Most nurses agree that incorporating evidence into practice is necessary to provide quality care, but barriers such as time, resources, and knowledge often interfere with the actual implementation of practice change. Published practice guidelines are one source to direct practice; this article focuses on the use of the National Comprehensive Cancer Network’s Clinical Practice Guidelines for Oncology: Distress Management, which articulate standards and demonstrate assessment for psychosocial distress. Planning for the implementation of the guidelines in a feasibility pilot in a busy radiation oncology clinic is described. Results indicate that adding a distress assessment using the distress thermometer and problem checklist did not present substantial burden to nurses in the clinic or overwhelm the mental health, pastoral care, or oncology social work referral sources with more patients. Understanding distress scores and problems identified by patients helped the nurses direct education interventions and referrals appropriately; improved patient satisfaction scores reflected this.

Distress Assessment:
Practice Change Through Guideline Implementation

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Distress is an unpleasant experience of an emotional, psychological, social, or spiritual nature that interferes with people’s ability to cope (National Comprehensive Cancer Network [NCCN], 2007, p. DIS-2). Oncology nurses are not surprised that distress is a phenomenon common to patients with cancer (Madden, 2006). An estimated 29.6%–43.4% of patients with cancer experience distress (Zabora, Brintzenhofeszoc, Curbow, Hooker, & Piantadosi, 2001). As cancer services move to a predominately ambulatory environment, the need for better psychological assessment is critical, yet less than 5% of distressed patients in the ambulatory setting receive psychosocial treatment (Bultz & Holland, 2006). Screening for distress often may be overlooked because healthcare professionals focus on physical symptoms; however, distress can impact the symptom experience and compliance with prescribed treatment (Clark, 2001). For that reason, NCCN included a standard that “[a]ll patients should be screened for distress at their initial visit, at appropriate intervals, and as clinically indicated, especially with changes in disease status” (p. DIS-3). This article will describe the process used by one institution to implement NCCN’s Clinical Practice Guidelines for Oncology: Distress Management in a clinic setting.

Planning for Implementation

Nurses have joined other professionals in the challenge to deliver evidence-based practice; one way to accomplish this is by using clinical practice guidelines. Guidelines follow a review of the evidence, are created by experts, and serve to direct practice. However, even when guidelines have been widely publicized, they often are not fully implemented in the clinical setting because existing barriers impede the process.

At a Glance

- Oncology nurses do not consistently use a standard when assessing for psychosocial issues in patients with cancer.
- The distress thermometer and problem checklist are efficient assessment tools that can be incorporated into normal practice.
- Nurses in a busy oncology radiation clinic were able to assess distress, provide educational and referral resources, and increase patient satisfaction through planned implementation of an assessment and intervention process.

Key barriers identified by nurses include the perception that nurses have insufficient authority to instigate change in the practice setting (Glacken & Chaney, 2004) and insufficient time to implement and read research (Funk, Tornquist, & Champagne, 1995; Glacken & Chaney). Other barriers include a lack of resources and awareness. After deciding that the Clinical Practice Guidelines in Oncology: Distress Management (NCCN, 2007) represented a value consistent with the center’s mission, a multidisciplinary task force set out to compare existing psychosocial services with those recommended in the standards. Consistent
screening of all patients with cancer was an identified gap, so a process was initiated to implement the assessment standard. According to Grol (2001), a diagnostic analysis that identifies stakeholders and interested parties as well as subgroups experiencing the most problems with practice change must take place for successful implementation to occur (see Figure 1). Similarly, Gillespie (2005) challenged nurses to build a toolkit to implement NCCN guidelines for supportive care. See Figure 2 for implementation strategies.

Stricker and Sullivan (2003) emphasized the use of principles-of-change theory to guide implementation efforts. Along with identifying stakeholders, expected outcomes, and relevance of the proposed change, they recommended cost determination for implementation and maintenance of the change. Other recommendations included building the change into the normal structure whenever possible and pilot testing before widespread use (Grol, 2001).

**National Comprehensive Cancer Network Distress Thermometer and Problem Checklist**

In preparing for the pilot, a distress screening tool had to be selected; benchmarking with other institutions aided in the decision. Several tools were considered in terms of ease of patient and nurse use, cost, and length of tool. The distress thermometer (DT) was selected for the pilot because it is short, simple to use, and easy and quick to assess. The DT is a self-report measure using an 11-point scale from 0 (no distress) to 10 (extreme distress). On the same page is an associated problem checklist, which asks whether the indicated level of distress is related to practical, family, emotional, spiritual or religious, or physical concerns (see Figure 3). Initially, the intervention for scores of 4 or less (i.e., mild or moderate distress) included offering patients educational materials. The intervention for scores of 5 or greater (i.e., moderate or severe distress) included referral to a mental health professional. Since the pilot, a multicenter evaluation comparing DT with longer-established measures (e.g., Hospital Anxiety and Depression Scale, Brief Symptom Inventory-18) showed that a score of 4 or greater is a more sensitive determination of distress (Jacobsen et al., 2005). Therefore, scores of 4 or greater now are considered moderate distress and referral is offered.

**Pilot Planning**

A feasibility pilot was requested by administration and designed by advanced practice nurses in conjunction with the staff.

- Who is interested in implementation?
- Who is involved in implementation?
- Who are the stakeholders?
- Which aspects of care should be addressed?
- Which recommendations are not followed?
- Which subgroups experience problems with changing practice?

**Figure 1. Diagnostic Analysis for Successful Implementation of Practice Guidelines**

Note. Based on information from Grol, 2001.

**Figure 2. How to Implement National Comprehensive Cancer Network Guidelines for Supportive Care**


Of the selected practice setting. Planning for the pilot was guided by Oncology Nursing Society (n.d.) application to practice recommendations, which include identifying the setting for the practice change to be implemented, identifying the process and any revisions needed, determining whether approval is needed and by whom, identifying barriers and bridges, and creating a time frame for staff education. Institutional review board approval was not sought, as consultation with the hospital’s compliance officer determined that the project was consistent with the goal of performance improvement rather than research. The outcomes sought did not require patient identifiers. The radiation oncology clinic was selected for the pilot for several reasons. The number of nurses involved was small enough to make communication manageable, the manager was enthusiastic and supportive, and the staff had participated in research previously and appreciated the importance of the psychosocial aspects of their patients’ care. Still, adding anything new to the workday of busy nurses necessitates careful planning to achieve staff support.

Selecting interventions for patients indicating distress or problems was another task. Again, the researchers wanted to provide information to educate patients and families about coping and symptom management but were restricted to time constraints of busy clinic nurses and patients eager to get their treatment and leave. A patient empowerment model was selected in which a resource booklet was created in a format consistent with the problem checklist. Available educational materials were listed, including Web site addresses. A phone number for the patient education department also was listed for patients without computer access. Nurses then could take the problem checklist and mark on the resource directory the corresponding education materials available; patients or family members could access them at their convenience. Support group information also was included. Patients rating 5 or greater on the DT were offered a referral to a mental health professional associated with the cancer center; either an oncology social worker or counselor was available by appointment. Pastoral care was offered for patients reporting spiritual distress.

Six months prior to implementing the pilot, a meeting was held with the staff and manager of the radiation oncology clinic. Advanced practice nurses reviewed the pilot project with the staff and facilitated a discussion about how the pilot would be
Operationalized in the clinic. The nurses proposed that the definition of distress appear on the tool itself and requested a space to document patient referrals and educational materials provided; these changes were added. The nurses also wanted the DT and problem checklist to be completed during the weekly treatment check so that patients would not have to wait an additional day to see a healthcare provider. The timing allowed the assessment to be built into the normal clinical structure for patients and nurses. A follow-up meeting was held one month after the project to determine any patient’s care or treatment. The National Comprehensive Cancer Network makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way. These guidelines are copyrighted by the National Comprehensive Cancer Network. All rights reserved. These guidelines and illustrations herein may not be reproduced in any form for any purpose without the express written permission of the NCCN.

A total of 57 adult patients completed the DT during the pilot: 31 females and 26 males. Disease sites included brain, breast, head and neck, lung, gastrointestinal, genitourinary, gynecologic, and lymphoma. A paraphrase of NCCN’s (2007) definition of distress, “an unpleasant experience of an emotional, psychological, social, or spiritual nature that interferes with the ability to cope with your treatment” (p. DIS-2) was printed on the tool to assist in distress rating. Based on the DT, initial distress scores ranged from 0–10, with a mean score of 2.2. Eight patients had an increase in their distress score over the course of their treatment. The nurse then reviewed the DT and intervened based on established guidelines. The nurse also shared any concerns checked from the problem checklist with the physician. Patients completed one to six weekly screenings depending on the length of their course of treatment. Pilot planning also included a list of questions to be answered through the project (see Figure 4).

**Results**

A total of 57 adult patients completed the DT during the pilot.
treatment and 11 patients had a decrease; all other patients with more than one assessment remained the same. Of the potential 35 problems listed, 14 patients identified practical, family, emotional, or spiritual concerns; in these 14 areas, the mean score was 2. The remaining 21 areas addressed physical problems; in these concerns the mean score was 4. The total number of problems identified over the course of participation (see Table 1) indicates that insurance/financial leads practical problems, and worry leads emotional problems. From a physical standpoint, fatigue and skin dry/itchy were the two most commonly reported symptoms, which would be expected in the radiation population. Overall, patients were receptive to completing the tool and some noted that the experience was the first time they were asked about a number of the issues.

Social work referrals during the three-month period increased by nine, and referrals to support counselors for patients with cancer increased minimally. No method existed to differentiate patients referred from the pilot versus self- or other referral; however, a minimal increase in mental health referrals was clear, and counselors’ workloads were not stressed—a concern that had been posed. Chaplain referrals during the three-month period increased by one.

In reviewing Press Ganey patient satisfaction data, the question, “How satisfied are you with our sensitivity to your needs” increased from 88.1% the quarter prior to implementation to 92.6% during the quarter the pilot was conducted. Patient satisfaction scores have continued to be higher than preimplementation (see Figure 5).

A follow-up meeting was held with the nursing staff after the pilot concluded. At the meeting, staff were thanked for their efforts and the preliminary data, tool burden, and tool benefit were reviewed. The staff confirmed that the DT and problem checklist were easy to use, helpful in identifying concerns, opened up dialogue regarding issues that otherwise may not be assessed, and had a well-defined referral process. One nurse stated the following.

I was caring for a woman who received chemotherapy prior to radiation for her breast cancer, and she checked under the physical section, sexual. When I spoke with her about this concern, she was complaining of vaginal dryness, and I was able to provide her with effective symptom management strategies. This symptom is not something I would have normally assessed for in this patient receiving radiation.

The nurses agreed that the benefit outweighed the burden of the assessment but felt that weekly use of the DT and problem checklist was too frequent for their workloads and sustained patient interest.

### Postpilot Implementation

After the data were finalized and nursing input was gathered, another staff meeting was held to discuss the next steps for distress assessment. The nurses decided that they would like to continue to use the DT and problem checklist in practice with all patients. Their preference was to implement them the first week of treatment and then again during the fifth week of treatment. The practice has been successful for 18 months following the pilot, although chart audits did demonstrate inconsistent use of the DT. Further follow-up with the nurses revealed some discomfort discussing emotional concerns, so educational sessions to assist nurses in discussing sexual and emotional issues are ongoing.

Recently, the Oncology Customer Satisfaction Committee divided into four teams, with one of the teams focusing on distress assessment and management. In response to the successful implementation and outcomes in one clinic, the committee is charged with assessing the current level of screening in all the oncology clinics and developing a standardized process for screening and a consistent process for referral to oncology counselors and social workers.

### Table 1. Problems Noted on the National Comprehensive Cancer Network Problem Checklist

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Practical</strong></td>
<td></td>
</tr>
<tr>
<td>Insurance/financial</td>
<td>27</td>
</tr>
<tr>
<td>Work/school</td>
<td>14</td>
</tr>
<tr>
<td>Transportation</td>
<td>7</td>
</tr>
<tr>
<td>Housing</td>
<td>5</td>
</tr>
<tr>
<td>Child care</td>
<td>3</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>Dealing with partner</td>
<td>14</td>
</tr>
<tr>
<td>Dealing with children</td>
<td>12</td>
</tr>
<tr>
<td><strong>Emotional</strong></td>
<td></td>
</tr>
<tr>
<td>Worry</td>
<td>60</td>
</tr>
<tr>
<td>Nervousness</td>
<td>36</td>
</tr>
<tr>
<td>Fears</td>
<td>34</td>
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<tr>
<td>Loss of interest in usual activities</td>
<td>26</td>
</tr>
<tr>
<td><strong>Spiritual/religious</strong></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>26</td>
</tr>
<tr>
<td>Depression</td>
<td>20</td>
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<tr>
<td><strong>Physical</strong></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td>79</td>
</tr>
<tr>
<td>Skin dry/itchy</td>
<td>48</td>
</tr>
<tr>
<td>Nausea</td>
<td>45</td>
</tr>
<tr>
<td>Pain</td>
<td>44</td>
</tr>
<tr>
<td>Sleep</td>
<td>43</td>
</tr>
<tr>
<td>Tingling hands/feet</td>
<td>37</td>
</tr>
<tr>
<td>Indigestion</td>
<td>34</td>
</tr>
</tbody>
</table>

N = 57

*Based on 165 assessments
Conclusion

This is one of the first pilot studies describing implementation of the NCCN DT and problem checklist in a radiation oncology clinic. The ease of use and referral process make the tool highly successful in clinical practice. Incorporating distress assessment into the existing practice model and providing education and support to staff regarding potentially uncomfortable communication issues are essential to successful implementation. Ongoing education and evaluation also are critical to maintaining the success of the tool in practice.

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References


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