

Alleviating Distress at the Bedside

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INTRODUCTION

- Emotional distress can greatly impact care
- Longer lengths of hospitalization
 - Uncontrolled pain and anxiety.
 - Inability to learn own care (stretches and wound care).
- Higher levels of inpatient distress can lead to poorer long term outcomes
 - Inpatient ASD predicts PTSD at two years post discharge
 - High inpatient pain levels predict suicidality, PTSD and depression up to two years post discharge

INTRODUCTION

- Few Burn Centers have mental health providers (psychologists, social workers or psychiatrists) available full time.
- Inpatient providers of all disciplines can be equipped with brief interventions that can be implemented at the bedside to reduce distress.
- Acute painful procedures (wound care, range of motion, pressure garment or face mask fittings, shots, IV's, etc), panic attack, nightmares and flashbacks, delirium.

INTRODUCTION

- Part of holistic patient care.
- The mind and body are not separate.
- We are treating the mind and body.

INTRODUCTION

- Assessment is Critical
 - Keep it short—long paper and pencil assessments are not typically appropriate during inpatient care.
 - Hit the important points
 - If you don't know the patient well and are not the one collecting the history, you can usually find the information that you need in the chart. If not, just ask them.

ASSESSMENT: RISK FACTORS

- Poor social support
- History of past traumas
- History of anxiety or depression
- History of substance abuse
- History of chronic pain

ASSESSMENT: SYMPTOMS

- How often are the symptoms occurring?
- Are symptoms getting better, worse or staying the same?
- Are symptoms interfering with functioning?
- What have they tried to make the symptoms better?
- Any obvious triggers?

ASSESSMENT: SYMPTOMS

- **Panic Attacks**
- **Depression/Demoralization**
- **Delirium**
- **Acute Stress Symptoms**

PANIC ATTACK

- Try to match their activation by communicating with them one notch down from theirs.
- Panic attacks do not last more than 10-15 minutes
- Lead them through a grounding technique.
- When they are calm, teach them to provide commentary for their panic attacks. Teaches them that they have control over it.

DEPRESSIVE SYMPTOMS

Assess and treat depression is one of the most common reasons for referral to our service. Few patients in the acute trauma setting meet the full DSM V criteria for a diagnosis of Major depressive Disorder.

What the team is witnessing is very real and can be just as debilitating. Can affect participation in care--
Often refusing treatments.

DEMORALIZATION

Often the more accurate term.

Demoralization refers to the “various degrees of helplessness, hopelessness, confusion, and subjective incompetence that people feel when sensing that they are failing their own or others’ expectations for coping with life’s adversities.”

- Frank and Frank, 1991

Rather than coping, they struggle to survive.

Demoralization

Vulnerability

- Confusion
- Isolation
- Despair
- Helplessness
- Meaninglessness
- Cowardice
- *Resentment*

Resilience

- Coherence
- Communion
- Hope
- Agency
- Purpose
- Courage
- *Gratitude*

DEPRESSIVE SYMPTOMS

- Behavioral Activation
 - Brainstorm a list of pleasant activities
 - Schedule in one thing to look forward to everyday.
 - Utilize recreation therapists (skilled therapy to treat low mood/demoralization) or volunteers when appropriate.
 - Set realistic goals for therapy and care to keep moving forward and promote independence.

DELIRIUM

Reduce Medications:

- Avoid benadryl, benzos, scopolamine, limit exposure to anesthesia
- Minimize opiates – high pain levels can also cause delirium

Assessment:

- Continue to assess orientation throughout the day (at least three times) and pinpoint triggers for delirium (time of day?)

DELIRIUM

Environment:

- All staff should introduce themselves at each visit.
- Tell them what you are going to do before you do it.
- Have visual cues within their sight (clock, calendar, familiar pictures, window)
- Regulate sleep/wake cycle—blinds open during the day, avoid napping. Lights off and minimal interruptions at night.
- Limit overwhelming stimuli

DELIRIUM

Communication:

- When a patient perseverates on a topic, validate and acknowledge and move on to a pleasant topic.
- Avoid arguments
- Use short, easy to understand sentences, straightforward language.
- Avoid open ended questions.
- Only one person talk to patient at a time. Take group discussions out of the room. Stop talking when overhead announcements come on, turn off the TV.

DELIRIUM

Continuity of providers when possible.

Predictable schedules and routines. Plan of the Day

Alleviating patients' distress
requires a multidisciplinary team.

Thank you!

