Frequently Asked Questions

for staff

at the

National Spinal Injuries Centre

RESPONDING TO CHALLENGING SITUATIONS IN A REHABILITATION SETTING

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INTRODUCTION

Welcome to the National Spinal Injuries Centre at Stoke Mandeville Hospital. Working in spinal rehabilitation is unique and can be a very stimulating and rewarding experience. However, the nature of the rehabilitation environment can produce unexpected, awkward or challenging situations that you, as a new member of staff, may feel unprepared to deal with.

Working in spinal rehabilitation is likely to be different to other places you have worked as patients are often here for long periods of time allowing good rapport and relationships to develop between staff and patients.

Developing the skills of appropriate interpersonal interactions between patients and staff is an important aspect of the rehabilitation process and requires some training. It is also vital to work as part of the multi disciplinary team, to know what everyone's roles are, and to communicate effectively with everyone in it. This will help create a positive and supportive atmosphere amongst staff.

PURPOSE

The purpose of this booklet is to:

1) present challenging situations you may encounter as a staff team member;

2) provide some guidance on how to approach these situations with more confidence.

This review is not meant to be exhaustive nor prescriptive, as problems can occur in a variety of situations and specific rules/instructions are not always universally applicable. However, we would like to provide you with some ideas and practical strategies that you can keep at your fingertips to help you through challenging situations. It is important to remember that these are situations that do not occur every day and with more experience you will become more competent at dealing with them. You are not expected to know everything straight away.

FREQUENTLY ASKED QUESTIONS (FAQS)

Inappropriate expectations for therapy outcome

Q1: "I have a patient with complete paraplegia on bed rest who mentioned to me, 'I'll be pleased when I get mobilised and start going to departments. Then, I'll get strong enough to walk.'

How do I deal with these inappropriate expectations?"

It is common for patients with SCI to ask the question, "Will I walk again?". Even patients with a complete lesion hold out hope that their outcome will be better than expected. Patients inevitably will see peers in the rehab gym who are practising transfers or walking with calipers and compare themselves to those people.

They may have found it difficult to understand their prognosis or may have received vague, conflicting or confusing messages. It can be difficult to accurately predict functional outcomes, especially in patients with incomplete lesions.

It is difficult to know just how to explain to the patient, as well as their family, that it is unlikely that they/their relative will reach a level of function that includes walking.

<u>Some helpful pointers</u>:

Often, the not knowing is the most anxiety-provoking part. Being in information "limbo" is frustrating. Empathise with this frustration. "It sounds like you have questions about your prognosis?". "It can be frustrating to not know…" etc. Suggesting to patients that they should discuss the issues with their medical consultant is important.

Then ask "What are your concerns about not being able to walk again?" (eg is it work, raising children, independence in general?). Then deal with that particular issue.

You could also ask "What is your understanding of your injury?"

- *It is helpful to advise patients to obtain clear information about their prognosis/diagnosis, preferably from their medical consultant. However, members of the team may help clarify this once a clear understanding of a person's injury has been made.*

- *It's best to give direct, factual information about the injury and the patient's impairment to the patient and family. It is usually easier to deal with known facts, even if they are not optimistic, than to fear the unknown or struggle with the frustration of unknown expectations.*

- *You should only attempt to answer questions from patients if you have sufficient experience and confidence, as patients are very vulnerable at this point. You should be honest when responding to patients, and admit when you do not know something but offer to get advice from senior members of staff, ideally their consultant.*

- *Patients sometimes struggle to understand the difference between incomplete and complete injuries (some patients with complete injuries have spasms and think it is motor movement). It can be useful to explain the difference.*

- *Patients will frequently compare themselves and their potential outcome to other patients of similar level injury, however the individual nature of SCI must be stressed as no two patients are the same.*

- *If the patient is fixated on walking, rather than continually confronting them about this it can be helpful to talk to them about what they could do to help improve their function in the meantime (eg "What do you think would help you to get stronger?").*

"Let's say you recover the ability to walk in five years' time. What can you do to make yourself as strong as possible in the meantime?", or "Even if you are able to walk at a later stage, it is important to be able to be as independent as you can now".

As the person develops more independence in wheelchair skills and can begin to see how this would help them in real life situations, they may become less concerned about walking.

Preventing Burnout

Q2: "The stories and burdens of my patients and their families sometimes get to me, and I feel emotional about their situations.

Also, I'm tense about meeting the demands of my high workload.

I find it difficult to stop thinking about my patients and wind down from my day once I leave work. Is this normal?"

Yes, this is normal. The quality of empathy that helps you to be a good health care worker does not come with an on/off switch.

In the course of a day, you expend a good deal of physical and emotional energy listening to your patients' stories and complaints, celebrating their successes, and monitoring their physical efforts. In addition, you are likely to be responding to family concerns, attending meetings, interacting with colleagues, completing paperwork, and more. You may feel pressured in meeting the demands of a high patient load. It may seem like every patient wishes to have their needs met ASAP, your to-do lists are getting longer, and you don't have a minute to get organised.

In addition, since you will be seeing your patients relatively soon after their injury, you will see them struggling to adjust to an understandably traumatic event and changed way of life. You may identify strongly with this struggle to cope with change, as we all have experienced some form of life event at some point. Consequently, it is quite common to "bring work home with you."

However, taking on the emotions of your patients and feeling swamped by your workload can lead to early burn-out and diminishes your energy resources to cope with your own life events.

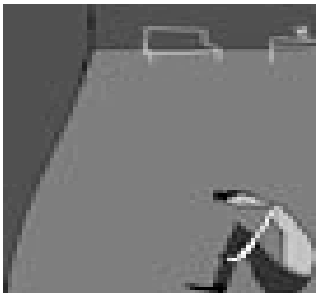
So, it is important to rely on both the support of the multidisciplinary team you are a part of, as well as implementing stress coping skills in your own life.

At work:

- Communicate with other team members.
- Discuss your concerns with a more senior member of staff whom you get on with and trust – this doesn't have to be your manager, although they may be helpful to talk to, particularly if the stress continues for a long time. They may be able to give you practical advice about managing your workload or changing the way you work.
- Use your support structures/debrief with the manager of your department.
- Contact the Occupational Health Department should you need further support or counselling (5022).
- Contact the Department of Clinical Psychology for support with clinical issues/tricky situations (5823).
- It is important for staff, especially nursing staff, not to get too worried if not everything is achieved during a shift as nursing is 24 hours. Your priority should be that patients are safe and well – if this is done you are succeeding.
- Each day, prioritise the three most important things to do and then review how you have done at the end. Less important tasks can be left until quieter times such as weekends.
- If you are too busy and a patient asks for something (e.g. help with their hair or make-up) to be done it can be useful to offer an alternative time when you will be less busy. Remember to always try to be polite.

Outside work:

- Relaxation.
- Exercise, which has been demonstrated to improve emotional, as well as physical, well-being.
- Fun.
- Take care of yourself (eg, sleep well, eat healthy foods, etc)
- Take time for yourself (eg, pampering).



Low mood/suicidal ideation

Q3: "I went to get a patient for her Physio session the other day and she said, 'I don't feel as though I am getting anywhere ... I'm tired … my life is over and I'd rather be dead than do this. What's the use?' How can I help her to feel better about rehab?"

Normal emotional reactions

People react to spinal cord injury in different ways. Although not everybody becomes depressed following SCI, it is common for people to experience a period of low mood at some stage during their rehabilitation. Quite often, this occurs as people start to accept the reality of their situation, but may not yet have worked out how to cope with the consequences of SCI. For example, common triggers for low mood may be following discussion of their prognosis, after mobilisation when the effects of the injury become more apparent, after weekend leave at home that was more difficult than expected, or when someone who has previously been hoping for recovery starts to accept that this is unlikely to happen. It is also common for people to feel low when experiencing setbacks in rehab, for instance, during a period of bed rest due to a urinary tract infection or pressure sore.

When people experience low mood they can start to become trapped in negative thinking, a bit like wearing purple tinted spectacles that make everything look dark. They lose the ability to keep a balanced perspective, so that difficulties with something specific such as transfers or feeding are translated as 'I can't do anything – my life is over'. Treatment for depression is about helping the person to regain a balanced perspective on things – in SCI, this is often about recognising that although there are many skills and abilities that are lost, there are also many that have not been affected by the injury, and new skills that can be learnt to reach some of the same goals.

How to respond

It can be hard to work with people who are feeling very low, and you may feel you don't know what to say, or may feel upset yourself afterwards. Remember that **you don't have to solve the problem**, and the person is probably talking to you because they just want someone to listen. The following may give you some ideas for how to respond to someone who is feeling very negative about rehab:

- Distinguish between temporary and permanent losses. People may assume that, for instance, because they are unable to carry out personal care now, they will always be dependent on carers. Give them information on the skills they will be learning during rehabilitation, and what you expect them to be able to do by the time they are discharged. The goal planning programme is often helpful with this.

- Emphasise the person's improvement and achievements. Give them some praise. It is easy for patients to forget how difficult things were initially, and consequently to minimise what they have achieved. It helps to remind them of the progress they have made, and what they still have to gain. Again, goal planning is a useful opportunity to do this.
- Help the person to problem solve new ways of doing things if the old ways don't work any more. For instance, help them to think about how they could take their children to the park, go on holiday, return to work, have a sexual relationship – whatever the person is concerned about. If you don't know what to suggest, tell them who the relevant staff member is who can help.
- People may need an opportunity to grieve for permanent losses, and may just want a sympathetic ear. This is a natural part of acceptance and it may be necessary for the person to go through a period of feeling sad about what is lost in order to be able to refocus on moving forward and making the best of their current abilities.
- Offering support to the patient via organisations such as Back-Up, SIA or other patients with similar injuries but further on in their rehab can be helpful in increasing their social support network.
- Suggest the person speaks to one of the clinical psychologists to explore their concerns in more detail, and offer to make a referral (5823). You should also discuss concerns about a patient's mood with their named nurse, consultant and keyworker.

Dealing with suicide risk

Sometimes, people who are low or depressed may express thoughts about death. It is fairly common for people to reflect on this following SCI, particularly if their injury was caused by a life-threatening event. People may talk about how they could have died during the accident, and it is fairly common for people to say that they wish they had died. This is different from people talking about suicide, which is less common.

If someone brings up thoughts about death and dying, it is important to listen carefully to what they are saying. If someone is talking about wanting to die or wanting to kill themselves (as opposed to wishing they had died during the accident), this should be taken very seriously, particularly if they are having frequent thoughts of this and have thought about methods of self-harm. You will have a duty to take action on this rather than keeping it confidential, even if the person asks you not to tell anyone. Tell the person that you are concerned about them, and need to get some help for them. Discuss the situation with a senior colleague, and refer the person to the Department of Clinical Psychology, marking the 'urgent' box on the referral form. If this is outside normal working hours, a referral to the on call duty psychiatrist may be required (Tindal Centre switchboard: 73-0).

It can be emotionally draining to work with people who are low or depressed, and it is important to get support from colleagues if you need it. You should also realise your own limits and know when to refer on to more experienced staff. If you are concerned about a patient's mood or want to 'debrief' after a difficult session, please contact one of the clinical psychologists for advice or support (5823). There is also TESS (Post Traumatic Events Staff Support Group) (6657).

Q4: I have a few patients who are forgetting to practise their exercises and don't seem to understand my instructions. This seems to be affecting their progress in PT/OT. What can I do to help them?

Cognitive Problems

You may see patients with a range of cognitive problems, including disorientation, learning and memory problems, difficulty communicating, reduced ability to understand information and reduced ability to plan and initiate activities. It is difficult to tell immediately whether these problems are indicative of the patient's pre-injury functioning, the result of a closed-head injury, a normal age-related decline in functioning, their medication or other physical problems (eg UTI). Being in hospital means that patients are having to cope with changes in their role, routine, motivation etc.

These cognitive problems can manifest in a variety of difficult behaviours or problems with engagement/compliance:

- Calling out.
- Socially or sexually inappropriate behaviour.
- Repetitive behaviour (eg, smoking or eating).
- Reduced activity.
- Refusing treatment.
- Difficulty following the timetable, not turning up to sessions on time.
- Verbal/physical aggression.
- Difficulty learning new techniques, eg self-intermittent catheterisation.
- Forgetting things you have told them so you have to repeat the same information again.
- Inability to do tasks independently.

Strategies for working with people with cognitive problems include:

- Gently orienting the person to your name/role, where they are, what day/month it is, why they are here. Be prepared to do this repeatedly.

- Providing structure and routine – make things predictable – same times, same procedures, same faces.

- Explain what you are doing clearly and repeatedly.

- Providing written notes and cueing techniques (eg, posters, alarms) and keeping personal space tidy.

- Negotiate and provide choices in therapy. You may need to structure those choices for patients.

- Reward anything approximating the desired behaviour (e.g. use verbal praise if patient not shouting/participating in treatment etc.).

- If patient is hallucinating or confused, don't try to reason - respond to the emotion expressed (e.g. reassure them that they are safe).

- Assess the need for 1:1 support from mental health nurse/carer. If you are not sure, discuss it with your manager/colleagues.

- Refer to Clinical Psychology for formal assessment if patient exhibits any of above which significantly affects their rehabilitation progress (5823).

- Try to make sure that there are times when patients can do activities that do not require mental effort (things that are not difficult/stressful/demanding, ie such as chatting) so that they get the opportunity to spend time with staff. It is much harder for people with cognitive problems to structure their own time and they can feel isolated.

- Whenever possible, if giving information try to find a quiet place off the ward in order to minimise distractions such as televisions, radios etc.

Sexually inappropriate behaviour

Q5: A patient flirts with me often and recently asked me to go out with him for a drink at a local pub. I felt uncomfortable saying "no." How should I have responded to this?

Professional boundaries are vital whilst working at NSIC as sexually inappropriate behaviour can occur more frequently than in other specialities due to the nature of the patients (predominantly young men) and the staff (predominantly female).

Sexually inappropriate behaviour can range from "harmless" flirtation, to lewd comments, to aggressive touching. The most effective response to a patient's behaviour varies depending on the severity of the transgression. It can be helpful to try to understand the patient's perspective and why they may be pushing boundaries and flirting e.g. maybe they are testing out their sexuality.

In all cases, **professional boundaries** should be made clear at the start of treatment and applied consistently. All members of staff belong to a professional group, each of which has clear guidelines concerning professional boundaries when working with patients – it is important that you are aware of these.

Staff and patients from NSIC do occasionally go out together but it is important that staff maintain professional boundaries as it is their responsibility to do so, not the patients'.

- For *low severity* behaviours such as flirting or lewd stares, **ignoring** the behaviour may work best
- For *moderate severity* behaviours such as lewd comments or brief minor touching, full eye contact, a stern facial expression, and a **clear comment** indicating that the behaviour is inappropriate should be sufficient. Advice can also be sought from colleagues and senior members of staff if difficulties persist.
- For *high severity* behaviours such as aggressive touching **break away** quickly and call for help. An incident report form should then be filled out.

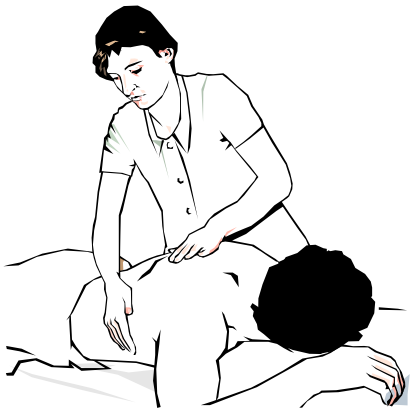
If a patient asks you on a date or even to accompany him/her socially on a friendly basis, a simple and direct answer communicates your position clearly.

- Consider how you would decline a date with other individuals.
- A simple "No, thank you" may work.
- Avoid making an elaborate excuse or leaving the possibility ambiguously open (ie, "I'm busy tonight" means you may consider the proposition some other time).
- Humour may help if you know the patient well.

- If necessary (patient is persistent), review professional boundaries with patient (ie “I am your OT and for me to do my job best with you, I cannot go out with you. It would be best if you developed a relationship with someone else who isn’t involved in your care/rehabilitation”).

However tempting, resist the opportunity to share details of any incident e.g. flirting with your co-workers unless they need to be directly involved. It can be surprising how quickly gossip spreads, and you can spare the patient potential embarrassment by being discreet.

For other questions or issues related to sexuality (perhaps raised in the Needs Assessment Checklist) there are two specifically trained nurses in out-patients (Mary Leonard 5914 & Debbie Bragg 5829) who are able to discuss these with patients.



Q6: Complaints from patients about not getting enough therapy

- When faced with this situation staff should emphasise to patients that rehabilitation is 24 hours a day and not just the scheduled physio and OT sessions in their timetable. Staff are around to assist where necessary, but it is up to patients to take the initiative.

- Staff should encourage patients to transfer what they have learned in structured rehab to new situations to continue their rehab doing every day activities.

Anger

Q7: "As I was working with a patient in the gym I noticed that he began to get restless and agitated. He then aggressively pushed my arms away and yelled angrily, 'Stop touching me! I'm not going to do this anymore!' How do I respond to angry outbursts such as this?"

In this situation it may be helpful to stop and give the individual some space to cool down and then discuss what happened. Be aware, the situation may have just lit the match (Rocket analogy below) and so the response might be larger than you would expect in the situation.

Anger/aggression

The analogy of a rocket can help in understanding the anger process. There are five stages in the process: triggers; fuse; explosives; explosion; aftermath.

1. When you are in hospital there can be many **triggers**/things that light the match. It can sometimes be something very small.

2. This is because often the **fuse** is shorter due to a variety of factors; being in hospital, pain, coping with SCI, decreased control, isolation (MRSA), relationships with family and friends, setbacks in rehabilitation, difficulties with discharge.

3. The rocket may already be pre-packed with some **explosives** eg pre-injury factors, anger at cause of injury, previous experiences of health care.

4. Therefore, the combination of a seemingly small event occurring can light a short fuse connected to packed explosives and lead to an **explosion**. The explosion can be manifested in verbal or physical aggression.

5. The **aftermath** is the consequences of the anger that the person has to deal with.

Initially, it may be best to say "I can see you are annoyed – I'll give you some space and come back in 15 minutes".

Being able to spot the warning signs that someone is becoming agitated can be helpful, although it often happens very quickly. Everyone is different but some features of anger may be a raised voice (shouting), pointing/pushing/slamming, a red face, frowning, flaring nostrils, rapid breathing, sweating on forehead, clenched jaw, trembling, swearing, close proximity, questioning competence, and threatening to complain to superior.

If in a crisis situation, where a patient's anger has escalated quickly, there are a few steps you can take to manage the situation:

1. **Calm self:** Relax, stop and think: "Can I deal with this?" Avoid heroics. Get into your coping mode.

2. **Calm aggressor:** The aim is to reduce the person's anger with nonverbal and verbal strategies. If the patient is over-aroused, they are not able to think rationally to solve the problem. It may be appropriate to move the discussions to a more private room such as the nurses' office.

Non-Verbal Strategies	Verbal Strategies
Create a bigger body buffer zone – give them more space	Match their level of anger with your level of concern
Don't make fidgety sudden movements	Paraphrase what they are saying/ reflect feelings to show you've understood
Reduce eye contact (keep looking but don't stare)	Depersonalise the issue (eg "The policy says I can't do that, but let's think about what else we could do.")
Don't smile	Avoid provocative words and phrases (eg "your problem")
Turn palms up	Use the words "we" and "together"
No physical contact	Ask for the behaviour you want (eg "I want you to let go of me")
Stand/sit at right angle (not head-on)	Avoid making promises you can't keep
	Humour – use with caution and only with those you know really well

3. **Problem-solve:** Arrange a time to sit down with the patient and talk through the issues in detail. The aim is to deal with the root cause of the aggressive incident. Clarify the problem, think of possible solutions and later evaluate whether these worked.

UNDERSTANDING DIFFICULT BEHAVIOUR

Assessing and understanding the function of difficult behaviour helps you see it objectively and helps you decide how to deal with it. Ask yourself: "*What does the person hope to gain*?". Everything that a person does, communicates something (even doing nothing communicates something!).

For example, a patient who is exhibiting unexpected or difficult behaviour may be:

- Seeking means of control or exerting a choice
- Expressing feelings/views
- Wishing to stop unpleasant events
- Trying to gain attention/trying to have their needs met
- Attempting to avoid dealing with more serious concerns

Assessing the function of difficult behaviour helps you to see it objectively and helps you to decide how to deal with it. Ask yourself "What does the person hope to gain?"

However, the problem with using behaviour as a method of communication on its own is that the message is often ambiguous/open to interpretation.

Why does a person communicate in a particular way?

- It may have worked in the past.
- It may have worked for others they have seen.
- In stressful situations all people's resources and energy are going into dealing with demands of the situation and they often have fewer resources left to cope with other demands (e.g. resolving problems and disputes).

How do you respond when dealing with someone whose behaviour you find difficult?

- Is the patient aware of what is/is not acceptable behaviour?
- What are they trying to communicate? Talk to the patient and/or, if you need to, discuss it with a colleague – they may take a different view.
- Why do you find it difficult? – be aware of own biases.
- Do you respond to them at other times when their behaviour is acceptable?

Need to strike a balance between understanding the individual and their needs, together with communicating to them what is/is not acceptable.

GENERAL PREVENTION OF DIFFICULT BEHAVIOUR

- Effective verbal and non-verbal **communication** is key

- Establish clear physical and conversational **boundaries** - communicate clearly a message about what is expected

- Maintain **consistent** boundaries with same patient and between patients

- Acknowledge that there are situations in which patients have significantly less personal control over their situation
    - Work to maximise patient **independence** and increase patient's sense of control, choice, decision-making

- Increase **awareness**
    - Promptly document all incidents in the MDT notes
    - Discuss events at ward round meetings
    - Identify high-risk places, situations, people, activities

- Self-**awareness**
    - It helps us to recognize our own feelings, as these will influence our response to difficult behaviour

Your Goal Behaviour	Useful Phrases
Pause and be attentive - Avoid being defensive - Stay curious about the patient's story	"Tell me about what's upsetting you."
Acknowledge the difficulty of the interaction	"Having to wait for 45 minutes to see me is a really long time." "It can be unpleasant to use the tilt table for the first time."
Find out the specifics of the story – encourage the patient to give details	"Tell me more about what so-and-so told you."
Express empathy for the patient – acknowledge the emotion by name	"It's very frustrating to have to (wait so long/ repeat this exercise/ be on bed rest)."
Make a statement guessing at the meaning behind the patient's anger and validate.	"Was it frustrating because it was a waste of your time?"
Take an action on the patient's behalf if possible. Be an advocate.	"I'll figure out what caused the delay today. Maybe it's something that can be avoided in the future."
Transition to the purpose for the visit	"Well, now that you finally got to see me, what would you like to start with?"

- If a patient has been persistently aggressive it is your duty to inform other members of staff e/g/ at hand-over.

- If you are unable to prevent the aggressive behaviour there are security staff who you can call as a last resort. They can act impartially to try to resolve any conflict. (Contact Ron Hale on ext 5109).

First printed June 2005