpreting signs and symptoms of insulin shock and diabetic coma to the patient.

No other member of the rehabilitation team can assume the responsibility undertaken by Mrs. Wright, for no one has had the experience and background necessary for proper evaluation of signs and symptoms.

In this incident it appears evident that the rehabilitation team needs the nurse.

**Incident Number Six**

Mr. Jacobson, a twenty-seven-year-old white male, was admitted to the center for intensive treatment to his left foot which was injured as the result of a fall from a tree.

On admission he appeared extremely nervous and irritable. Upon questioning from the staff, it was learned that he had had recurrent stomach ulcers and that he was following a very strict ulcer
regime. When interviewed by the investigator, he implied that he did not care to talk about his condition. He said:

"If you were a nurse, I'd tell you everything. In fact, I'd even ask you a few things."

When questioned further, he said:

"I've been to see Mrs. Wright a few times about problems at home. You see, my wife just had a baby. She wanted to know about the formula."

When the investigator spoke to Mrs. Wright about this incident, she confirmed the fact that Mr. Jacobson had come to her to ask her advice about caring for the newborn baby. She stated that he appeared extremely concerned about the formula because the wife had written that the baby was colicky. He wanted all kinds of information about vitamin drops, layettes, types of nipples and anything she cared to discuss with him. Mrs. Wright answered the patient's questions and offered to procure pamphlets and articles on infant care if he so wished.

In analyzing this incident, it is again apparent that patients feel free to discuss their problems with a nurse. The very fact that Mr. Jacobson said: "If you were a nurse, I'd tell you everything" demonstrates the trust and confidence that patients place in a nurse. To them she becomes a "confidant".

This incident further demonstrates that the nurse is a teacher. She becomes important to the patient because she can advise and recommend methods of treatment which give great satisfaction to all concerned.
Observation of Interdisciplinary Rapport

Various ways in which disciplines communicate with one another include regularly scheduled conferences, telephone conversations, informal discussions and daily evaluations.

Every morning selected patients are seen by the staff physicians. It is at this time that the patients are evaluated, treated and given a chance to discuss their problems. Mrs. Wright accompanies the doctors at all clinics and on all rounds.

To gain information on what goes on between the physician and Mrs. Wright during these clinics, the investigator observed four patient evaluations. Before the patient is seen, Mrs. Wright reviews the case record with the physician and interprets any new data since previous examination to him. She may assist the doctors during examination or treatment, secure necessary equipment or prepare for special tests although routine preparation of the examining room is the medical secretary's responsibility.

If injections are required, Mrs. Wright is asked occasionally to give them. If medications are required, she dispenses them. During these observations the investigator observed that the doctors relied on Mrs. Wright's judgment. Comments such as the following were made:
"Watch that pressure area and pad it if you think it's necessary."

"Test his urine a.c. We'll have to keep a close watch on his sugar."

During the data collecting period, frequent observations were made by the investigator of various disciplines in their day to day communications with Mrs. Wright. These observations might have been made while interviewing a therapist, talking to a doctor or attending conferences.

In one instance, Mr. Jarmon, a patient with a below-the-knee amputation, was being fitted to an artificial leg. He suddenly complained to the prosthетist that he felt dizzy and couldn't see the floor. The prosthетist said:

"Hold on for a second. I'll get the nurse for you. She's right here. She'll take care of you."

He rushed into Mrs. Wright's office and asked her to see him. She attended to the patient's immediate needs, then referred him to the physician for further evaluation.

There were instances when the physical therapists called on Mrs. Wright. One observation involved a patient who had suffered a left hand amputation and a disarticulation of the right shoulder. At the time of the incident, he had finished physical therapy treatment and was descending a flight of stairs to the main floor when he lost his balance and fell fracturing his nose and sustaining multiple bruises to his cheek and face. The therapist located Mrs. Wright and said:
"Mr. Jarmon just fell downstairs. Please come and see how badly he's injured. He's bleeding quite a bit."

After giving first aid, the nurse called the doctor and sent the patient to the hospital for further treatment.

The therapists also were noted to have called Mrs. Wright to check on temperatures and blood pressures. One gentleman, a known cardiac, had a cerebral accident with resultant hemiplegia. He became extremely flushed and somewhat dyspneic during a whirlpool treatment. When checked by the nurse, he was advised to lie down. The symptoms subsided. The therapist revealed that she felt safer in having had the nurse see him.

Communications between personnel in the field and the rehabilitation center were described by Mrs. Wright as follows:

Reports and evaluations of patients being admitted to and discharged from the rehabilitation center are discussed by letter or telephone conversations with rehabilitation nurses who are working out in the field. These nurses are hired by the insurance company to investigate and report on cases of injured personnel. They act as a liaison between the rehabilitation center, the employer and the referring physicians. If a patient is a suitable candidate for rehabilitation, he is referred to the center for treatment.

The communication between the rehabilitation nurse out in the field and the rehabilitation center is maintained through Mrs. Wright. Information on all cases is relayed either by letter or by telephone. One method of communication within the rehabilitation center is the
regularly scheduled team conferences. All members are urged to participate in discussing and analyzing problems regarding patient care.

The investigator noted that at all conferences the nurse served as team leader. When questioned about this, she replied:

"I have tried to delegate this duty to all members of the team, but they preferred to have me as leader."

The other members' comments were as follows:

"Mrs. Wright has done a good job so far, so why not let her continue?"

"I feel that she sees the patient in all phases of treatment and can sort of tie the whole picture together better."

"Mrs. Wright does a great deal of public speaking. I think she is used to organizing speeches and conferences."

Discussion

In analyzing the observations made of interdisciplinary rapport, it is obvious that the nurse is recognized by various disciplines as a valuable member of the team. Need for consultation with her regarding patient care seems necessary. The attempts noted to seek her help and advice are pertinent.

The physician, the physical and occupational therapists, the prosthetists and the rehabilitation nurse in the field have all communicated freely with Mrs. Wright. It would be interesting to determine what other communications would have been attempted by the involved
disciplines if Mrs. Wright had not been a nurse. Who could have
taken over the duties that have been asked of her?
Review of Two Case Records

The investigator studied case records of patients who had recently been discharged from the rehabilitation center. The two case records presented for analysis were chosen at random and typify the problems that can be encountered during a rehabilitation period.

Mr. Bowen, a sixty-four-year-old white male, was admitted to the rehabilitation center on August 3, 1955 with bilateral below-the-knee amputations. He gave a history of a mild diabetes. When his blood sugar was checked, it was found to be 220 mgs. He was immediately started on insulin, urine tests and a special diet.

He complained to the doctor that his left stump was bothering him. He reasoned that he hurt himself badly when he fell in the hospital and split the end of his stump. He said:

"The stump sticks out like a hog's nose."

X-rays were taken to rule out a "chip fracture". When the results were proven negative, he was told that he could not be fitted to a prosthesis until the stump was completely healed. In the meantime he received daily occupational and physical therapy. Special care was given to the stump to insure a proper fitting for the prosthesis.

On March 7, 1956 the patient developed a skin abrasion under the left buttocks which was caused by a crease in the stockinette. Because of danger of infection due to the severe diabetes, special
care was taken to prevent complications. Alcohol was applied to the broken area faithfully after which it was exposed to the air. It was deemed advisable to continue this treatment after clinic hours. For this reason the company hired a nurse to care for Mr. Bowen during his stay at the hotel.

The patient became very depressed during this period and did not want to see his family or chat with his friends.

When the abrasion was healed sufficiently, he again was allowed to use the prostheses. However, further complications arose. The patient complained of soreness around the artificial limb. When checked, several reddened areas were noted. These were treated with boric acid ointment and wrapped with ace bandages. The patient was discharged on March 28, 1956. At that time his diabetes was controlled, and he was using his prostheses with dexterity.

In reviewing this case with Mrs. Wright, the investigator asked her about her role in this case. It was learned that the nurse:

1. Gave the insulin injections.
   Taught the patient to test his urine and give the insulin to himself.

2. Checked the special diet with the two restaurant chefs.

3. Cared for skin abrasion by cleansing with alcohol and exposing to air.

4. Checked reddened areas, treating them with prescribed ointments.

5. Taught patient to check for reddened areas and to report same to her.
6. Hired nurse to care for patient after clinic hours, and conferred with her regularly to better coordinate treatment and encourage his ambulation outside of the center.

In analyzing this case it is apparent that the nurse played a major part in this patient's total rehabilitation. She not only served as coordinator of services by bringing together various specialists for the welfare of the patient, but also gave extensive nursing care and education specific to his diabetic condition.

Second Case

Mr. Anderson, a forty-two-year-old white married man with three children, fractured his left femur twenty six years ago. This fracture necessitated plating. In December of 1954 he fell on a concrete pavement and hit a curbstone causing a laceration of the scalp, fracture of the left pelvis, fracture of both wrists, fracture of the right os calcis, fracture of both tibias and fibulas and bilateral nerve injuries involving both legs. He was hospitalized immediately. Plans were made for him to attend the rehabilitation center and in the latter part of June, 1955 was transported daily to the clinic even though he was still a patient at a nearby hospital until July 11, 1955.

Because of the long period of inactivity, Mr. Anderson developed lime atrophy of all bones. He also had some sensory and motor disturbances, most marked on the right side.
At the time of injury, Mr. Anderson worked as a roofer and carpenter, earning approximately eighty-five dollars weekly. Because of his extensive injuries, he was not able to return to his former employ. However, he showed a keen interest in radio, television and electronics. Plans were made for him to attend a school twice weekly which afforded him an opportunity to learn a trade in which he showed some ability.

In discussing this case with Mrs. Wright, she explained that her role in this case consisted of:

1. Making arrangements for patient to be transported to and from the hospital.
2. Working closely with orthopedic and medical doctors by having patient evaluated for progress frequently.
3. Interpreting injuries and prognosis of patient to former employers.
4. Estimating ability of patient to return to former employ or not.
5. Testing natural abilities for job placement.
6. Arranging radio and television courses.

Analysis

In analyzing this case, one again sees Mrs. Wright functioning as a nurse, coordinator, teacher and counselor. Her responsibilities were varied which again demonstrates that a nurse is a person of many abilities and can be a valuable asset to the medical rehabilitation team.
CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was concerned with demonstrating the contributions of a nurse to an out-patient rehabilitation center. It was undertaken so that the allied professions and lay people may become more aware of the value of a nurse on the rehabilitation team. As previously stated, it is the philosophy of the investigator that the duties of a nurse are not strictly those concerned with bedside care, but that they also include duties of a teacher and coordinator.

A total of forty hours was spent at the rehabilitation center in ascertaining attitudes of the staff in regard to the nurse on the rehabilitation team, observing incidents, interviewing personnel and patients and reviewing case records.

In reviewing the literature, no studies similar in nature were found. Articles dealing with today's concept of the role of the nurse have previously been quoted.

From this study there appears to be a definite role for a nurse in an out-patient rehabilitation center, for she contributes as a nurse, as a teacher, and as a coordinator.
Conclusions

Attitudes of the Staff about the Nurse's Role in a Rehabilitation Center.

The Physical Therapists

1. Three physical therapists stated they often felt the need for a nurse.

2. One felt that a nurse was not necessary in this particular setting.

3. Three felt that a nurse was necessary to handle small accidents that occurred to patients during their stay at the rehabilitation center.

4. Two expressed the need for someone who could take blood pressures and give injections.

5. Because it was sometimes necessary to teach patients to give their own insulin, to interpret diets to them or answer problems about health problems, three saw the nurse functioning as a teacher.

6. One physical therapist, recognizing that the nurse led conferences and became leader of the team, stated she saw the nurse functioning as a coordinator.

7. All the physical therapists felt that the nurse functions as a counselor because patients feel free to discuss their problems with her.
The Occupational Therapist

1. All the occupational therapists stated that they had felt the need for a nurse.

2. All the occupational therapists stated that the nurse was needed to care for minor injuries and to interpret and evaluate symptoms.

3. Two of the occupational therapists saw the nurse as a leader of conferences because of her overall contact with the patients.

4. One occupational therapist stated that she saw the nurse as a teacher because of the many guided tours that she led through the rehabilitation center.

5. Two occupational therapists felt that the nurse was a counselor because she helped alleviate family problems and arranged for job placements.

Cases and Incidents Observed

1. All patients in the study availed themselves of nursing service. There was evidence of strong nurse-patient relationships.

2. There are indications that the progress of a few patients was furthered because of the mutual understanding and nursing care given the patient by the nurse.

3. Lack of knowledge by some patients that the counselor was a nurse hindered maximum rehabilitation.

4. The patients expressed their concern over having someone other than a nurse care for their ulcers and dressings.
5. Information and symptoms regarding complications were communicated to the nurse for evaluation by the therapist.

6. There was a great deal of teaching done by the nurse because members of other disciplines neglected to explain to the patients the meaning of various treatments.

7. Patients apparently prefer to discuss their health problems with a nurse.

8. Information regarding problems and fears was readily given to the investigator when it was determined that she was a nurse.

9. There was much planning done by the nurse for patient teaching and interpretation of symptoms.

10. Examples of worry, apprehension and fear by the patients over progress or family conditions are demonstrated. These were alleviated by the nurse.

11. The various disciplines feel that a nurse is best fitted to assume responsibility for the patients if complications arise.

12. New patients were unfamiliar with the fact that the counselor was also a nurse and received no explanation relative to this on admission.

13. The special diets that were needed by the patients had to be checked with the restaurant chefs by the nurse.

14. Any medications or injections that were ordered were given by the nurse.

15. All urine tests were done by the nurse who later taught the patient
to test it himself.

16. The nurse in many cases served as consultant to prosthettist, physical therapist and to the occupational therapist.

17. The nurse was requested to do all soaks that were ordered by the physician.

18. Examples are given whereby the nurse accompanies the patient to and from the clinics or hospital.

19. Information relative to the patient's condition, progress and prognosis is interpreted to the employer by the nurse.

20. The nurse was required to explain patient's condition to the family.

21. As a guide for all tours of the rehabilitation center, the nurse is seen functioning as a teacher and coordinator.

Observations of Interdisciplinary Rapport

1. The nurse attends all medical rounds and clinics.

2. Review of cases and interpretation of data to the physician since previous examination of patient is done by the nurse.

3. Instances are given whereby the physician demonstrates the value of the nurse's judgment and ability to carry out orders.

4. All disciplines communicated with the nurse to give advice, to check on symptoms or to give nursing care to patients.

5. Examples are given whereby the nurse communicates with other
doctors and nurses out in the field regarding care of patients in the rehabilitation center.

6. The team conferences are all lead by the nurse.
7. Other disciplines stated that they felt the nurse should lead the conferences because she had had previous experience in discussion groups and outside speaking.

Case Records Studied

1. It was learned that the patient required insulin injections which had to be given by qualified personnel, in this case, a nurse.
2. Plans were made to have the patient learn to give his own insulin. The nurse was given this responsibility.
3. The patient developed a skin abrasion which necessitated cleansing and dressings.
4. Reddened areas were noted when the patient started using his prosthesis.
5. The patient was advised by the nurse regarding prevention of reddened areas and injuries.
6. A registered nurse was required to stay with the patient during after-clinic hours. She was hired by the nurse in the rehabilitation center.
7. The nurse made arrangements for transportation of ill patient to and from the hospital.
8. The nurse interpreted injuries and prognosis of patient to former employer.
9. The nurse estimated the ability of the patient to return to former employ.
Recommendations

Since no previous study had been undertaken to determine the contributions of a nurse to an out-patient rehabilitation center, it was most interesting to secure data which strongly indicated to the investigator how much the nurse became an asset to the rehabilitation team.

As an outgrowth of this study, the investigator makes the following recommendations:

1. That patients, during their orientation period, be informed that a nurse is available.
2. That orientation of all new personnel to this center be evaluated to insure understanding of the role of all disciplines.
3. That the nurse be included in the orientation to interpret her role.
4. That the nurse's job description be changed from that of vocational counselor to vocational counselor and registered nurse giving details of the responsibilities of this position.
5. That all groups touring the center be made aware that the guide is a nurse, thus helping to make the public aware that the nurse also functions as a teacher.
6. That nurses in the field tell all patients being admitted to the rehabilitation center that the vocational counselor is the nurse who will care for them.
7. That all insurance agents and employers be made aware that a nurse is employed at the rehabilitation center.

8. That the public be made aware that the vocational counselor is a nurse and that she functions as a nurse by writing up her job description in the insurance pamphlet "The Rehabilitation Centers".

9. That nurse-patient meetings be held at least once every two weeks to discuss ideas, problems, progress and prognosis.

10. That a special first-aid room be available for the nurse to handle small accidents, give soaks and do dressings.

11. That a study be done to investigate the educational value of the rehabilitation team conference.

12. That, when future descriptions of the insurance rehabilitation center are given such as in Henry Redkey's Rehabilitation Centers in the United States, the nurse should definitely be included as one of the selected personnel.

13. That further studies be done concerning the role of the nurse in vocational and community rehabilitation centers.

14. That a study be done in other out-patient rehabilitation centers having no nurse to determine if a nurse would be an asset to those centers.
Bibliography


