Anxiety in Critical Care

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Anxiety in critical care- a background

- *Local Background/National Context*
- *Royal Marsden NHS Foundation Trust*
- *Oncology*
- *Critical Care*
- *Oncology Critical Care*
- *Patient Demographics*

Patient Demographics

- *Mean Apache II +/- SD-13.28 +/- 5.1*
- *60 elective admissions monthly*
- *LOS 5.6 days.*
- *Age 18-83 years*
- *All have a cancer diagnosis*

- *NICE 2004*

“ Trusts need to be fully compliant in providing an holistic assessment of a patients supportive care needs at key points in their journey”

(Improving Supportive and Palliative Care for Adults with Cancer)

Cancer

- *Many people admitted electively into an ICU/HDU have a cancer diagnosis*
- *Many have consented to major complex surgery*
- *Surgery most effective method of establishing cure- 60% of people with cancer are cured (Poston, 2007)*
- *People with cancer have a much higher level of anxiety and depression (Bergquist et al 2007).*

Cancer

- *People with cancer undergoing surgery may be burdened with several types of extreme stress (Matsushita et al, 2005)*
- *An admission to ICU adds to that overall stress load (Cochrane, 1984)*
- *Patients with a high levels of symptoms are more likely to have poorer psychological outcomes (DOH,2002)*
- *Distress is not often recognized as such by oncology professionals (Bauwens et al, 2008)*

Cancer- Anxiety- Elective- ITU

- *Anticipation*
- *Disease progression*
- *Surgery attempted/successful- histology*
- *Profound and further assaults on body image*
- *Pain*
- *Loss of independence*
- *Poor pre operative performance status*
- *Fear of dying- future treatments*
- *Procedures- sedation holds*
- *Risks of complications*
- *Noise/sleeplessness*
- *Not understanding the surrounding technology-witness*
- *Loss of personhood/status/voice*

Anxiety

- *Certain characteristics that make certain people with cancer more susceptible*

Gender

Age

History of anxiety and depression

Fatigue

Tumour type

Disease progression

ICU Anxiety

- *Majority of surgical patients are admitted to critical care facilities electively*
- *47% of patients in critical care have clinically significant anxiety levels (Scragg et al, 2001, O'Brian, et al 2001)*
- *2/3s of critical care patients who survive critical care experience psychological and work – related problems (The Audit Commission,1999)*

Anxiety ….so what is it?

- *"A state of uneasiness or tension"(Collins dictionary, 2000)*
- *"Unpleasant emotional disturbance of a psychological, social and or spiritual nature which may interfere with the ability to cope effectively" (National Comprehensive Cancer Network, Holland et al 2007)*
- *"Uncomfortable, subjective phenomenon, which precedes objectively detectable signs and behaviour" (Frazier at al, 2002)*

Anxiety in ICU

- *Under-reporting of anxiety*
- *Mismatch of clinicians perception and patients self-rating (much higher)* *(O'Brian et al, 2001)*
- *Lack of specificity in assessment*
- *Anxiety can rapidly escalate into severe delirium* *(Dyson, 1999)*
- *Increase morbidity/ mortality/LOS*
- *Identify and manage anxiety.*

Anxiety

- *The desire to improve anxiety management*
- *Humanitarian perspective*
- *Drive for quality care*
- *It could become a quality outcome and mandatory indicator*
- *Beware of premature reassurance*

Anxiety Management in our unit……

- *“she was amazing- caring, gentle and so, so kind. I cannot thank her enough”.*
- *“I was not feeling good emotionally. The first night was very difficult and I needed much more emotional help. Felt very alone and frightened”.*
- *“Apart from the claustrophobic timeless mess it offers medical and nursing care at its true best”*

Assessment of Anxiety

- *HADS/ State Trait theory*
- *Long and complex although validated and effective tools*
- ***Distress thermometer***
- *Assesses level of distress*
- *Problems list where people can indicate their reason for distress.*
- *Helps the person identify their focus for distress*
- ***Assessment = Management***

Equipping staff to manage anxiety

- *Acknowledging anxiety*
- *Opening a dialogue with patients*
- *Limit assumptions*
- *Help patients with mild anxiety/often its about lack of information*
- *Develop staff skills in basic relaxation/ CBT*
- *Consider pharmacology*
- *Consider referral to specialists*

Introducing the Distress Thermometer

- *Met with key people*
- *LP psychological care*
- *Nurse Consultant in rehabilitation*
- *Matron for pre assessment*
- *Sent an email to recruit staff*
- *Study afternoon*
- *Anxiety training*

Who Why How

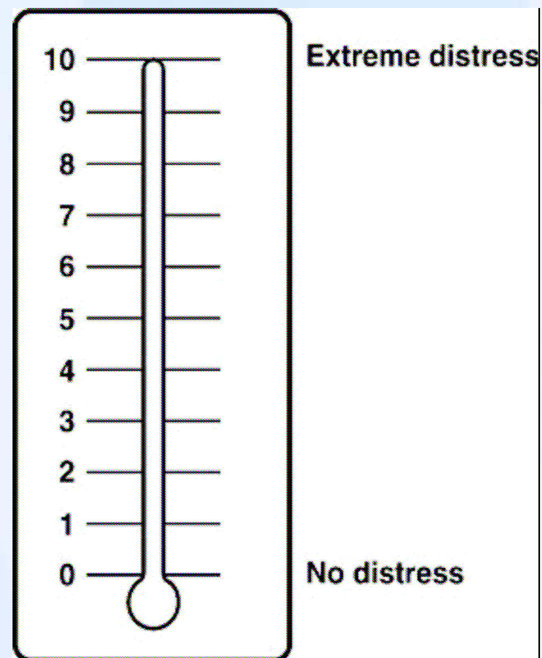
- *Pilot*
- *Introduce tool at pre assessment*
- *Level 2 –alert and non delirious patients following a Whipples procedure*
- *In the unit 4-5 days*
- *Ensure pain is well controlled <4*
- *Only those nurses in group would participate in measuring and managing distress alongside the nurse working with the patient*

Distress Thermometer

- *An 11 point scale*
- *0 = no distress*
- *10 = extreme distress*

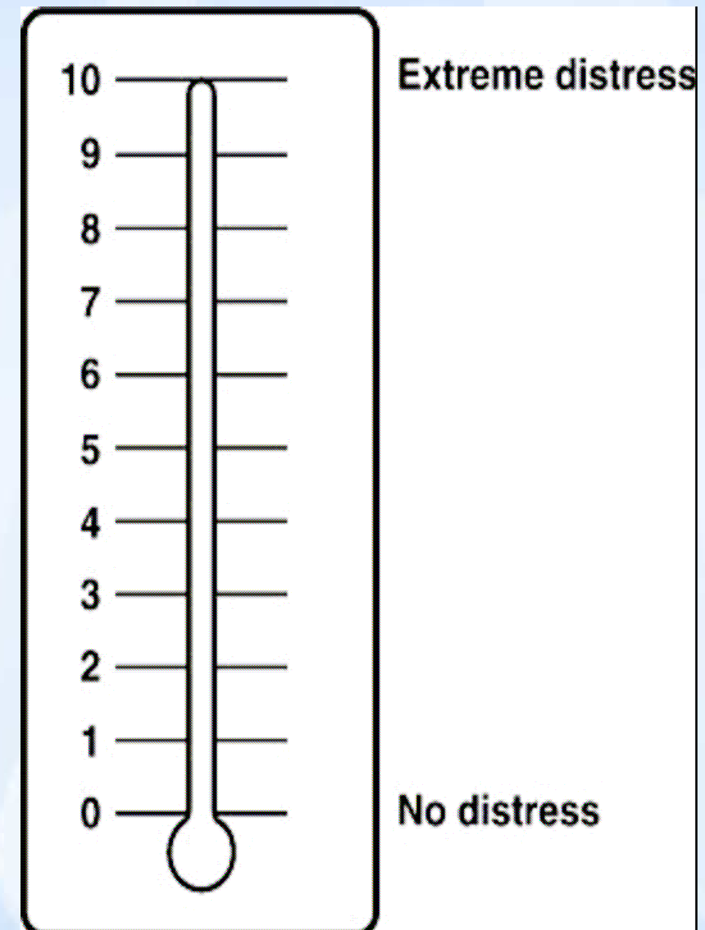
- *Used in conjunction with a 31 patient problem list.*

Distress Thermometer



Distress Thermometer

- **Yes/ No Practical Problems**
- O O Housing
- O O Work/school O O Transportation
- O O Child care
- **Physical Problems**
- O O Diarrhea O O Nausea
  O Fatigue
- O O Sleep O O Getting around
- O O Constipation O O Changes in urination
- O O Fevers O O Skin dry/itchy
- O O Nose dry/congested O O Feeling swollen
- O O Sexual O O Breathing
- O O Eating O O Indigestion
- O O Mouth sores O O Pain
- O O Tingling in hands/feet
- O O Bathing/dressing
- **Family Problems**
- O O Dealing with partner O O Dealing with children
- **Emotional Problems**
- O O Worry O O Fears
- O O Sadness O O Depression
- O O Nervousness
- **Spiritual/Religious Concerns**
- O O Relating to God O O Loss of Faith



Distress Thermometer

- *Compares favorably with the HADS and the BSI-18 as a method of screening for distress in ambulatory cancer patients (Gessler et-al 2005, Jacobson et-al 2005).*

- *Provides a suitable level of psychological assessment.*

- *A score above 4-5 indicates symptoms in need of intervention.*
- *Valid for a UK population (Gessler et-al 2008).*

- *The DT is an initial screen and is aimed to open up discussion between the health professional and the patient.*
- *'Immediate referral to psychological or other tertiary services, particularly for those who score just above threshold, should be avoided without multidisciplinary discussion' (Gessler et al 2008).*

- *Acknowledge the level of distress and if over 4 establish via the patient problem list what the nature of the problem is and how you can support the patient to improve their level of distress.*

- *Ultimately it will mean engagement with the nature of peoples fears.*
- *Before we engage with cognitive interventions we initially just need to give people the opportunity to express how they feel and why.*

- *Showing understanding of this summarising what people have told us and showing empathy can frequently be sufficient and = level 1-2 support…*

- *What would be an acceptable level of distress for them?*
- *What would they settle for?*
- *How would they like their current level of distress to be managed?*
- *Initial empathic and explorative / clarifying conversations (listening) remain the priority in nearly all cases*

- *Teaching sessions and presentations September – capture staff*
- *Start September 18th*
- *Evaluate*
- *Patient questionnaire*
- *Nurse questionnaire*
- *Evaluation*
- *Role out to more patients*

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