THE EXTENDED ROLE OF THE REGISTERED NURSE IN EXTENDED CARE

The R.N. in long term facilities, has the golden opportunity of extending her role, not only in so far as her relationship to the physician is concerned, but to the various paramedical groups as well. This challenging role has to be developed if we wish to initiate a harmonious and knowledgeable plan of action from which the patient can benefit.

The various disciplines each have high ideals for their professions, but in their effort to maintain their identity, they covetously appear to hold their aims to themselves, lest, perhaps, someone infringe on their clearly defined territory. Therefore, the system or "non-system" we have now, generally, delivers tasks to the patient in fragmented bits and pieces and sets it together like a jig saw, in the hopes that the end result will spell quality care. It does not. The care obtained through this restricted, biased, and unrelated manner creates confusion among all personnel, to say nothing of the unfortunate patient who is caught between this power play.

There is keen interest in the extended role of the nurse, by the nurse, as she relates to the physician. She sees his technical skills as a great challenge - could it be because it provides her with more tasks? However, the physician has grave doubts about accepting her, in many cases she is not welcome.

In extended care the R.N. is welcomed, and we have a very interesting and dynamic role for her. Here, she can truly extend her role in so far as the physician is concerned. Physicians are few in numbers in proportion to our population, and according to statistics, we have every indication that this situation can become worse. Therefore, the physician who already is desperately pressed for time will have to set priorities, naturally, his time will be given to the more challenging and acutely ill. In many cases, the needs of the chronically ill and aged, for

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the physician's time, is minimal. The nurse and the physician, from the patient's diagnosis and history, can mutually, or with a team approach if these disciplines are available, assess abilities and needs. From these, they can plot a course of action. After this initial encounter, the physician can become a consultant to the R.N.

One discipline has to coordinate all this unstructured care into one knowledgeable and meaningful plan of action. Will it be the R.N.? She is the only logical discipline for this role as she maintains a 24-hour vigilence. Generally speaking, however, she looks at her clay feet. She hasn't been fired with enthusiasm or vision, she hasn't raised her eyes sufficiently to see the total spectrum of care her extended role can embrace.

Because the R.N. does not comprehend this extended role, she cannot activate the development of a viable extended care philoscphy and without first absorbing this philosophy, she cannot develop a meaningful program. The nurse clings to her task oriented philosophy of acute care. Recently, an author stated that the R.N. is more concerned that the patient's bed is properly made and that the casters are kicked into place than she is about the patient. This is a bit harsh, but I tend to agree with her in principle.

From the above extended role, the nurse can further broaden her scope. This can done by embracing all disciplines to make comprehensive care a truly living experience. However, the medical and paramedical professions must reciprocate, and it can't be a one sided love affair. In this case, bigamy would not be frowned on.

In the main, our nurse prefers the union with the medical profession, the paramedical disciplines hold little interest for her. While we are striving for total care for the patient, she provides lip service, the total person remains a

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stranger to her, and she prefers it this way. Paramedical disciplines, too, are geared to the acute care philosophy so they have difficulty relating to the aged with impairment.

The availability of paramedical disciplines, interested in the long term, poses a problem. This, again, deprives the extended care patient of quality care. Physical and occupational therapists, dieticians, and social workers, frequently on consultative basis only, can give very little time to the care of the individual patient. Therefore, the R.N. must provide the environment and expertise knowledge under which quality care is possible. She has to support these disciplines and extend herself from their roles in order to follow through with the proposed care and techniques on a 24-hour basis. Yet, I have heard statements such as, "I didn't go in training to walk patients". The R.N. does not see that in encouraging mobility she can extend herself from the role of the physiotherapist. Feeding a patient is another extension from the occupational therapist. Independence, in these areas, can again be gained through intelligent application of principles and skills. Because the R.N. lacks vision, she sees these duties as demeaning "nurse aide work". A further extention is the nurses' concern for diets and menus. This is very important in order to deliver the food to the patient in the proper form or consistency so as to maintain or regain independence. By encouraging and becoming involved in social activities, her role is extended to embrace the social worker. Yet, she cannot identify herself in this role either, she is more concerned with applying some technical skills. If these are not necessary, and she is stripped of much of her administrative duties, she becomes preoccupied with charts, pills, and "make work", she avoids the face to face encounter with the patient as a person.

Dr. Helen K. Mussallem, Executive Director of the Canadian Nurses Association,

shows her concern in this regard when she states, "We have made changes based on needs or demands as identified by nurses, but have we made changes based on health needs and sought solutions in collaboration with other health practitioners? If we do not alter our services in view of all needs, then like the lovable village smith, we will quietly fade away".[1.]

With this warning, some agency must become concerned in providing long term facilities with suitable personnel. Basically, the R.N. has much of the learning and skills necessary, but she has received this training under an acute care, short-term philosophy. We must become aware that we are dealing with two distinct philosophies and they are not compatible. Can the R.N., interested in extended care, learn to identify herself with the proper philosophy and it's application in an acute care center? Under our present system, she cannot, by the time the nurse graduates she has been indoctrinated by the acute care philosophy. When she arrives in a long-term facility much time is lost in retraining this nurse, and in the process of readjustment, she does much damage in that she asserts herself as she still believes in her acute care philosophy, which she does not give up easily. Therefore, there is a constant battle to maintain an extended care philosophy.

Another reason she cannot embrace the extended care philosophy, is because of the teaching faculty of all disciplines, generally, they too, are acute care oriented. Much time is required, within the environment itself, to develop and embrace a meaningful extended care philosophy. All the book learning and illustrations in class don't help you when you attempt to apply theory to a living experience.

To date, faculties, generally, have not become oriented to the extended care and unless they do, it is difficult for them to make an impact which will benefit the long term patient. I believe they will only perpetuate the acute care philosophy

1. Catholic Hospital, July, 1971 - Page 4

perhaps, watered down, but never the less, acute care.

Possibly, we have the cart before the horse. An extended care philosophy applied to an acute care patient can enrich the experience, however, an acute care philosophy applied to the long term patient creates deterioration and vegetation. This dilemma must receive priority, because in Victoria alone in the next three years, we will be faced with approximately 1100 long term patients (mentally retarded included). Where will the leadership and qualified staff come from to make quality care for the long term a fact? This is an earnest plea for immediate action.

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5/2