Psychosocial Concerns in Cancer Care: The Role of the Oncology Nurse

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Oncology nurses know the importance of helping patients with cancer cope with their diagnosis and treatment. The impact of the disease and complex treatment regimens affects patients and families on many levels and often results in psychosocial concerns. The Oncology Nursing Society has been a national leader in advocating for complete care of patients with cancer, including the assessment of psychosocial concerns. New standards for accreditation of cancer facilities have brought national attention to this important element of cancer care.

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Digital Object Identifier: 10.1188/12.CJON.316-319

Communication between patients and healthcare providers is a cornerstone in the provision of high-quality cancer care (Street, Makoul, Arora, & Epstein, 2009). Communication about the psychosocial concerns of patients with cancer has gained increasing attention from national organizations, particularly since 2007. A National Cancer Institute (NCI) report by Epstein and Street (2007), Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering, highlighted the importance of communication in improving cancer care outcomes and decreasing suffering for patients with cancer. New standards for assessment of psychosocial concerns were written into the Standards for Safe Chemotherapy Administration by the American Society for Clinical Oncology (ASCO) and the Oncology Nursing Society (ONS) in 2009. In addition, ONS’s 2009–2013 Research Agenda highlights the need to design interventions that reduce negative psychosocial outcomes for patients with cancer (Berger, n.d.).

In addition to the 2007 NCI report, two national organizations have brought the psychosocial care of patients with cancer into the spotlight. The National Comprehensive Cancer Network (NCCN) has been developing and revising guidelines for distress management in people with cancer for more than 12 years (NCCN, 1999). The NCCN Distress Guidelines state that “distress should be recognized, monitored, and documented and treated promptly at all stages of the disease and in all settings” (NCCN, 2012, p. DIS-3). In 2011, the American College of Surgeons Commission on Cancer® (CoC) created a new accreditation standard for all cancer centers. Standard 3.2 requires screening for psychosocial concerns at least once during cancer care and documented guidelines for treatment or referral and documentation for all cancer centers in the United States by 2015 (CoC, 2011). Implementation of this standard will be done by the Cancer Committee at each cancer center, a committee that requires the representation of oncology nursing. Therefore, clarifying the terminology (see Figure 1), tools, and processes that lead to screening, identification, and treatment of psychosocial issues is crucial to ensuring high-quality cancer care and now mandated for accreditation at cancer centers nationally.

New Standards for Commission on Cancer Accreditation

The American College of Surgeons’ CoC (2011) is a consortium of 47 professional organizations, including ONS. Established in 1922, the CoC is dedicated to improving survival and quality of life for people facing cancer. The CoC has an Accreditation Committee of physician and nonphysician members who set standards for accreditation of facilities that provide cancer care. Accreditation is categorized by one of 12 categories based on the services provided and number of newly-diagnosed patients seen at the facility, such as Integrated Network Cancer Program, NCI-designated Comprehensive Cancer Center Program, Community Hospital Cancer Program, or Veterans Affairs Cancer Program. Accreditation is awarded in one of three categories: three years with commendation, three-year accreditation, or three-year accreditation with contingency.

Questions to Consider When Reading This Column

• How do we assess psychosocial concerns? What tools should we use?
• Who should do the assessment?
• How often?
• At what other times should patients be assessed?
• How and when do we refer patients with significant psychosocial concerns?
• How do we document assessment?
• What are the processes for follow-up care?
After two years of work, the CoC (2011) published new standards on the accreditation of facilities that provide cancer care. The 2012 version includes new standards to meet the psychosocial needs of patients for cancer-related pain, as well as palliative and hospice care. One new standard regarding the psychosocial care of patients with cancer, Standard 3.2—Psychosocial Distress Screening, is applicable to the accreditation of all categories of cancer centers. Citing an NCI report (Adler & Page, 2007), Standard 3.2 highlights the importance of screening all patients for distress and psychosocial health needs as a vital step to providing high-quality health care. The Cancer Committee at each facility or center “develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care” (CoC, 2011, p. 76). The Cancer Committee must have a psychosocial representative (i.e., oncology social worker, clinical psychologist, or other mental health professional trained in the psychosocial aspects of cancer care) to oversee activity for the standard.

Specifically, Standard 3.2 requires cancer centers to develop and implement mechanisms for screening, follow-up, and reevaluation of psychosocial concerns. Screening for psychosocial concerns must occur at least once per patient at a “pivotal” medical visit (CoC, 2011, p. 77) such as time of diagnosis, postsurgical visit, or during more routine care such as a weekly treatment check in radiation oncology, a follow-up visit in medical oncology, or a postchemotherapy visit.

However, screening also may be important at other critical times in the cancer care trajectory. The NCCN Distress Guidelines highlight periods of increased vulnerability to psychosocial distress, such as treatment failure, recurrence or progression of disease, and transition to survivorship (NCCN, 2012). Those may be times when people are at risk for greater distress and require more frequent assessment and support. Nurses, because of the extended periods of time they spend with patients, are ideally suited to direct when further assessment may be warranted. In addition, oncology nurses frequently notice changes in their patients; changes in thought, behavior, or mood may indicate the need for further assessment interventions such as referral or treatment.

The new standard also specifies referral for moderate or severe distress with appropriate documentation for follow-up care. The Cancer Committee at each cancer center may decide whether distress is measured by the NCCN guidelines or another measure for depression or anxiety and what the appropriate referral process will entail. Finally, appropriate documentation is necessary to ensure comprehensive care and follow-up.

Tools

Screening for psychosocial concerns requires tools that consistently measure concerns and distress. In addition, assessment of psychosocial concerns requires patient-centered communication that identifies treatable issues and provides appropriate interventions such as referral or treatment for significant distress (Sharpe et al., 2004; Strong et al., 2008). The ONS Putting Evidence Into Practice (PEP) program was one of the first initiatives to review the literature and compile levels of evidence for translation to clinical practice. The PEP Web sites for anxiety (www.ons.org/Research/PEP/Axiety) and depression (www.ons.org/Research/PEP/Depression) contain a compilation of current tools that are useful in measuring these conditions.

However, oncology nurses and other healthcare providers are faced with challenges when assessing psychosocial concerns in cancer care. In one study, 57% of oncology nurses responded that a lack of time was the greatest barrier to providing psychosocial care in oncology settings (Gosselin, Crane-Okada, Irwin, Tringali, & Wenzel, 2011). If psychosocial assessment is to become the standard of care, efficient tools are needed to screen patients and documentation of this assessment needs to be incorporated into the medical record.

One specific tool for measuring distress in people with cancer was developed by NCCN, which has been advocating for screening of distress since 1999 and created a global tool to measure distress for use in clinical practice, the Distress Thermometer (DT). The paper tool contains two components: a visual scale ranging from 0 (no distress) to 10 (extreme distress) on the thermometer and five categories of concerns (practical, family, emotional, spiritual/religious, or physical problems) containing 58 yes-or-no items (NCCN, 2012). If a patient scores 4 or higher on the thermometer, referral and/or intervention are warranted to address specific concerns (NCCN, 2012). The simplicity of the tool allows oncology nurses to administer it and refer patients with significant distress (4 or higher) and/or unrelieved physical symptoms to the primary oncology team for additional assessment and interventions.

In one pilot program, oncology nurses incorporated the DT into the electronic medical record (EMR) (see Figure 2). They chose the DT because it was easy to use and required less than five minutes for the patient to complete. Because the DT is not medical diagnosis-specific, the nurses could capture a wide variety of concerns, including family and emotional concerns, as well as physical symptoms. The required fields in the EMR included the score on the DT and a pull-down menu for the five categories. Options for follow-up consultations were located in a drop-down menu and included further assessment by the nurse practitioner, psychiatry or psychology, spiritual care, nutrition, complementary therapies, or social work (D. Harris & C. Arcieri, personal communication, March 12, 2012).
In addition to paper-and-pencil tools such as the DT, electronic tools for patient self-report may provide simple and efficient methods for assessing these concerns. The Electronic Self-Report Assessment–Cancer (ESRA-C) was developed to assess patient-reported cancer symptoms and quality-of-life issues (Berry et al., 2011) and includes embedded, reliable measures of depression (Patient Health Questionnaire–9) and emotional functioning (European Organization for Research and Treatment of Cancer Quality of Life Questionnaire–Emotional Functioning). The results of the first ESRA-C clinical trial demonstrated that psychosocial concerns were addressed significantly more often when providers received a summary report of symptoms and quality-of-life issues prior to a visit (Berry et al., 2011). In addition, electronic tools may be incorporated into the EMR for ease and consistency of documentation. They also operationalize a patient-centered approach to documentation of care as they contain information about patients’ view of their symptoms, quality-of-life issues, and psychosocial concerns, rather than just the provider’s interpretation, in the EMR.

**Putting Evidence Into Practice**

The ONS PEP teams for anxiety and depression have performed systematic reviews of the literature and compiled levels of evidence for interventions to decrease anxiety and depression in people with cancer. The PEP Anxiety team found evidence for the effectiveness of psychoeducational interventions in decreasing anxiety (Sheldon, Swanson, Dolce, Marsh, & Summers, 2008). The PEP Depression team found evidence to recommend psychoeducational and psychosocial interventions and pharmacologic interventions for people with depression or depressive symptoms (Fulcher, Badger, Gunter, Marrs, & Reese, 2009). ONS and the work of the PEP teams have contributed significantly to the translation of evidence from studies to clinical practice, which now is included in the Agency for Healthcare Research and Quality National Guideline Clearinghouse (www.guideline.gov).

**Provider Communication**

Oncology providers have a responsibility to assess psychosocial concerns. Oncology nurses understand the value of therapeutic communication and incorporate evidence-based strategies when talking with their patients. In addition, how providers respond when patients reveal these concerns influences subsequent disclosure or lack of disclosure and may affect patient outcomes such as psychosocial well-being (Ong, Visser, Lammes, & de Haes, 2000; Stiles, Shuster, & Harrigan, 1992). In other studies, facilitating, exploring, and providing validation of psychosocial concerns may decrease patient anxiety and distress (Fogarty, Curbow, Wingard, McDonnell, & Somerfield, 1999; Iwamitsu et al., 2005; Zachariae et al., 2003). In addition, acknowledgment and exploration of concerns are necessary to completely assess psychosocial concerns within the context of a cancer diagnosis (Maguire, Faulkner, Booth, Elliott, & Hillier, 1996), as well as other potentially life-threatening conditions such as heart disease (Doering et al., 2010). However, those concerns often are underdetected (Kruijver et al., 2001; Sheldon, Hilaire, & Berry, 2011), resulting in patients with unresolved distress (Arora, 2003; Massie, 2004). Evidence-based provider communication is necessary to facilitating discussion and assessment for potentially treatable problems such as distress, depression, anxiety, and even risk for suicide (NCCN, 2012).

**Conclusions**

Oncology nurses need to be visible and articulate as advocates for timely and effective assessment of psychosocial concerns in cancer care. Although oncology nurses are not usually therapists, they do provide supportive care, assess patient psychosocial concerns, and pursue further assessment for significant concerns or changes in functioning. They also implement evidence from the growing body of research in this area into clinical practice. In addition, they always have included psychosocial care as one part of nursing care. Look at the Statement on the Scope and Standards of Oncology Nursing Practice from ONS (Brant & Wickham, 2004). Look at the daily care provided by oncology nurses everywhere. Although the new CoC accreditation guidelines will force cancer centers to develop guidelines for psychosocial assessment, they do not include nurses as deciding forces on the Cancer Commit-tees at these centers. Nurses, because they spend the most time with patients in...
oncology care, often detect the changes in mood, thinking, or feeling of patients that indicate the need for more support, assessment, and perhaps interventions. Because of this frequent contact, oncology nurses should be instrumental in deciding how and when to assess patients for these concerns, when to refer, the process for follow-up, and the necessary documentation to ensure continuity of care.

This standard is not new to oncology nursing. Just ask an oncology nurse.

References


