

# Guías de cooperación entre el grupo de Enfermeras y Terapeutas en Rehabilitación Neurológica

## *Guidelines for Cooperation between Nursing Staff and Therapists in Neurological Rehabilitation*

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### Resumen

En la rehabilitación neurológica, el trabajo en equipo es obligatorio para asegurar un resultado óptimo para el paciente. Las relaciones entre el grupo de enfermeras y terapeutas son a menudo tensas debido a la carencia de un lenguaje común, diferencias en las metas y expectativas que se plantean, y la asignación de roles en el trabajo diario. En el hospital de Hochzirl se llevó a cabo una mesa de trabajo con el fin de formular las

guías de cooperación multi-profesional. Las metas eran definir asignaciones de roles y los límites de cada una de las profesiones, aclarar malentendidos en ambos grupos, y para promover una atmósfera de respeto mutuo y de satisfacción profesional para todos los implicados. Desde la implementación de estas guías, el trabajo en equipo interdisciplinario no es un cliché vacío, sino más a menudo una realidad. El respeto mutuo entre las profesiones ha aumentado, realzando la satisfacción profesional y creando una mejor atmósfera de funcionamiento. Los conflictos que ocurren pueden solucionarse desde una base de hechos más que desde una base emocional.

**Palabras clave:** trabajo en equipo interdisciplinario, Rehabilitación, equipo del cuidado del paciente

### Abstract

In neurological rehabilitation, well-functioning teamwork is mandatory in order to ensure an optimal outcome for the patient. Relations between nursing staff and therapists are often strained due to lack of a common language in rehabilitation. Differing goal settings and expectations, and the assignment of roles in the daily workload. At Hochzirl Hospital a task force was called into existence in order to formulate guidelines for multi-professional cooperation. The goals were to define role assignments and boundaries of the professions, to clarify misunderstandings on both sides, and to promote an atmosphere of mutual respect and professional satisfaction for all involved.

Since implementation of these guidelines, interdisciplinary teamwork is no longer an empty cliché, but more often a reality. Mutual respect between the professions has increased, enhancing job satisfaction and creating a better working atmosphere. Conflicts that occur can be solved on a factual instead of an emotional basis.

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**key Words:** interdisciplinary teamwork, rehabilitation, patient care team.

## Introduction

Neurological rehabilitation centres demand close Cooperation between members of various professions. The team consists of physicians, nurses, therapists, as well as social workers, neuropsychologists, dieticians, and others. Due to differing professional backgrounds, conflicts can arise relating to rehabilitation goals, interpretation of patient's symptoms and their potential for recovery, and the role each professional plays in the overall framework of rehabilitation. Problems within the team have been ascribed to ambiguity toward one's role, lack of knowledge about other disciplines, lack of individual accountability, and the relative absence of ego rewards in the team environment<sup>1</sup>.

Models of teamwork have previously been discussed; the subtle differences lie in the degree of flexibility of the boundaries between the professions. Multidisciplinarity is defined as bringing together knowledge from different professions, each remaining within its boundaries; interdisciplinarity links the specialties of all professions into a collaborative whole; and transdisciplinarity integrates the disciplines, transcending traditional boundaries<sup>2</sup>.

Relations between nursing staff and therapists (physical, occupational, and speech therapists) are especially subject to strain, a phenomenon which seems to cross international borders. Communication between the two groups is of utmost importance to minimize prejudices and to define guidelines in order to provide a harmonious atmosphere of working for the sake of the patient.

## Methods

The Department of Neurological Rehabilitation at Hochzirl Hospital is a 75-bed facility involved in early rehabilitation of predominately stroke, traumatic brain-injured and other neurological patients. Recognizing the existence of strained relations between the two professional groups, the heads of nursing staff and therapy called a task force into existence, consisting of the supervising nurse of each of three wards and the heads of department of physical, occupational

and speech therapy. The purpose of this group was to form guidelines for the teamwork between nurses and therapists. To this end, the following goals were defined.

- Definition of interfaces and overlapping of the duties of nurses and therapists
- Allocation of areas of tasks and responsibility
- Establishment of a professional association between the two groups, devoid of envy, global accusations, or polarization
- Clarification of misunderstandings and misinterpretations
- Increase in transparency
- Creation of an efficient daily routine
- Enhancement of job satisfaction

The six members of the group were encouraged to speak openly about the conflicts which arose during the daily workload. The problems were divided into two groups, as to whether the conflict of interest primarily concerned the nursing staff or the therapists, and solutions sought which were acceptable to both teams.

## Results

The following lists of conflicting interests and the resolutions there of pertain naturally to problems specific to our hospital.

### Conflicts of Interest I: Nursing Staff → Therapy

#### Communication

A magnetic board hangs in the middle of each ward, where patients, visitors, and staff have access to it: this serves as a communication aid. The board represents a timetable with eight hours on the y-axis and a column for each patient on the x-axis. The board is further divided into two halves, representing the wings of the ward.

- Each therapist plans his/her time daily, placing a card with his/her name at the appropriate time under the patient's name.

- An occupational therapist updates the patient's daily appointments for examinations scheduled on or outside the ward.
- The nursing staff places cards with their names on the appropriate half of the board, according to daily assignment to the respective wing of the ward.
- Unforeseen occurrences such as fever, infections, bed rest, or falls are signalled by a red triangle under the patient's name.
- Nursing staff define which patients take a nap after lunch and marks the time with a card.
- Cards for treatments such as group therapy, basal stimulation, robotics, or lymph drainage massage, which take place daily at the same time, may not be removed from the board.

Nurses or therapists can consult the head of nursing staff on the respective ward and/or the chief therapist when problems occur that cannot be solved between the involved parties.

### **Documentation**

Therapists must write down relevant information for the nursing staff on the therapy page of the nursing documentation system, with his/her name and the date, updating as necessary.

Such information as the necessity to thicken liquids, apply splints at certain times of the day, or walk with patients, is valid only when is writing; each nurse must read the notes and act accordingly.

### **Emergency in therapy rooms**

In case of emergency in the therapy rooms (e.g. vomiting, loss of consciousness, falls, epileptic seizures, cardiac arrest, etc.), the therapist must inform the ward at once.

Physicians and nurses must immediately come to the therapy room and take over management of the situation. A suction apparatus for emergency situations is in the therapy area, the therapist must have it available when needed.

### **Visiting hours**

Visiting hours – at Hochzirl Hospital from 12:00 – 7:30 pm – apply for both the wards as well as

the therapy area.

Exceptions can be stipulated when the presence of family members is desired in order to learn to care for the patient, help with transfers or activities of daily living (ADL), or to be instructed and involved in the therapy; nursing staff and therapists must inform each other when this is the case.

### **Daily routine**

The nurses specify which patients need to take a nap after lunch. Afterwards, the nurses help the patient to get up and if necessary, back into the wheelchair in time for the next therapy appointment.

Patients who do not have ADL training with the occupational therapist are to be readied for the day by the nursing staff, i.e. washing, dressing, and transfers to the wheelchair. The last patients (the most severely disabled) should be ready for therapy by 11:00. These patients should not begin therapy treatments later than 3:30 pm, so that the nursing staff has sufficient time to prepare them for bed.

When the appointments cannot be kept, for reasons of examination appointments, shortage of nursing staff, or unforeseen occurrences, the nurses must inform the therapists involved.

### **Positioning**

Positioning of patients is a crucial factor in neurological rehabilitation. Differences of opinion and misunderstandings between therapists and nurses may occur. In principal, the supine position should be avoided if possible, and the patients should be helped into a position which is comfortable and well supported with pillows, in order to reduce abnormal muscle tone. In the sitting position, the hemiparetic arm should be with a wheelchair table or pillow.

Individual cases should be discussed by the assigned therapist and nursing staff. The weekly patient conference is a good opportunity to make sure that all follow the same policy.

The nurses provide new patients with wheelchairs from the central supply. In cases of positioning problems due to stiff joints, extreme muscle hypertonia, etc., or when the choice between

standard or special wheelchair is not clear, the therapist reaches the decision about what is needed and organizes an appropriate chair.

### **Transfer**

In the principle, the nursing staff is responsible for mobilizing the patients from bed to wheelchair. The assigned physical or occupational therapist can be called to help with new or severely afflicted patients. The type of transfer should be discussed and agreed upon in the weekly patient conference, as consistency of handling contributes to the success of rehabilitation.

## **Conflicts of Interest II: Therapy → Nursing Staff**

### **Eating and drinking**

Assistance given to patients with swallowing problems at breakfast or lunch is defined by the speech therapist and provided as a therapy unit. The type of assistance is documented by the therapist in the nursing documentation system, so that in his/her absence, e.g. on weekends and in the evening, nurses can carry out the required help. When possible, family members can be instructed in the assistance so that they can take over this responsibility.

### **Casts and splints**

The nursing staff applies simple splints, when no preparatory handling of the limb in question and no special proficiency is required. All other splints are to be applied by occupational or physical therapists. Information about handling and duration of wear, particularly whether during the day or night, is recorded and updated in the nursing documentation system. Physicians are responsible for any emergency removal of casts, e.g. in case of swelling or pain, when the therapists are not present.

### **Walking with patients**

The physical therapist decides when the patient is allowed to walk on the ward with nursing staff or family members, as well as the type of aids and support to be given by the helper.

This information must also appear in writing in the documentation system on the ward.

### **Voiding**

During the therapy unit, i.e. from the time the therapist picks up the patient from the ward to the time he/she returns the patient, the therapist is responsible for helping the patient in using the toilet. Normally no nurse will need to help, except in cases of diarrhea, when a urinal must be attached, or when the assistance of one person is not enough. In case of incontinence in the therapy rooms, the therapist changes the diapers or clothing when, bring clothing, etc. If the patient's clothing is wet or he/she has massive diarrhea, the therapist brings the patient back to the ward and delivers him/her to a nurse.

### **ADL**

The morning ADL training is to be understood as an occupational therapy unit and not as alleviation of the nurses' work load. The therapist formulates goals as pertaining to furthering autonomy, improving perception or cognition of body or space, or analysis of function. The respective duties of nursing staff and occupational therapists are made clear: showering is integrated into ADL only when therapeutically indicated, bandaging of the enteral nutrition tube or wounds, changing of the urinal, and care of indwelling catheters are to be performed by nurses. Therapists change diapers and supervise the patient's washing of intimate zones. The therapist informs the nurses if he/she notices discharge, redness, or other skin anomalies. In case of failure to be present for ADL, the occupational therapist must inform the ward nurses.

### **Enteral nutrition and intravenous drips**

As dangling tubes disturb the mobility of the patient in therapy, therapists may ask if it is possible to disconnect the nutrition or intravenous tubes for the duration of the therapy session; nurses perform this task. After therapy the therapist reports to the nurse so that the tube can be reconnected. Therapists are allowed to detach the nutrition tubes, but must then inject lukewarm water so that the lumen will not clog. After therapy, the therapist may reconnect the tube.

## **Discussion**

Many of the conflicts which had occurred earlier were based on misunderstandings of

the respective roles of nurses and therapists. The boundaries between the two professions are often blurred, and hierarchy within the team is challenged. Emotional issues also complicate cooperation: whereas some therapists resent the incursion of nurse into "their" territory, some nurses consider their contribution to rehabilitation to be underestimated. Nurses may see their role through the eyes of the therapists as being reduced to preparing the patient for therapy<sup>3</sup>. On the other hand, assisting the nursing staff in the morning routine does not normally constitute therapy, a factor which gives rise to misunderstandings between the two professional groups. Defining the problem as it arises and assigning it to a conflict of interest helps to defuse the situation in order to look at it objectively.

Interpretation and advantages/disadvantages of the different models of teamwork (i.e. multidisciplinary, interdisciplinary, transdisciplinary) are often perceived differently by the two groups. In every facility, the natural tendency toward one of the model of teamwork exists on its own. Analysis of the structure and functioning of the hospital in question on the basis of the three different models should point out weaknesses and strengths in the existing situation. The type of multi-professional collaboration to be aspired to in a particular setting must be clear. In our case, interdisciplinary teamwork is deemed the best choice. Interdisciplinary teamwork necessitates a high level of team communication, mutual goal planning and evaluation and working alongside each other<sup>4</sup>. Nonetheless, complete elimination of blurred role boundaries is neither possible nor desirable<sup>5</sup>. Education and emphasis of the professions of nursing and therapy are diverse, and each must be respected for its expertise.

## Conclusion

Teamwork is generally acknowledged to be vital in rehabilitation. However, it is impossible to provide a set of general rules to follow in order to guarantee efficient collaboration; on the contrary, the introduction of theoretical care pathways has been shown to have made no difference in attitudes to team working<sup>6</sup>. Guidelines can only be recommended after individual analysis and interpretation of the structure itself.

Since implementation of the guidelines in Hochzirl, the working atmosphere has improved greatly. The heads of department of both professions

represent commitment to the same ideals, resulting in working better together to enhance the welfare of the patient. A positive approach to solving the problems identified has led to greater understanding between nurses and therapists, as well as mutual trust.

Transparency has increased as well through a series of seminars in which therapists and nursing staff present their working concepts and techniques to each other. The nurses explained e.g. basal stimulation and kinaesthetic, and therapists e.g. walking with hemiparetic patients, ADL training, and the basics of Bobath handling and positioning. Communication has improved through efficient documentation and the "communication board" on the ward.

The guidelines presented above are specific to the structure of Hochzirl Hospital. They may, however, be useful as examples applicable to other similar facilities.

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