

Psycho-social
REHABILITATION
in burn care

Why Me?
What will
I LOOK LIKE?
When will
I FEEL better?
WHO can I TALK to?
how will I COPE?

Introduction **How to use this training – trainer’s notes**

The National Burn Care Review in 2001 produced a consensus report identifying that psycho-social support provided for burns patients was a major weakness in UK burns services. A psycho-social working party, set up in 2003, culminated in producing a revised set of standards in 2008 aiming to address this important area of care. The overall aim of these revised standards is that all staff are able to recognise distress signals and that the relevant staff are fully equipped, trained and resourced to deliver the appropriate tools, strategies, psychological support, information and advice responding to patients’ needs, therefore empowering patients and their families.

This training package, commissioned by the London and South East Burns Network, is designed to contribute towards achieving these standards and ultimately improve the delivery of psycho-social care within burns services and patient outcome.

This training package has been piloted in the burns services of the London and South East Burns Network and evaluated by the Centre for Appearance Research (CAR) with successful results.

Training all staff in a burns service is a challenge as team members will have different levels of experience, educational level and knowledge. Throughout this pack there are guidelines provided relating to the use of the package which will help you use the training resource effectively.

Allocating staff to the appropriate training tier

Staff should be allocated to one of three tiers:

Tier 1: Mainly non-clinical staff who do not have direct clinical contact with patients (receptionist, porter etc)

Tier 2: Majority of clinical staff who have clinical contact with patients (nurse, occupational therapist etc)

Tier 3: Staff whose job role involves providing specialist psycho-social care (including spiritual care) or staff who have particular skills, experience or responsibility for psycho-social care (assistant psychologist, chaplain etc).

To assist you in allocating staff to the appropriate tier a ‘Tier Allocation Questionnaire’ is provided. This questionnaire is multiple-choice and staff should answer six simple questions about the degree to which they have contact with patients in their job role and the nature of this contact. Adding up their answers will provide them with a ‘Tier Suggestion’. The results of the questionnaire should be used in conjunction with a manager’s opinion to ensure all staff receive the appropriate training for their job role.

The structure of the training package

There are five modules. We suggest modules are completed as follows:

	Module 1	Module 2	Module 3	Module 4	Module 5
Tier 1 staff	✓	✓			
Tier 2 staff	✓	✓	✓	✓	
Tier 3 staff	✓	✓	✓	✓	✓

It is suggested that each module will take approximately one hour to complete. Tier 1 staff undertake two hours of training; tier 2 staff undertake four hours of training and it should take tier 3 staff five hours to complete the training package.

Note – modules 1 and 2 are very basic for tier 2 and 3 staff, and these two modules will probably be completed in less than two hours. This will allow the tier 2 and 3 learner to spend longer on modules 3 and 4.

The aims of the modules

Module 1: To understand the importance of psycho-social care and to review the member of staff's role in the provision of this support for burns patients;

Module 2: To recognise and show an understanding of a patient's physical, psychological and social needs;

Module 3: To continue to explore the impact of burn injuries on the patient as well as the patient's family, friends and significant others;

Module 4: To investigate the factors that predict good psycho-social outcome and the role of the health care professional in facilitating this;

Module 5: To explore other factors that predict or hinder psycho-social outcome and to discuss the role of psychological therapies, and other providers offering patient and family support.

How to conduct the training

The training has been developed to offer maximum flexibility of delivery. It can be offered to a multi-disciplinary or uni-disciplinary group, and modules 1 and 2 can be covered as a cross tier group if thought to be appropriate.

Suggestions for delivery:

- *During the resource pilot, the learning experiences and benefits achieved by those learners undertaking the training as a group were found to be significantly greater and more positive than the gains from those undertaking the training individually (self-directed).*
- *It is therefore recommended that where possible the training is offered in multi-disciplinary group format. This offers more opportunity for reflection and discussion, and learners will gain maximum benefit from the exercises in this way.*
- *If learners are given a booklet to complete by themselves then it is recommended that a mentor or a trainer supports them to supplement their self-directed learning.*
- *Tier 1 learners may not be used to self-directed study and therefore consideration should be given as to how the training is conducted and followed up with this group of staff.*

What you will find in your trainer package

- *One copy of the trainer manuals for tiers 1, 2 and 3; all trainer manuals contain recommended learner responses and additional 'points for discussion';*
- *Copies of the student manuals for each tier which can be photocopied;*
- *A CD with PowerPoint slides which can be used to supplement the student booklets. You are able to put these slides onto your own organisation's PowerPoint template;*
- *The CD also contains electronic copies of all the manuals, from which you are able to print the whole manual, or selected sections;*
- *A DVD with video clips to supplement the training.*

Using the package effectively

Each module is designed to be worked through systematically. The training package is designed to meet a range of learning styles and therefore includes a variety of materials.

Throughout the course the learner will have the opportunity to participate in reflection, a discussion of case studies and will be able to consolidate theoretical information. References are provided throughout the modules to provide further information on the topics covered.

Throughout the manuals you will see the following symbols:



Key information

These sections provide a discussion of some of the key theoretical information and knowledge relating to the key aims of the module. These sections can be taught with the aid of the PowerPoint slides.



Case study

These sections introduce a patient scenario. Each one is usually followed by some questions or a structured discussion on the issues raised. You can replace the case studies with your own if this is thought to be more appropriate.



Task

These are tasks designed to encourage thinking and learning around the main teaching points. Optimal learning is achieved through active participation in these tasks.



Reflection

Students are asked to reflect on their own experiences and patients they have worked with to encourage integration of their learning into their work. Although all reflection can be undertaken individually, learners will gain more from sharing experiences.



Further reading

Further information such as journal articles, books and web links are given here.



Task

Who else is involved in Kev's care and the care of his family and friends? You may want to draw a diagram of your service, or write down the other professionals or members of the multi-disciplinary team with whom you work on a day-to-day basis.

They should show a basic awareness of other professionals involved in Kev's care. This should include the main medical staff and the wider multi-disciplinary team such as physiotherapists, health care assistants and occupational therapists (as appropriate). They may need help to identify other staff as being important in Kev's care such as volunteers and chaplains.

The learner may be able to detail wider services such as outside agencies and voluntary groups, patient support networks etc.

What is psycho-social care? (PowerPoint 1)



Key information

Psycho-social care can include supporting patients with their emotions, feelings and behaviours and in addition, helping them to communicate with others. Many patients also require support and reassurance with other areas of their personal and social life; this may also include meeting the needs of their family and friends.

Burns injuries, especially if they are severe, can be a life changing experience and may involve a long stay in hospital and further treatment after discharge. Patients will often need help and specialist support to develop new strategies to cope with the effects of their injuries. This can include helping them with the effects of trauma, a changed appearance or scarring, and adapting to physical limitations. Without such support people may develop long term psychological and social difficulties, such as becoming withdrawn from society, struggling in school and work and not feeling able to live a full and happy life. The term 'quality of life' is used to reflect how much a person's physical, psychological and social needs contribute to their ability to enjoy their life. The more difficulties they have, the lower their quality of life is likely to be. Meeting a patient's needs and helping them to help themselves will improve their quality of life. For the purpose of this manual we will use the acronym SPEMS to describe the areas of a patient's life where they may need psycho-social support.

SPEMS



ocial

Interacting and successfully communicating with family, friends, colleagues and other members of society. Participating in daily life activities and social occasions, such as going to the supermarket, meeting friends, or attending a social group or class.



hysical

Includes needs such as eating, sleeping, drinking, exercising, washing, dressing etc. May be a rapid change from being totally independent to needing help with simple tasks.



otional

These needs may be easier to recognise. Expression of sadness, anger, loneliness, anxiety, depression, confusion and others. Some may report positive feelings such as being 'happy to be alive'.



ind

May seem slowed down or less sharp if someone cannot attend school or work for a long period of time. May worry more, e.g. about money if they are unable to work, or if they need to support others. Hobbies and routines may be difficult to stick to when hospitalised for any length of time. Keeping your mind active is important for quality of life.



piritual

May question their religion or beliefs or seek comfort from them. They may not be religious, but may still have questions such as 'Why me?' or in the case of a parent 'Why not me?' They feel they are being 'punished' in some way.

Physical and psycho-social care should both be included and incorporated into the patient's care. Effective, holistic care will take into account all these needs for all patients. From admission, throughout their hospital stay, on discharge and through community follow-up, these needs should be assessed, acknowledged and met as effectively as possible.



Reflection

Looking back at our case study, reflect on and list Kev's SPEMS needs.

The learner should be encouraged to complete this section in their own time or as part of the session if time allows. They may already keep a reflective journal as part of their practice.



Task

The patient journey describes the process a patient will take from the initial trauma and injuries, throughout their time in a hospital setting to being discharged home. During this journey they will meet many professionals, both clinical and non-clinical in a variety of different settings. Using the box below, write or draw the key stages of Kev's patient journey before and after he reaches you on your ward. Or, you could think about a recent patient who has been on your ward and map their journey instead.

May involve transportation to hospital, A&E, intensive care, admission to the burns service, surgery, referral, and discharge. Try to encourage the learners to have six or more steps.



Task

Burns injuries are very sudden and may involve a long time in hospital and cause great disruption to a patient's life.

If you or someone you know received a burn injury and ended up in hospital, think about and write down how you/they might feel at each of these points below.

The time of the accident

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Being admitted to the ward and meeting all the staff

Two horizontal dashed lines for writing.

Seeing the doctor to discuss your treatment for the first time

Two horizontal dashed lines for writing.

Seeing your friends and family for the first time at visiting time

Here we are looking for brief answers. This section should help the student to realise that there will be a range of emotions experienced, and these emotions may change with new events. Ideally this section should encourage students to think about how they would feel if they were in the patient's shoes.

Module 2 **Recognising patient needs**

Aim: to recognise and show an understanding of patients’ physical, psychological and social needs.



Case study 2 – Shane

Shane has been admitted to the burns service. He is 32 years old and has a wife and two children aged 6 and 8. He had an accident at work and it is likely that he will spend at least a couple of weeks on the ward. Shane's injuries will probably leave scarring to his hands, arms and upper body. Shane usually works long hours to support his family, as they are very important to him. In his spare time he takes an active role in managing the local Sunday league football team.



Task

Using your knowledge from module 1, identify and write down Shane's SPEMS needs.

This isn't designed to be an exhaustive list but will give some indication of what the learner sees as Shane's main needs. Tier 1 learners should be able to list a couple of points in each category.

Social: examples like – interacting with his children, wife, local football team, employers, colleagues, reintegrating back into society.

Physical: unable to use his hands – difficulty in eating, dressing, washing, and writing. Pain and discomfort, possible difficulties when returning home – intimate relationships, appearance of scars, being able to play/demonstrate football skills, being less active.

Emotional: examples like – sad, upset, anxious, angry, vulnerable, worried, uncertain.

Mind: being out of work for a long time, interacting with his family, participating in hobbies, his own needs with regards to his treatment options, and understanding the hospital setting. May also revolve around financial issues and worries.

Spiritual: there may be questions such as “Why me?”, “What did I do to deserve this?”, or feeling lucky to be alive. Shane may seek answers in religion or through other means; although we don't know anything about Shane's faith, it may be important to him. New dependence on family and friends may challenge his own ideals of life.

Shane and society

Shane will have feelings about himself. They may surround the trauma of the injuries, how he will cope, the way he looks, returning home and so on. However, Shane's family, friends, colleagues and other people he doesn't know will also have thoughts, feelings and beliefs about Shane. This section will explore some of these issues.



Task

Sometimes feelings can lead us to behave in particular ways. Think of another three potential feelings or behaviours Shane might have, and three feelings or behaviours society might have and add them to the box below.



Shane's feelings/behaviours	Society's feelings/behaviours
scared for himself	embarrassed – they don't know what to say
useless – he won't visit his colleagues at work	distressed
depressed	pity
anxious	they may stare and look
withdrawal – he won't go out with his friends anymore	strangers ask difficult questions
anger	shock
uncertain	intrigued
embarrassed	sympathetic
(and others)	(and others)



Task

Have a look at the situations below. These are some of the things Shane might want to do once he is discharged from hospital. What may be some of the issues that could arise in these situations? Discuss these in your group. How might Shane behave or feel? How might his friends and acquaintances behave or feel?

Leaving the hospital and going home for the first time

Leaving the safety net of the hospital – where other people may understand/have similar injuries, worries and concerns as him.
Having to return to independence, or have to rely on people to do things for him / change of roles from being the breadwinner, working 9-5 and so on.

Going to the pub to meet up with his friends for a Friday evening drink

May worry about people staring, comments, pity and unwelcome interactions with others.
Anxieties around returning to his usual activities, 'looking different', being with friends and other people who knew him before the accident. However, his friends may be really happy to see him, or could be quite overprotective.

Going back to manage the local Sunday football team

People making presumptions about his ability to cope, not being able to be the person he was before and therefore frustrated. May be a welcome relief as a return to some level of normality. Interacting with others, people who knew him 'before'.

Going to wait at the school gates for his children

People staring, whispering, pity, comments, parents acting differently to before/embarrassed. Not wanting to scare children, children asking outright questions to parents or himself, worried about other people's reactions.

Doing the washing up

May have concerns with bandages, scarring, and possibly pain. This may not yet be a task that Shane can accomplish, which may be upsetting. He may not feel like he is able to contribute to daily household tasks.

Returning to work

Unable to return to his normal position in the company due to injuries, returning after significant time off, scared as he had his accident at work, this may bring back difficult emotions. What will his colleagues think?



Communicating with patients (PowerPoint 2)

Communication

There are two main types of communication: verbal (speech) and non-verbal (body language). These two forms of communication go hand in hand. When we communicate, the majority of the messages we send to others come through our body language. This might be our posture, the way we are holding our hands and arms, eye contact and our facial expression. The other important part of communication is the 'way' we say our words, for example if we said "do you want a cup of tea?" angrily, then it wouldn't sound welcoming or caring. The words that are spoken are actually thought to be the least important when sending a message. If a carer had their arms crossed, and wouldn't look the patient in the eye, there is little chance of having a successful relaxed conversation. The most approachable carer would have a relaxed body posture, maintain good, natural, eye contact, smile and have their hands in a relaxed position by their side.

Top tip

- Think before you speak; also think about what your body is saying as well as your words.

Communication in a health care setting

For many patients and their families, the hospital environment can be a distressing and daunting place. As we have seen from module 1, patients will meet many professionals in clinical and non-clinical roles during their stay at a burns service. At times, patients may experience a lack of control, lack of dignity and understanding. We know that loss of control, unfamiliarity and high levels of unpredictability all contribute to high levels of stress. This may be accompanied by feelings of distress, pain and other complications

due to their injuries. Patients can therefore feel vulnerable during a long stay in hospital. For this reason it is very important to communicate sympathetically with the patient. This gives the opportunity to reassure them, and allow them to express their feelings and worries if they wish to.

Top tip

- Hospitals are daunting and distressing places for patients and their families. If you are meeting them for the first time always remember to introduce yourself (preferably with a smile) and say what you are there to do.

Normalising feelings

As we have seen throughout modules 1 and 2, patients, their friends and families may experience a variety of feelings and emotions throughout their time in hospital. Any patient who has experienced the trauma of burn injuries is likely to experience a whole range of unfamiliar or even overwhelming emotions. This is usually perfectly normal and understandable. It is important that the patient and staff understand and acknowledge this. A patient may also try to hide their feelings or suppress their emotions and some will try to 'be brave' or 'hold it together' for the sake of their family. As a member of the multi-disciplinary team it is very important that you help the patient to recognise that expressing their feelings is OK.

Top tip

- It can really help a patient if you tell them how they are feeling is normal.



Task

Even if you are in a role at the hospital where you don't contribute to patient care directly, or if you are busy and don't have a lot of time, you can still help to normalise a patient's feelings. Have a look at the two scenarios below with answers, and then attempt to answer the next two.

- 1 Patient** "I just feel so sad and depressed; life will never be the same again."
You "I can hear how upset you are; have you thought about talking it through with someone?"
- 2 You** "How are you feeling today?"
Patient "I don't want to bother you with how I'm feeling, you don't want to know."
You "It is alright to feel bad sometimes, you have been through a lot; have you thought about talking to someone about how you are feeling?"

What might you say if...

- 3 Patient** "I want a cup of tea now." (said angrily)
You

- 4 Patient** "Don't draw back my curtains today; I want to sit in the dark."
You

These answers should be appropriate to the learner’s job role and what they are comfortable with saying. However, we want to encourage them to think about what they would say, and how they would say it (including tone of voice), for example staying calm with the angry patient.

Working with different cultures

In your unit you are likely to meet staff and patients from many different cultures and faiths, who respond differently to illness. Some cultures express their emotions very openly and some will be much more reluctant. Some patients will have large extended families and expect lots of visitors, and some will want to be more private. The same will apply to staff members that you work with. They too may have different ways of talking about things and doing things.

Some people form opinions about others on the basis of what they look like or what they wear. Often these conclusions can be incorrect and we must be careful not to stereotype people before we know anything about them. Many of your patients may have very different ways of doing things at home compared to the hospital. They may also not like the ways and routines of the hospital as they are strange and different.

If you are uncertain about what would be best for a patient, then ask. Generally people don’t mind being asked. You may not be able to change something but it does show that you care and are interested.

Top tips

- Try not to make assumptions about the way people are used to doing things, or about how they are. The reality may be very different to what you see.
- Try to treat everybody as an individual and with respect.

Practicalities and logistics

When patients are admitted to the hospital they will be in a strange and unfamiliar environment. They will probably not have much control over their life as many things, such as waking up, meal times and visiting hours will be dominated by the hospital routine. Patients may have many questions about their new environment and it is important to know the answers to give them.



Task

What practical things are there in your hospital that patients should know about?

For example they may want to know about meal times, visiting hours, who is who, travel (for family wishing to visit), where the hospital shop is, parking regulations and so on.

If you do not know the answers to these questions please try to make time to find out, so you can help a patient and their family if they need this information.



Reflection

Think of a patient on the ward now, or who has been there in the past. How well were you able to meet their needs? Could you have done anything else?

The learner should be encouraged to complete this section in their own time or as part of the session if time allows.



Looking after yourself

Working on a burns unit can be tough. It can be difficult seeing people every day who have been severely injured, in pain or distressed. You may see patients who remind you of someone you know, and this can make you think that something awful could happen to them too. This can be hard as it may make you feel sad or angry. Sometimes you may even feel quite shocked. If this happens, it is important that you seek support from your manager straight away.

Top tips

- Make sure you switch off from work when you are off duty. Try to do something you enjoy that will help you unwind.
- Try not to take it personally if someone gets angry or upset with you. Remember they are probably angry with their situation, not you.
- Notice how you are generally. Have a chat with a manager or a colleague if you feel you are getting short tempered, irritated or not your 'usual self'. Has there been anything particularly upsetting at work that may be causing this?
- It is OK to feel sad. Sometimes staff too can get tearful. This is not a sign of weakness but a normal reaction. We are all human and cannot always switch off our feelings.



Further reading and links

Clarke A (1999) **Managing the future after burns, Addressing Psycho-social Needs, a guide for health professionals.** Changing Faces.

Partridge J, and Robinson E (1995) **Psychological and Social Aspects of Burns.** *Burns*, 21(6), 453-457.

Partridge J (2006) **From burns unit to boardroom.** *British Medical Journal*, 332, 956-959.

Rumsey N, Clarke A, and Musa M (2002) **Altered body image: the psychosocial needs of patients.** *British Journal of Community Nursing*, 7(11), 563-566.

Rumsey N, Clarke A, and White P (2003) **Exploring the psychosocial concerns of outpatients with disfiguring conditions.** *Journal of Wound Care*, 12(7), 247-252.

British Burn Association: www.britishburnassociation.org

Changing Faces: www.changingfaces.org.uk

National Burn Care Group Standards for Psycho-social Care and Rehabilitation, 2008

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London and South East
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