Aims and objectives. To explore nurses’ understandings and expectations of rehabilitation and nurses’ perceptions of patients’ understandings and expectations of rehabilitation.

Background. Within the context of a broadening appreciation of the benefits of rehabilitation, interest in the nature of rehabilitation is growing. Some believe that rehabilitation services do not adequately meet the needs of patients. Others are interested in the readiness of patients to participate in rehabilitation.

Design. Qualitative.

Method. Grounded theory using data collected during interviews with nurses in five inpatient rehabilitation units and during observation of the nurses’ everyday practice.

Findings. According to nurses working in inpatient rehabilitation units, there is a marked incongruence between nurses’ understandings and expectations of rehabilitation and what they perceive patients to understand and expect.

Conclusion. Given these different understandings, an important nursing role is the education of patients about the nature of rehabilitation and how to optimise their rehabilitation.

Relevance to clinical practice. Before patients are transferred to rehabilitation, the purpose and nature of rehabilitation, in particular the roles of patients and nurses, needs to be explained to them. The understandings of rehabilitation that nurses in this study possessed provide a framework for the design of education materials and orientation programmes that inform patients (and their families) about rehabilitation. In addition, reinforcement of the differences between acute care and rehabilitation will assist patients new to rehabilitation to understand the central role that they themselves can play in their recovery.

Key words: Australia, nurses, nursing, patient education, rehabilitation

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Background

In Australia, rehabilitation services originated during the Second World War and were aimed at returning injured servicemen to active duty (Smith 1994). After this, rehabilitation as a specific type of health service, became available to people with a wide range of disabilities associated with the ageing process or acquired conditions, such as stroke and spinal cord injury.

More recently, an expansion in the number and type of rehabilitation services (inpatient, outpatient and community-based) in Australia and other Western countries has occurred. In addition, the scope of diagnostic categories, for which rehabilitation is considered appropriate, is growing. This includes people with conditions such as HIV (Cervizzi et al. 2000) and cancer (McCollom 2002) as well as people in critical care units (Mumma 2001) and nursing homes (Clay 2001).

The capacity for rehabilitation to increase quality of life for people with such a wide range of conditions is related to its focus on increasing the ability of patients to undertake activities of daily living. Function at the ‘person level’ is the
domain of rehabilitation, hence the common use of measures of function like the Functional Independence Measure and the Barthel Index (Clarke & Granger 2000). However, despite a strong belief that rehabilitation services are effective (Stroke Unit Trialists’ Collaboration 1997), several criticisms of these services appear in the literature.

One criticism is that rehabilitation services do not meet the needs of patients. Claims that rehabilitation services adopt a bio-psycho-social approach have been contested. For example, the most consistent criticisms of rehabilitation are its inability to address the broader consequences of disease, such as handicap (Barnitt & Pomeroy 1995), and to measure successful reintegration into the community, which according to Whiteneck (1994) is the most appropriate outcome measure of such services.

Another related, but less explicit, concern relates to the readiness of patients to participate in rehabilitation. Research confirms that the experience of newly acquired disability is confronting and adjustment to disability requires work (Morse 1997). Despite this, little has been written about how to assist rehabilitation inpatients to adjust to their disability. Of relevance to this study is the limited literature about patients’ understandings and expectations of rehabilitation. Grenenger (2003) argues that patients transferring to rehabilitation units experience relocation stress syndrome, and to ameliorate patient distress nurses should assist patients to learn about rehabilitation. Two subsequent studies (Gibbon 2004, Sondermeyer & Pryor 2006) that analysed patient interviews, however, note that in the acute care setting patients receive little assistance to develop accurate understandings and expectations of rehabilitation before transfer to a rehabilitation unit. Whether this is an issue for nurses working in inpatient rehabilitation units has not been the primary focus of any published studies.

The aim of this study was to develop a grounded theory of nursing’s contribution to inpatient rehabilitation. This article will describe one aspect of this large study. Specifically, it will describe nurses’ understandings and expectations of rehabilitation and nurses’ perceptions of patients’ understandings and expectations of rehabilitation.

Methods

Using grounded theory method (Glaser 1978, Strauss & Corbin 1998), this study sought to develop an understanding of nurse and patient factors surrounding the delivery of patient care in rehabilitation settings. This grounded theory study was informed by symbolic interactionism, which is a theoretical perspective that focuses on relationships between individuals and the world around them (Charon 1989).

Symbolic interactionism and grounded theory underpin the construction of meaning through human action and interaction within contextual structures and processes.

The study commenced after ethical approval was obtained from two universities and two clinical health care settings.

Settings and informants

The study was conducted in five health care units in regional Australia that provided rehabilitation and aged care/geriatric assessment services. The number of beds in each unit ranged from 17–25. All registered and enrolled nurses (ENs) working in these units were invited to participate in the study. A total of 53 nurses participated in the study, their ages ranged from 21–55 years with a mean age of 40.4 years. The majority (90.6%, n = 48) were female. About two-thirds (66%, n = 35) were registered nurses (RNs) and one-third (34%, n = 18) were enrolled nurses (ENs), their total years of nursing experience ranged from four to 38 years, with a mean of 17.8 years. One-fifth of the RNs were employed as nurse unit managers (NUMs). On average, informants had 6.5 years of experience working in rehabilitation, but for individuals this ranged from a few months to 20 years. Most (82.7%) obtained their basic qualifications through hospital training but 11.5% attended university and 5.8% reported having both hospital and university-based undergraduate qualifications. About one quarter (26.9%) reported having undertaken rehabilitation-specific postregistration education, while about half (53.8%) had completed other postregistration studies.

Data collection and analysis

Using purposeful and theoretical sampling procedures (Strauss & Corbin 1998), data were collected through field observations (Dey 1999), and by conducting formal interviews. To capture the significance of nursing’s 24-hour presence in relation to their contribution to patient rehabilitation, field observations were conducted on all days of the week as well as during the day, evening and night.

Data were collected from multiple sources, specifically nurses were observed during their everyday practice and observation notes were recorded in the field. Interpretations of these observations were discussed with the nurse who was observed, as soon as possible following the event, after which additional notes were recorded when indicated. Semi-structured interviews were used in this study. These audio-taped interviews were conducted in clinical settings while the nurse
informants were on duty. To avoid interruption to the nurse's work, a mutually suitable time and location for each interview was negotiated.

Information from a review of the literature was also used as study data. Morse (2001, p. 10) argues a need to compare emerging categories with those already existing in the literature to develop 'greater explanatory power' by reducing the identification of 'unique concept labels' required for qualitative meta-analysis and enhancing 'theoretical cohesion among studies'. Consequently, a comparison was made between the newly developed categories emerging in the current study and concepts previously reported in the literature.

Data were analysed using the constant comparative analysis where data were reviewed using open-, axial- and selective-coding techniques (Strauss & Corbin 1998). The analytical processes of induction, deduction and abduction were used to acquire an understanding of the phenomenon (Ezzy 2002). As well as maintaining theoretical sensitivity, memos and diagrams were used to assist data analysis (Strauss & Corbin 1998).

Rigour

The rigour of the study was maintained using audit trails (Rodgers & Cowles 1993), member checks that solicited feedback from informants about findings and the researcher's interpretations of findings (Guba 1981, Sandelowski 2002), data analysis trails as recommended by O'Connell and Irurita (2000) and reflexive self-awareness as described by Hall and Callery (2001).

Findings

Incongruence between nurses' and patients' understandings and expectations of rehabilitation

The incongruence identified in this study relates to patients possessing different understandings of the nature of rehabilitation, the spaces and times where and when it occurs and the roles of patients and nurses. While nurses knew that patients needed to be active participants in their own rehabilitation, patients did not share this view. Moreover, patients expected rehabilitation to be comprised of intermittent activities carried out by only some staff in some places, instead of a continuous process dependent upon their active participation and engagement with nurses. This finding infers that patients did not think rehabilitation took place at the bedside and therefore expected nurses to actively care for them.

This issue caused them some concern as it impacted on the patient's willingness to set goals and participate in rehabilitation. This incongruence is described and explicated with excerpts from the study data, along with the four factors found to contribute to this incongruence.

Nurses' understandings and expectations of rehabilitation

Nurse informants possessed a shared understanding of rehabilitation, which informed the way in which they delivered care and their expectations of patients. They believed the primary purpose of rehabilitation was to facilitate patient self-care and for the patient to 'become as independent and as able as they can be' (RN 11). To a lesser extent, nurses understood rehabilitation to include two further dimensions: the first was helping patients 'cope with their disabilities' and adjust to their situation (RN 15). The second was preventing re-admission of patients to hospital: 'We're trying to keep patients away from hospital as much as possible' (RN 4). These beliefs are consistent with the relevant policy document, A Policy Framework for Medical Rehabilitation in NSW (New South Wales Health Department 1995), in which promotion of patient self-care and psychological adjustment are explicit, and prevention of hospital re-admission is implied.

Nurse informants also believed rehabilitation was a distinctive type of health service requiring patients and staff to act differently from the way they usually acted in acute care wards. These beliefs, about facilitating patient self-care and coping and about limiting re-admissions, translated into four over-arching principles about rehabilitation-focused care: (1) rehabilitation is a continuous process; (2) rehabilitation requires active patient participation; (3) rehabilitation is goal-directed and (4) rehabilitation requires multi-professional teamwork.

None of these findings are unique to nurses in this study, as they are partially supported by the literature. For example, there is widespread agreement that rehabilitation is a goal-directed activity (Kneafsey & Long 2002, Siegert & Taylor 2004) involving the input of health professionals from a variety of disciplinary backgrounds (DeLisa et al. 1998). On the other hand, there is somewhat less support for the finding that rehabilitation is a continuous process requiring active patient participation.

Nurses in various studies (Kirkevold 1997, Burton 2000, Long et al. 2002) are described as 'carrying on' and 'integrating' the work of allied health as part of their role to ensure continuity of patient rehabilitation. Pryor and Smith (2000, 2002) describe nurses in their study as adopting a rehabilitative approach. This approach ensured that
rehabilitation was part of everything nurses did with patients, so that rehabilitation became a continuous process. Some nurses in Booth and Waters (1995) study also understood rehabilitation this way, but others did not. Instead, they saw rehabilitation as episodic in nature. Lincoln et al. (1996, p. 20) also seem to view rehabilitation as episodic by definition of the ‘rehabilitation day’ as limited to between 8:30 a.m. and 4:30 p.m., with other times described as the ‘non-rehabilitation day’. By limiting their classification of disciplines that provide therapy to the allied health disciplines, Lincoln et al. (1996) reveal their belief that rehabilitation is episodic rather than continuous and had nothing to do with nursing. Similar sentiments are reflected in Young and Gladman’s (1995, p. 333) comment that, ‘in hospital it is easy to forget that rehabilitation is taking place against a background of 24-hour personal and general care’.

Mixed views have also been reported about staff’s expectations of rehabilitation patients. Robinson (1988) recognised the need for patients to be active participants in their own rehabilitation, as did nurses in studies by Thompson (1990) and Campbell (1999). Nurses in Gibbon and Thompson’s (1992) study, however, did not and Waters and Luker (1996, p. 112) were concerned that patients were viewed as passive and ‘acted upon’ by staff. These concerns stemmed from study informants’ use of the word ‘rehab’ as a verb when they talked about ‘rehabbing a patient’ (p. 111).

In summary, as compared with the literature, nurses in this study had a comprehensive grasp of the purpose and nature of rehabilitation. According to the nurses however, patients did not share their understandings and expectations of rehabilitation.

Nurses’ perceptions of patients’ understandings and expectations of rehabilitation

Nurses expected patients to be active participants in rehabilitation. Patients were described however, as possessing little (if any) understanding of rehabilitation, or awareness that a different role was expected of them. In particular, nurses found patients did not know rehabilitation would be different from acute care and that active patient participation was required as part of the continuous rehabilitation process. Despite nurses ‘asking them to be active patients in rehab’ (RN 1), the reality was that nurses encountered many patients who, for at least some time during their hospitalisation in a rehabilitation unit, were not interested in being actively engaged in self-care.

In their study of nursing’s role in rehabilitation, Long et al. (2001, p. 125) report similar findings, describing the situation as a ‘mismatch between the clients’ expectations and the goals of the rehabilitation process’. In relation to patient expectations, the nurse is ‘someone who ‘does for’ the client’ and this impacts negatively upon a nurse’s rehabilitation contribution as patients do ‘not always welcome the emphasis on ‘independence’” (p. 126, italics original). Similarly, Thompson (1990) found nurses and patients had ‘different ideas about rehabilitation and rehabilitation nursing’ with the major issues being ‘limited information on the part of the patient as to what rehabilitation entailed and the roles the staff played’ (p. 112). Jones et al. (1997) referred to this as ‘incongruence of expectations’ (p. 103) and as ‘dissonance of role expectations’ (p. 104).

Thus, the incongruence between nurses’ and patients’ understandings and expectations of rehabilitation was an everyday challenge for nurses. Four factors were found to contribute to this incongruence (see Fig. 1).

Minimal pre-transfer preparation of patients for rehabilitation Regardless of the referring ward or hospital, nurse informants reported patients were only minimally prepared, if at all, for their transfer to rehabilitation. Hill and Johnson (1999) and Gibbon (2004) found the same. In Clark and Smith’s (1998) study of patient satisfaction with rehabilitation following stroke, almost a quarter reported they did not know what to

Figure 1 Factors contributing to incongruence between nurses’ and patients’ understandings and expectations of rehabilitation.

expect of rehabilitation on admission. The lack of pretransfer preparation of patients for rehabilitation in the current study, is noted in the following comment:

I don’t think it’s explained to them [patients] in acute services what we are. I think it’s sort of looked at, ‘Oh, and then you’ll go to rehab’, and when they [patients] ask ‘What’s that’, they’ll [the acute care staff will] say, ‘Oh, that’s where you go before you go home’. So most older people look at it as a convalescent home before they have to go home or make any decisions about anything else. It’s a convalescence period and they just need that little bit longer to get ready. They don’t think they’ve got to come here and work really hard. (NUM 1)

Nurses reported that, because rehabilitation and acute care were markedly different, rehabilitation came as a shock to many patients. It was a surprise to them that nurses in rehabilitation units did not do everything for them, but attempted to help them do for themselves. A nurse in Thompson’s (1990, p. 165) study also talked about patients being shocked when they initially arrived in rehabilitation and realised that nurses were there ‘to help them do for themselves, not to do it for them’. In Sheppard’s (1994, p. 28) study, patients themselves reported coming to rehabilitation as a shock, because they arrived ‘with only the vaguest ideas about rehabilitation’.

Occasionally, however, nurses reported patients were pleased about coming to rehabilitation. In these instances, patients had been in a rehabilitation unit before or heard about rehabilitation while in an acute care ward. The latter seemed more likely to happen when the rehabilitation unit was in the same hospital as the acute care ward where the patient was hospitalised.

Many more nurses recalled patients who were misinformed about rehabilitation before being admitted to a rehabilitation unit. Some patients believed they could expect little (if any) improvement and that life as they knew it was over:

Well, rehab is usually an incredible shock to a lot of people. I think a lot of people think it’s the end of the road. A lot of people haven’t got any idea of what rehab is about. ... they will be usually devastated that they’ve had to come to rehab. (RN 15)

Nurses also said patients were misinformed about specific aspects of rehabilitation by staff in the transferring hospital. In particular, patients were given incorrect information about what services to expect. Some expected more services than were provided. Specific examples of how patients acquired misinformation included patients being told unpleasant stories about rehabilitation by acute care staff. Either they were told ‘some bad stories about rehab’ (Field note) or rehabilitation was used in acute care settings as a threat, with some patients being told ‘they’ll get you going, they’ll make you work!’ (RN 16). Sometimes, the threat was more particular with patients being told rehabilitation nurses do nothing for patients. As a consequence, some patients arrived in rehabilitation with considerable apprehension:

A lot of them [patients] are so frightened when they come in here because they’re told [by staff in the transferring hospital], you know, ‘Oh, they’re going to make you do this and make you do that’. (RN 9)

Thompson’s (1990) study revealed similar findings. One nurse participant in that study was reported as saying:

A lot of times the patients have been prompted before coming over to rehabilitation about all they are going to have to do here. I think some of them [patients] believe we have a chain and whip. They are told that ‘we will make them do things’. (Thompson 1990, p. 148)

Patients were also reported to have ‘readily admitted that they were frightened, uninformed and awed the prospect of doing for themselves with their new limitations of movement’ (Thompson 1990, p. 113).

In the current study, minimal pretransfer preparation for rehabilitation made patients ill-prepared to work with nurses. This may have been due to patients’ understanding of rehabilitation as an episodic activity.

Nurses’ perceptions of patients’ understanding of rehabilitation as an episodic activity

Many nurses said patients did not share their understanding of rehabilitation as a continuous process. In fact, various patient behaviours led nurses to believe patients thought of rehabilitation as an activity they participated in intermittently. In particular, some patients understood rehabilitation to be an activity they only undertook with certain staff and in certain places.

Several nurses reported that patients appeared to understand rehabilitation as an activity only involving allied health staff. Some patients anticipated they would work exclusively with allied health staff in rehabilitation. Similarly, patients in studies by Sheppard (1994), Lewinter and Mikkelsen (1995) and Long et al. (2001, p. 39) saw rehabilitation as ‘something that the physiotherapist does’. When nurses in the current study encountered patients with this view, the patients were less co-operative:

The physio over at the rehab centre, they’ll say oh, the patient does lots for them over there, but when they come over here because we’re not physios, they [the patients] don’t think they have to do it the same as they did over there. It doesn’t seem to flow over onto the ward. They do what they will do for the physios over in the gym but as soon as they come to the ward it’s not on, they won’t do it. (EN 10)
Nurses also said some patients thought rehabilitation took place only in specific areas, for example, designated allied health therapy areas, such as the gymnasium or occupational therapy areas. These patients were often less co-operative on return to the unit, where they thought they should be able to rest:

Some patients do feel that when they come onto the ward then it’s time to rest and when the nurse asks them to walk, ‘Oh, I’ve done my walking in the gym’. (RN 13)

Other studies (Thompson 1990, Campbell 1999) report similar patient behaviours. One of Thompson’s nurse informants described patients as expecting to be ‘served by the nurse’ when they returned to the unit after working with allied health staff (p. 155). Campbell (1999, p. 40) found ‘a patient will ‘perform’ while at physio, yet upon returning to the ward the patient may feel that this is no longer necessary’. More generally however, nurses perceived patients lacked an awareness of the demands of rehabilitation.

Nurses’ perceptions of patients’ lack of awareness of the demands of rehabilitation

Nurses said that patients who were new to rehabilitation did not share their understanding of rehabilitation as requiring active patient participation. Lacking preparation for their role in rehabilitation, patients were described as expecting the roles of patient and nurse to be the same as experienced previously. Nurses believed that, in acute hospitals patients were used to ‘lying in ... bed, waiting for the nurse to do it all’ (RN 16). Nurses described this as the sick role and when in the sick role, patients were not expected to be self-caring. They identified the sick role as a common experience of patients in acute hospital wards but said it was unsuitable in a rehabilitation unit.

In Thompson’s (1990) qualitative study of one rehabilitation unit in the USA, nurses consistently reported patients did not share their understanding of rehabilitation. As with nurses in the current study, one nurse believed patients ‘don’t differentiate rehabilitation nurses. They think nurses take care of you. ... They’re used to patients having a passive accepting role. And in rehab they are expected to be active’ (p. 155).

Because something quite different was expected of patients, nurses in the current study reported patients as experiencing shock on their transfer to rehabilitation. Getting dressed (in day clothes) and eating in a dining room were commonly reported as big changes for patients. Accordingly, patients’ understanding of what should be done for them in rehabilitation was based on what had been done for them in acute care. On this basis, they reminded rehabilitation nurses about what they should be doing for them. It seemed some patients interpreted acute care nurses’ actions to mean that, as patients, they were not encouraged to do certain things for themselves.

To facilitate patient self-care and independence, nurse informants intentionally developed a different style of nurse-patient interaction. As a result, many acquired extensive interaction, communication and facilitation skills in this area. However, many nurses reported patients were often unhappy with the different approach rehabilitation nurses adopted. They said patients compared this approach to acute hospital nursing and found it difficult to accept. Nurses standing back and encouraging patients to do self-care, in their view, was not what nurses should be doing. Miller’s (2003, p. 139) belief that ‘consumer knowledge of what constitutes rehabilitation nursing and its contribution to the recovery process is virtually non-existent’ may explain this. In the current study, this lack of understanding was more the case with older patients.

Nurses also remarked that, because they were persistent, patients viewed them as ‘lazy’, ‘mean’ and even ‘cruel’. This was associated with nurses expecting patients to do things for themselves instead of nurses doing everything for them. Other studies also report patients being displeased with the self-care approach used by rehabilitation nurses. In Hill and Johnson’s (1999, p. 154) study, nurses said patients perceived them as ‘uncaring’, a nurse in Thompson’s (1990, p. 165) study reported patients as thinking, ‘Wow, these people [nurses] are mean!’ and in Sheppard’s (1994, p. 28) study, patients found the new roles for patients and nurses ‘extremely disconcerting’ and ‘unwelcome’. Patients’ general lack of awareness of the demands of rehabilitation was compounded by their lack of motivation to participate in rehabilitation.

Nurses’ perceptions of patients’ lack of motivation to participate in rehabilitation

Patients need to be motivated to participate in their own rehabilitation. Motivation means patients possess the will to work towards self-care and be ready to work co-operatively with nurses. The importance of patient motivation for successful rehabilitation is emphasised by Resnick et al. (1998) and Siegert and Taylor (2004). In the current study, nurses described being positive and making an effort as valuable attributes in a rehabilitation patient.

However, due in part to negative feelings about their situation, many rehabilitation patients were described as lacking motivation to participate in rehabilitation. Johansson (2002, p. 3) notes that in the older person ‘maladies of the spirit – depression, loss of will, bitterness [and] despair’ commonly thwart the efforts of the rehabilitation team. Price

et al. (1997) also found motivation to be a problem in a rehabilitation unit in New Zealand. She reports that once patients were medically stable, there was more time to grieve and patients had ‘to come to terms with loss and grief issues before they were able to actively participate in a rehabilitation programme’ (p. 85). Several nurses in the current study expressed an understanding of their patients’ difficult circumstances and how this might impact upon patient motivation. The following is a typical description:

He’s very emotional … suddenly they’ve gone from being a whole person and being very independent, to being someone who is exceptionally dependent. ... Like someone who has had a big stroke, they’ve gone from being maybe a bloke who’s very fit, very agile, always doing everything for himself, always out in the garden and all of a sudden he’s sitting there in a chair and very debilitated or finds that he can’t do anything for himself. He might need to be fed, he might need assistance with walking and he’s got to learn this all over again. (RN 20)

Some nurses also reported that patients were daunted by what was ahead of them and often saw it as insurmountable. Believing significant improvement to be unachievable, some patients were described as becoming disheartened about participating in rehabilitation.

Nurses attributed patients’ lack of motivation and negativity to lack of confidence, frustration, anger and depression as well as, in some cases, to not wanting to be in rehabilitation.

**Discussion**

The finding of ‘incongruence between nurses’ and patients’ understandings and expectations of rehabilitation’ is not unique to this study. A mismatch between nurses’ and patients’ understandings of rehabilitation has been recognised for many years (Thompson 1990, Jones et al. 1997, Long et al. 2001, Miller 2003) as is also the acknowledgment that patients need to be educated about rehabilitation (Arts et al. 2000, Berger 2000, Pryor & Smith 2000, Grenenger 2003). By explicating the nature of this mismatch and its relevance for patient rehabilitation, this study adds to existing knowledge. This more in-depth understanding was made possible through the analysis of interview and observational data using grounded theory.

The mismatch identified in this study relates to patients possessing different understandings of the nature of rehabilitation, the spaces and times where and when it occurs and the roles of patients and nurses. While nurses knew that patients needed to be active participants in their own rehabilitation, patients did not share this view. Moreover, patients expected rehabilitation to be comprised of intermittent activities carried out by only some staff in some places, instead of a continuous process dependent upon their active participation and engagement with nurses. This finding infers that patients did not think rehabilitation took place at the bedside and therefore expected nurses to actively care for them.

In addition, findings from this study explicate over-arching principles underpinning the practice of rehabilitation nursing more clearly than previously reported. These four principles informing nurses’ expectations of rehabilitation service delivery are: (1) rehabilitation is a continuous process; (2) rehabilitation requires active patient participation; (3) rehabilitation is goal-directed and (4) rehabilitation requires multi-professional teamwork. While these beliefs are not new in the broader rehabilitation literature, they are seldom mentioned in the nursing literature.

These four principles provide a framework for the design of education materials and orientation programmes that inform patients (and their families) about rehabilitation. In attempting to bring patients’ (and families’) understandings and expectations of rehabilitation in line with that of nurses, these materials and programmes should pay close attention to the specific points of incongruence reported in this study. In particular, at the same time each patient’s right to determine which aspects of rehabilitation they participate in, and to what extent, needs to be respected.

Few reports of nurses’ understandings of rehabilitation are available in the literature. Moreover, those studies (Gibbon 1991, 1994, Waters 1994) portray nurses as possessing limited understanding of the purpose or nature of rehabilitation. This has frequently been associated with the absence of adequate rehabilitation content in undergraduate nursing curricula (see Gibbon 1991, 1993, Nolan & Nolan 1999, Pryor 1999). However, findings of more recent studies (Burton 2000, O’Connor 2000a,b, Pryor & Smith 2000, 2002, Singleton 2000, Long et al. 2001), while seldom explicit, suggest nurses understand rehabilitation to be about promoting patient self-care and independence, and to be about enabling patients to cope with and adapt to functional limitations. The findings of this study make possession of those understandings explicit. They also highlight the importance of preventing patient re-admission to hospital as an additional purpose of rehabilitation, a purpose not explicit in the findings of previous studies.

The findings of this study indicate that rehabilitation patients do not share nurses’ understanding of these four principles of rehabilitation. The findings of other studies, however, suggest that at least some patients may possess an understanding of rehabilitation similar to that of the nurses. Cox et al. (2002) describe some of the male trauma patients...
in their study as active participants in their rehabilitation, who worked towards goals they had set for themselves. Similarly, patients in Lucke’s (1997) study of rehabilitation following spinal cord injury were described as actively learning what they needed to know. While neither study indicated whether patients knew what to expect upon entering rehabilitation, it is clear that some rehabilitation patients are better informed than nurses in the current study believe them to be.

In summary, the findings of this study revealed that the important contributions that patients and nurses make as participants in rehabilitation are not fully explicated. Consequently, rehabilitation as a process is not fully optimised. Based on the findings of the current study it may be useful to develop patient educational material explaining the nature of rehabilitation and advising patients what to expect and how to optimise their participation. It is important that this information is given to patients in the acute care setting prior to their transfer to rehabilitation. Further research is required to evaluate the effectiveness of these educational materials and to evaluate whether they impact upon patient’s readiness to participate in rehabilitation.

Contributions
Study design: JP; data collection and analysis: JP; peer review of data analysis trails: BO and manuscript preparation: JP, BO.

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