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Nurses' interpretations of complete bed rest

NURSES' INTERPRETATIONS OF COMPLETE BED REST

BY

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CHAPTER I

INTRODUCTION

Modern man, having met and fought successfully contagion, the arch enemy of his ancestors, has created for himself a new and complex problem; his lengthened life span has increased the possibility of his falling victim to the progression of degenerative processes within his own body. Chief among these degenerative processes is cardiovascular disease, which has rightfully been named the number one health problem of our time.[1] Coronary heart disease constitutes two-thirds of all heart disease,[2] and its development as a major health problem may represent a phenomenon peculiar to this century and this country. Kitchell has stated that little attention was paid to coronary thrombosis in the nineteenth century, and that the only logical answer would seem to be that coronary disease was rare as a cause of death during that period. This would indicate, as he further states, that an

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[1]U.S. Public Health Service, Department of Health, Education and Welfare, Heart Disease Control Program, Heart Disease Control Program, April, 1960.

[2]Thomas Dawber and William Kannel, "Susceptibility to Coronary Heart Disease," Modern Concepts of Cardiovascular Disease, XXX (July, 1961), p. 671.

epidemic of atheromatous coronary disease may now exist in this country.[3]

The major clinical entity comprising coronary heart disease is myocardial infarction,[4] or necrosis of the myocardium resulting from occlusion of one of the coronary arteries,[5] usually as a result of atherosclerosis.[6] Myocardial infarction was first accurately described by Herrick in 1912,[7] but a decade passed before his concept of myocardial gangrene resulting from complete occlusion at some point of the coronary circulation gained widespread acceptance. "Heart attack," the layman's translation, received recognition as an important cause of death and disability, and the treatment of myocardial infarction became an area of vital interest to medical personnel, who became involved in the care of victims of this condition.[8]

Rest has long been recognized as an important therapeutic measure in the treatment of myocardial infarction. Guyton explains it thus:

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[3]J. Roderick Kitchell, "General Considerations in Treatment of Myocardial Infarction," American Journal of Cardiology, I (February, 1958), p. 224.

[4]Dawber and Kannel, op. cit., p. 672.

[5]Charles P. Emerson and Jane S. Bragdon, Essentials of Medicine (Philadelphia: J. B. Lippincott Co., 1955), p. 285.

[6]Dawber and Kannel, op. cit., p. 672.

[7]Blake Cabot, Motion of the Heart (New York: Harper and Bros., 1952), p. 42.

[8]Ibid., pp. 43-44.

> The degree of cellular death is determined by the ratio of the degree of ischemia to the degree of metabolism of the heart muscle. When the metabolism of the heart muscle is greatly increased, such as during exercise, in severe emotional strain, and as a result of fatigue, the heart musculature needs increased oxygen and other nutrients for sustaining its life. Furthermore, anastomotic blood vessels which supply blood to the ischemic areas of the heart must still supply the areas of the heart that they normally supply. When the heart becomes excessively active, the vessels of the normal musculature become greatly dilated, and this allows most of the blood flowing into the coronary vessels to flow through the small anastomotic channels supplying the ischemic areas. Consequently, one of the most important factors in the treatment of a patient with coronary ischemia is observance of absolute rest. The greater the degree of rest during the first few months following sudden coronary occlusion, the less will be the death of the cells.[9]

Although there has been a trend in recent years towards allowing patients with acute episodes of myocardial infarction to rest in chairs, many physicians continue to employ bed rest as the therapeutic method of choice. To insure that bed rest is maintained for the hospitalized patient, the physician routinely writes an order for "bed rest," "complete bed rest," "coronary precautions," or a similar term which implies restriction of patient activity.[10]

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[9]Arthur Guyton, Textbook of Medical Physiology (Philadelphia: W. B. Saunders Co., 1961), p. 393.

[10]Marjorie Burrell and Miriam O'Neil, "A Study to Determine if the Concept of Complete Bed Rest for the Acute Myocardial Infarction Patient Differs Between Head Nurses and Clinical Instructors" (unpublished Master's field study, School of Nursing, Boston University, 1962), p. 7.

The nurse responsible for interpreting the physician's written order for bed rest to the personnel rendering care to the patient has an obligation to direct the nursing care given the patient in a manner that reflects the physician's therapeutic intent. As Lucile Petry Leone has written:

> Nursing care is the person-to-person application of scientific principles for the sake of achieving a physician's therapeutic purposes for patients. . . . A physician studies and tests a patient and the manifestations of his illness and wellness. He defines therapeutic purposes and designs and prescribes a therapeutic program or a health maintenance program for each patient. Some of these actions the physician carries out by himself; some are carried out by others, many by nurses who also assist him directly in his diagnostic, therapeutic, and preventative actions.[11]

Statement of Problem

This study will investigate nurses' interpretations of the physician's written order of complete bed rest for the patient admitted with an acute myocardial infarction.

Importance of Problem

Accurate interpretation by the nurse of the written order for complete bed rest for the patient with an acute myocardial infarction is perceived as an area of difficulty. To insure that the physician's order is executed successfully, decisions must be made by the nurse regarding the amount and types of activity the patient may have in such functions as eating, bathing, and elimination.

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[11] Joseph Owen (ed.), Modern Concepts of Hospital Administration (Philadelphia: W. B. Saunders Co., 1962), p. 344.

Although rest is generally agreed to be an important therapeutic measure for the patient with acute infarction of the myocardium, physicians may vary concerning the amount and type of restriction of patient activity. Many physicians have endorsed individualized programs of rest in this condition, as this disorder admits of degrees of severity.

An order for bed rest is frequently employed for patients hospitalized for various conditions. The rationale underlying the order may vary somewhat in each condition as may the amount and types of patient activity permitted by the order. Furthermore, an order for bed rest is a less specific order than many others, and thus is subject to misinterpretation, with resultant harmful effects for the patient.

Would the nurse interpretating the physician's written order for complete bed rest for the patient with an acute myocardial infarction find it necessary to communicate with the physician concerning patient activity, if no hospital policy defining this order existed?

CHAPTER II

THEORETICAL FRAMEWORK OF THE STUDY

Review of Literature

The literature was reviewed for direct and indirect relevance to this research. There were no studies discovered which dealt with the specific problem, although there is much in the literature which has an indirect bearing on the issue.

As it has been previously asserted, rest is regarded widely as an important therapeutic measure in the treatment of acute myocardial infarction. Its efficiency in the promotion of repair of the damaged myocardium is upheld strongly by cardiologists both in this country and in Europe. Levine,[1] White,[2] and di Cantogno[3] concur as to the paramount importance of rest. Although questions have been raised as to whether rest is best accomplished in bed or in a chair, many physicians continue to utilize bed rest as the method of choice.

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[1]Samuel Levine, Clinical Heart Disease (Philadelphia: W. B. Saunders Co., 1958), p. 147.

[2]Paul Dudley White, Heart Disease (New York: Macmillan Co., 1958), p. 561.

[3]Lorenzo di Cantogno, Hellmut Hartert, and W. Clotens, "Myocardial Infarction: Evolution of Therapy," ABBOTTEMPO, I (March 22, 1963), p. 14.

Bed rest, then, is a highly significant treatment for the patient who has suffered an acute myocardial infarction. Attainment of this rest is initiated by the physician's order. As Burrell and O'Neil state:

> The physician communicates by written order to the head nurse the medical care the patient is to receive. The terminology used by the physician to indicate rest for the cardiac patient may be expressed by such terms as "coronary precautions," "cardiac care," "complete bed rest," "maximum rest," "coronary care," or "absolute bed rest."[4]

This order must be interpreted by the head nurse or one acting in that function so as to reflect the physician's intent, since inaccurate interpretation may result in physical harm to the patient and legal implications for the hospital and for the nurse herself. In reference to the head nurse, Burrell and O'Neil emphasize the importance of her understanding of the meaning of complete bed rest as prescribed by the physician for the patient with an acute myocardial infarction.[5]

Lesnick and Anderson indicate that accurate interpretation of physicians' written orders may have legal implications. They describe the one dependent function of nursing, based upon legal and judicial decision, as "the application and the execution of legal orders of physicians concerning

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[4]Burrell and O'Neil, op. cit., p. 8.

[5]Ibid.

treatments and medications, with an understanding of cause and effect thereof."[6]

Would an order for complete bed rest or bed rest be interpreted by everyone in exactly the same manner? This seems unlikely. As Sondel points out:

> The meaning of words--as we read and speak and listen--is filtered through and through by the personal experience of the user. For this reason, the meaning of a word is (at least slightly) different for each user.[7]

She also states that "communication takes place only when the words of a user refer the thoughts of all participants to the same objects."[8]

The question may arise as to whether the order, "complete bed rest," contains sufficient information for precise interpretation. Barabas has emphasized that:

> Any doctor's order should contain sufficient information to indicate the actual intention of the doctor. Nothing should be implied. If the intention is not clear, the doctor should be questioned at the time the order is written.[9]

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[6]Milton Lesnick and Bernice Anderson, Nursing Practice and the Law (Philadelphia: J. B. Lippincott Co., 1955), pp. 259-260.

[7]Bess Sondel, The Humanity of Words--A Primer of Semantics (Cleveland: The World Publishing Co., 1958), p. 53.

[8]Ibid.

[9]Mary Helen Barabas, Contemporary Head Nursing (New York: Macmillan Co., 1962), p. 66.

Statement of Hypothesis

If no hospital policy defining this order exists, the nurse interpreting the physician's written order for complete bed rest for the patient with an acute myocardial infarction will find it necessary to communicate with the physician concerning patient activity.

CHAPTER III

METHODOLOGY

It appeared to the researcher that an order for rest is both somewhat vague and rather singular. Vague, in that it necessitates translation into concrete terms; singular, in that although most physicians' orders initiate positive action, the implication in this order may be seen to be a negative one; the patient is being urged to refrain from activity. While activity is thus being restricted, it is obvious that certain basic bodily functions must be maintained. Therefore, an analysis of rest in terms of essential activity was perceived as logical. That this type of analysis has precedent in nursing literature is demonstrated by the assertion of Amy Frances Brown that absolute bed rest implies that self-feeding and brushing of teeth is forbidden.[1] In reference to the order for complete bed rest for the patient with an acute myocardial infarction, Hayter has stated that during the first few days the nurse should feed the patient, brush his teeth and turn him.[2]

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[1]Amy Frances Brown, Medical Nursing (Philadelphia: W. B. Saunders Co., 1957), p. 325.

[2]Jean Hayter, "Acute Myocardial Infarction," American Journal of Nursing, LIX (November, 1959), p. 1602.

The testing of the formulated hypothesis was seen to focus about two major areas: the construction of an instrument adequately designed to test the hypothesis, and the selection of an appropriate sample.

Construction of Instrument

Initially, a list of typical patient activities, relating to eating, elimination, hygiene, exercise and diversional therapy was constructed. An attempt was made to include functions about which inquiry might be anticipated to arise. The questionnaire was selected as the method of presenting the activity list in the most objective form. Selltiz has said that the impersonal nature of a questionnaire, with its standardized wording, order of questions, and instructions for recording responses tends to promote uniformity from one measurement situation to another.[3] Good and Scates agree that the questionnaire aids in standardization "by singling out particular aspects of the situation . . . and by specifying in advance the . . . terminology for describing the observations."[4]

A pretest was administered to nurses of various levels of experience, student and graduate. These nurses were asked

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[3]C. Selltiz et al, Research Methods in Social Relations (New York: Holt, Rinehart and Winston, Inc., 1962), p. 239.

[4]Carter Good and Douglas Scates, Methods of Research (New York: Appleton-Century-Crofts, Inc., 1954), p. 606.

to decide which of the listed activities were inherent in an order for complete bed rest. The pretest group indicated that there were too many variables in the situation, evidenced by such statements as "it all depends." There appeared to be a tendency evident among the group to regard interpretation of this order as an independent, rather than dependent, nursing function.

The necessity of alteration of the instrument in some manner was obvious. Therefore, a hypothetical situation was created around the activity list; the circumstances of the situation were constructed so as to limit the choice of response to either an affirmative or negative one. The revised instrument (Appendix A, Questionnaire) was then pre-tested and determined to be sufficiently well designed to test the hypothesis.

Selection and Description of Sample

Since the hypothesis to be tested was concerned with nurses' interpretations of the order for complete bed rest for the patient with an acute myocardial infarction, the decision was made to select the sample from those nurses, who by the nature of their duties, might be assumed to have the greatest familiarity with this problem. It was assumed that nurses engaged solely in the care of patients suffering from medical disorders would be experienced both in transcribing orders written for patients admitted for acute myocardial

infarction, and in administering care to these patients. Accordingly, thirty-two graduate professional nurses employed in segregated medical units in two hospitals were selected. One agency is a general hospital of over 600 beds, the other, a 1000 bed federal hospital. No attempt was made to classify the participants as to age, experience, or basic nursing education. Originally it had been planned to select head nurses only, since traditionally, responsibility for the transcription of physicians' orders rests with this group. In the hospitals designated, however, general staff nurses may rotate to evening and night duty, and, in the capacity of charge nurses, be obliged to assume this duty. In consideration of this, general staff nurses, as well as head nurses and assistant head nurses, were respondents in this survey.

Procurement of Data

Contact was made with the agencies by means of letters. Permission was requested and granted to administer the instrument and arrangements were completed for its distribution. Charge nurses, a supervising nurse, and the researcher administered the questionnaires to the sample.

Each of the thirty-two respondents was required to decide as to the necessity of physician consultation for each of the sixteen items comprising the activity list. There was, therefore, a total of 512 possible responses in the

survey. Examination of the collected data revealed that eight items had been inaccurately utilized in some manner, either by omission or by employment of both the affirmative and negative options. The inapplicable responses were subtracted from the total, and the remaining 504 responses were tabulated in the order in which they had appeared on the questionnaire.

It was determined that verification of the hypothesis would require affirmative responses to more than one-half of the total activity items.

CHAPTER IV

FINDINGS

Introduction

Nurses' interpretations of the physician's written order of complete bed rest for the patient admitted with acute myocardial infarction was perceived as a problem, and the hypothesis was formulated that without a hospital policy defining it, the nurse interpreting this order would find it necessary to communicate with the physician regarding patient activity. A questionnaire designed to test this hypothesis was administered to a sample of thirty-two graduate professional nurses. Their responses to the instrument were tabulated so as to indicate agreement or disagreement concerning the necessity for physician consultation. This chapter is devoted to an analysis of the data obtained and the findings which were derived from it.

Presentation and Discussion of Data

Computation of the responses disclosed 354 positive and 150 negative replies, as indicated in Table 1. These outcomes established verification of the hypothesis on the basis of the previously determined criterion.

TABLE 1

NURSES' OPINIONS REGARDING NECESSITY FOR PHYSICIAN CONSULTATION CONCERNING ACTIVITIES ALLOWED ON COMPLETE BED REST

Patient Activities	Physician's Consultation Necessary		
	Nurses in Agreement	Nurses in Disagreement	Total Responses
Sitting in Fowler's (upright) position	12	18	30
Feeding himself	23	9	32
Brushing his teeth	23	9	32
Washing his face	25	7	32
Washing his chest	26	6	32
Washing his legs	27	5	32
Washing his genitalia	24	7	31
Using the bed pan	5	24	29
Using the commode	28	4	32
Combing hair (male)	22	10	32
Combing hair (female)	25	7	32
Smoking cigarettes, less than 1/2 pack a day (pt. does not inhale; no O_2 in room)	22	10	32
Hold and read a book or magazine	20	11	31

TABLE 1--Continued

Patient Activities	Physician's Consultation Necessary		
	Nurses in Agreement	Nurses in Disagreement	Total Responses
Reach a short distance (8") for drinking water	19	12	31
Receive passive motion of joints twice daily	26	6	32
Perform active motion of joints twice daily	27	5	32
Total	354	150	504

Fourteen of the sixteen activity items received affirmative responses from more than one-half of the respondents, while only two of the items elicited negative answers from more than one-half of the respondents. These two items related to the employment of Fowler's position and to the use of the bed pan. The explanation for a large number of negative replies (eighteen out of thirty) to an item concerning Fowler's position may possibly be found in Amy Frances Brown's assertion that the back rest is to be kept flat unless the doctor orders otherwise.[1] Research conducted in the past few years has strongly indicated that an upright position entails less work for the heart than does a recumbent one, a finding that has been utilized by many clinicians in the adoption and prescription of either the arm chair treatment or elevation of the head of the bed of patients with myocardial infarction.[2] Text book discussion of nursing care of these patients may possibly be expected to reflect this trend in the future.

The large number of negative responses (twenty-four out of twenty-nine) accorded the item relating to the use of the bed pan may reflect the nature of the item and that the need for provision for elimination in some fashion is apparent.

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[1]Brown, op. cit., p. 325.

[2]Levine, op. cit., p. 154.

The marked preponderance of positive replies is illustrated in Figure 1. Of particular interest is the large number of affirmative answers scored by the two items relating to active and passive motion of joints. It was anticipated that this might occur, since widespread recognition of the importance of these features of patient care has developed within the past few years. It may be expected that nursing texts in the future may possibly reflect this trend.

Omission of responses to four items occurred. Whether this was an oversight or represented an inability to decide regarding these items can only be postulated. Since three of the four omissions occurred on one questionnaire, it would appear that this factor was not directly related to the instrument, but rather to the respondent.

Two of the thirty-two respondents selected both options for two items, and included qualifying statements. On one questionnaire, the respondent indicated that it would be necessary to consult with the physician if the patient desired to sit in Fowler's position for intervals only, but not "if it was to be a constant position." The same respondent also checked both "yes" and "no" for using the bed pan; "yes" "for use by self"; "no" with the assistance of two people.

Another respondent selected both options regarding Fowler's position, declaring that "it depended on the patient." Both affirmative and negative replies were made by this

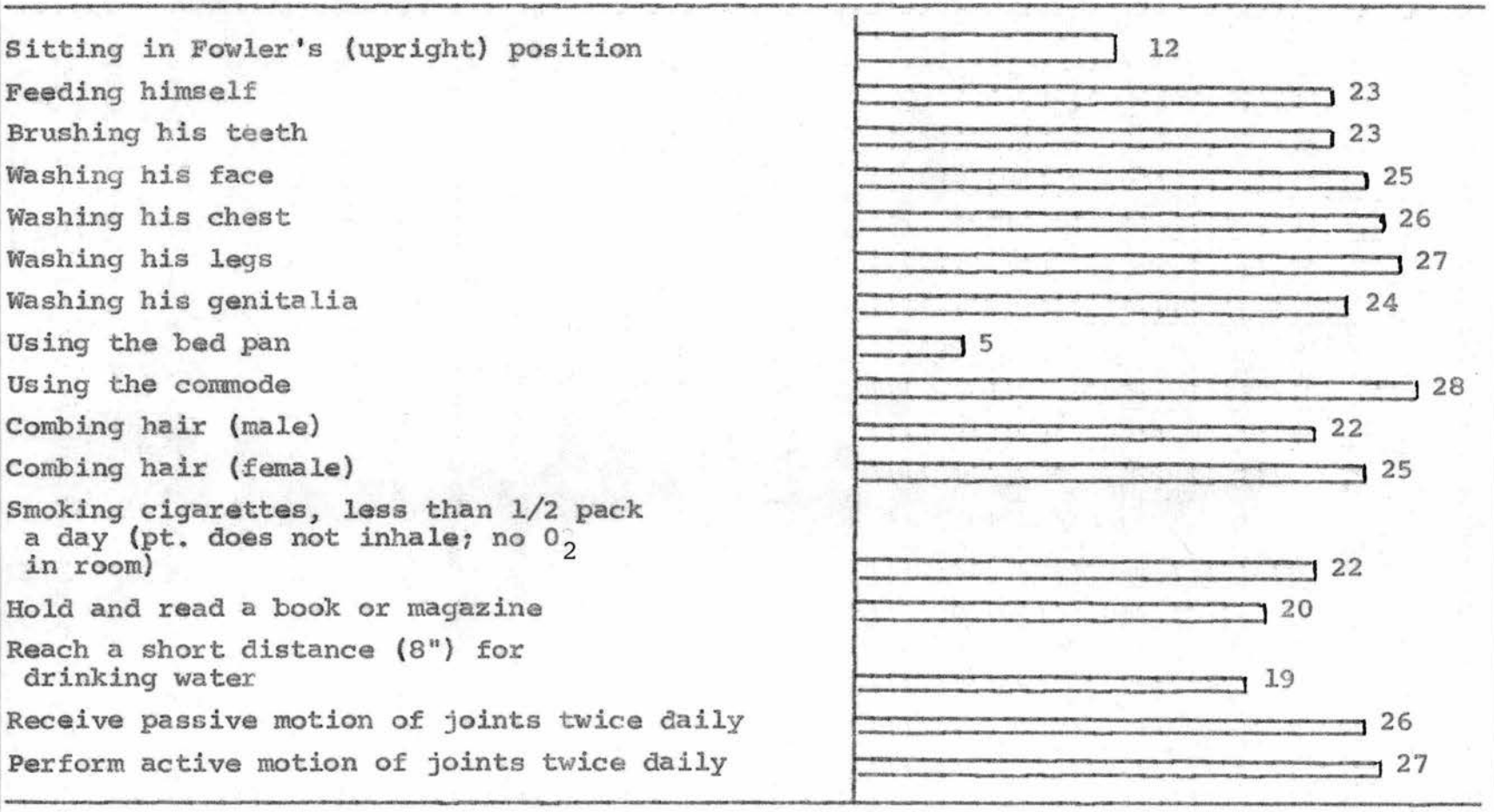

Fig. 1.--Comparison of patient activities as to respondents' need for physician consultation.

respondent in relation to the use of the bed pan, qualifying the negative option by the addition of the phrase "with two people helping."

As it was stated previously, the hypothesis was verified on the basis of the established criterion. A large majority of affirmative responses was noted; speculation concerning the rationale behind such an overwhelming affirmation can only remain speculation.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

This study was concerned with determining if the nurse interpreting the physician's written order of complete bed rest for the patient with an acute myocardial infarction would find it necessary to communicate with the physician regarding patient activity, if no hospital policy defining this order existed.

Review of the literature failed to disclose research bearing directly on this problem, although a great amount has been written with indirect relevance. Some of the aspects examined were the significance of rest for the victim of myocardial infarction and the transmission of the physician's therapeutic intention for the attainment of this rest by the written order. Treatment in the literature of the importance of accurate interpretation of the written order by the nurse responsible for transmission of physicians' orders to personnel administering care to the patient was also considered.

The hypothesis proposed that the nurse interpreting the physician's order for complete bed rest for the patient with an acute myocardial infarction will find it necessary to communicate with the physician regarding patient activity.

Testing the hypothesis necessitated the construction of an adequate instrument and the selection of an appropriate sample. An analysis of rest in terms of essential activities appeared logical. A list of typical patient activities was devised and incorporated into a questionnaire, which was subsequently pretested on a group similar to the proposed sample. Examination of the results of the pretest uncovered the existence of many variables in the instrument, and the necessity for its alteration in some manner was apparent. Accordingly, a hypothetical situation was created for inclusion in the questionnaire. The circumstances of this situation were designed so as to restrict the choice of response. An affirmative or negative response was required regarding the inherency of a particular activity in the order, "complete bed rest." The revised instrument was then pretested and determined to be sufficiently well designed to test the hypothesis.

The sample to whom the instrument was administered consisted of thirty-two graduate professional nurses employed in two agencies, one a general hospital of over 600 beds and the other a 1000 bed federal hospital.

A list of patient activities, necessitating sixteen responses, gave a total of 512 possible answers in the survey. It was determined that affirmative answers to more than one-half of the items would verify the hypothesis.

Analysis of the data revealed 354 affirmative and 150 negative replies, establishing verification of the hypothesis on the basis of the previously determined criterion.

Conclusions

Consideration of the size of the sample prohibits generalization of the results. However, in relation to this sample the following conclusions are drawn:

1. There appears to be a certain amount of agreement among nurses as to which activities are implied in the order of complete bed rest as prescribed for the patient with an acute myocardial infarction.

2. A physician's order for complete bed rest in a hospital in which there is no policy adequately defining this order requires further clarification.

3. An order for complete bed rest may necessitate physician consultation for many common patient activities.

Recommendations

On the basis of the findings of this study, the following recommendations are made:

1. that further research be undertaken to confirm the findings of this study.

2. that research be conducted to determine to what degree physicians prescribing complete bed rest are cognizant of common activities of the hospitalized patient, both as to type and amount.

3. that a standardized list of common patient activities be established to serve as a guide to enable physicians in making comprehensive decisions concerning restriction of patient activity.

4. that research be undertaken to ascertain if a need exists for clarification of other physicians' written orders.

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APPENDIX A

QUESTIONNAIRE

In the following situation, presume that you are responsible for interpreting the written orders of physicians to the nursing staff.

1. A physician writes an order for complete bed rest (or some other term which denotes the same restriction of activity, such as coronary precautions or cardiac care) for a patient recently admitted for a myocardial infarction.
2. There is no hospital policy which limits the amount and types of activity allowed by this order.
3. You have had no previous communication with the physician concerning the amount and types of activity he customarily allows such patients.
4. The physician offers no additional written or oral directions (such as "may feed self") which might aid you in interpreting this order.

To insure that the order of complete bed rest is carried out successfully, decisions must be made by the nurse regarding the amount and types of activity the patient may have in such functions as eating, bathing, and provision for elimination.

PLEASE ANSWER THE FOLLOWING

Check YES or NO to each item

When interpreting an order of complete bed rest for a patient with a myocardial infarction, I would find it necessary to consult with the physician before I allowed the patient to

	YES	NO
Sit in Fowler's (upright) position		
Feed himself		
Brush his teeth		
Wash his face		
Wash his chest		
Wash his legs		
Wash his genitalia		
Use the bed pan		
Use the commode		
Comb hair (male)		
Comb hair (female)		
Smoke cigarettes, less than 1/2 pack a day (pt. does not inhale; no O_2 in room)		
Hold and read a book or magazine		
Reach a short distance (8") for drinking water		
Receive passive motion of joints twice daily		
Perform active motion of joints twice daily		