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Educating Oncology Nurses on Identifying and Managing Cancer-Related Distress

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
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Abstract

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MSN, Walden University, 2012

BSN, Ryerson University, 1989

Project Submitted in Partial Fulfillment

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Abstract

Up to 50% of patients diagnosed with cancer will experience significant levels of distress. Cancer is related to psychological distress and can negatively impact recovery from surgery, increase treatment side effects, and decrease overall quality of life. The National Comprehensive Cancer Network recommended screening for distress as part of comprehensive cancer care. In the practice setting, there was a need for better assessment of distress in cancer patients. The purpose of this staff education project was to address a gap in practice regarding the lack of knowledge of screening for distress by providing education to oncology nurses on how to identify and manage cancer-related distress in patients with cancer. The practice-focused question asked whether oncology nurses increased their knowledge on how to identify and manage patients with cancer-related distress after an education program. The Roy adaptation model was used to inform this project. The staff education session delivered via the zoom platform lasted 20 minutes. A pre and posttest questionnaire was used to assess improvement in knowledge. Six oncology nurses participated in the study. Data analysis from a paired samples *t* test showed no statistically significant improvement in knowledge: pretest (*M* = 32.33, *SD* = 3.83), posttest (*M* =38.33, *SD* = 7.47), paired differences (*M* = -6.50, *SD* = 7.61), *t* = -2.09, *df* = 5, *p* = .091. However, all participants strongly agreed or agreed that the program increased their knowledge of cancer-related distress. Findings may contribute to social change by improving nursing knowledge, adding to the body of nursing knowledge, and improving quality of life for patients with cancer.

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Dedication

This scholarly project is dedicated to my parents, Mary and Thomas Jeffers, who would have been very proud of me reaching this milestone of the highest educational level in nursing.

I also dedicate this to my nieces and nephews. I hope that I have served as an example and role model and have inspired you to become scholar practitioners who contribute to positive social change. Remember, if I can do it so can you.

I share this with my husband, Caleb Emmanuel Irish JD, who was always present providing love, support, and encouragement throughout this journey. I thank you and appreciate all of your efforts to ensure that I succeed.

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I want to give thanks to our heavenly father, the Lord and Savior Jesus Christ, as I constantly remind myself that "I can do all things through Christ who strengthens me."

To my sisters, Maureen and Cecile, thank you for your ongoing support, love, and encouraging words and for editing my work from time to time. It meant a lot to me. I appreciate and adore you.

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I extend special thanks to my project team, Mary, Elaine, and Jing, for reviewing the program and making valuable suggestions and recommendations. Your efforts were very much appreciated.

Finally, to the study participants, thank you for engaging in this scholarly project. To my nursing colleagues who have supported and extended words of encouragement, I say thank you. I hope I have served as an inspiration and role model for your continued learning, growth, and development.

Table of Content

List of Tables

Section 1: Nature of the Project

Worldwide, cancer is a major health problem and the second leading cause of death, with 10 million deaths occurring in 2020 (World Health Organization [WHO], 2022). A cancer diagnosis is a life-changing experience that can affect many aspects of a person's life, including physical, social, and emotional well-being. Many individuals diagnosed with cancer will experience some levels of psychological distress along the disease trajectory. An estimate of up to 50% of cancer patients have been reported to have significant levels of distress following a cancer diagnosis (Mehnert et al., 2018; Zebrack et al., 2015). This means that many people diagnosed with cancer experience a great deal of suffering if their distress is untreated.

Cancer-related distress is defined as a complex unpleasant experience that can be of a physical, psychological, social, and/or spiritual nature that can negatively affect a person's ability to cope with cancer, its physical symptoms, and treatment (National Comprehensive Cancer Network [NCCN], 2019). The person may experience normal feelings of sadness, fears, and other problems that can be disabling, such as anxiety, depression, isolation, or spiritual concerns (NCCN, 2019; National Cancer Institute (NCI), 2019). The term "distress" is used because it is easily understood and does not carry the stigma that is often associated with psychiatric terminologies (NCCN, 2019).

Distress or psychosocial distress, as is often used in patients with cancer, is not new, yet distress is often unrecognized and untreated (NCCN, 2019; Pal, 2018; Zebrack et al., 2015). If distress is not identified in patients with cancer, it cannot be treated. This makes screening for distress in cancer patients an essential component of cancer care, and nurses are well positioned to identify those who are experiencing distress and ensuring that the required interventions or services are provided.

The NCCN (2019), a not-for-profit alliance of leading cancer centers committed to patient care, research, and education, proposed that distress should be identified, monitored, documented, and treated along various stages of the cancer trajectory. Despite this recommendation, many cancer care agencies, including the project setting, fail to recognize and address symptoms of distress (NCCN, 2019). This means that when a patient's distress is not identified and treated, suffering may occur. Oncology nurses see cancer patients throughout their cancer journey and are in an ideal position to assume a leadership role in screening and addressing cancer-related distress.

This staff education project addressed the effectiveness of an education program on screening for distress for oncology nurses who care for patients diagnosed with cancer. The project may contribute to positive social change by bringing about change in nurses' knowledge, attitude, and practice. The project may also contribute to the body of knowledge and help to influence changes in oncology practice. Additionally, the project may lessen the burden of distress experienced by those diagnosed with cancer and enhance their quality of life (QOL).

Problem Statement

The nursing practice problem involved the lack of nursing knowledge on how to screen and manage psychological distress in cancer patients. In the project setting, there was no formal education for nurses on how to screen and manage cancer-related distress. Patients diagnosed with cancer were not screened for distress. The focus of this project was to address this gap in nursing practice by providing education to oncology nurses on how to identify and manage distress in patients with cancer. The practice-focused question asked whether oncology nurses show an improvement in knowledge on how to identify and manage patients with cancer-related distress after an education program.

The significance of this project was that oncology nurses in the project setting gained the knowledge needed and added to their skill set on how to detect and manage cancer-related distress following the education program. In addition, the project holds significance for the field of nursing because the knowledge gained from the education program can be applied to all areas of oncology practices. Additionally, the project can add to the body of knowledge and influence changes in nursing practice.

Cancer-related distress is a complex psychosocial phenomenon that negatively impacts patients and families (Bultz et al., 2011; Pal, 2018). Evidence has shown that distress can negatively impact adherence to treatment, decision making, and overall QOL (NCCN, 2019; Yee et al., 2017). Evidence has also shown that intervention addressing physical, educational, and psychosocial care enhances the QOL of cancer patients (O'Sullivan et al., 2011). The need for detecting and treating those who are experiencing distress must be addressed. When distress is not recognized or treated, a patient's care can be compromised, and patients may endure suffering.

The NCCN (2019) recommended that at various stages of the cancer journey, cancer-related distress should be identified, documented, monitored, and treated. Evidence has shown that early screening, detection, and intervention can improve patient outcomes, yet cancer-related distress is often unrecognized, and untreated (Pal, 2018;

Zebrack et al., 2015). Despite the NCCN recommendation, distress screening is not being done consistently throughout many health care agencies. Zebrack et al. (2015) examined the distress screening protocols at two cancer treatment centers and found that across the centers, adherence to the screening protocols ranged from 47% to 73% of eligible patients.

When screening is not done, distress is not detected and may go untreated. This means that patients who may have benefited from psychosocial care and other supports do not receive the help needed. Patient care is compromised, and the problem continues. The current project's significance for nursing practice is that nurses will be able to recognize and acknowledge distress in cancer patients as part of routine standard of care. This means more comprehensive patient care may result in overall better health outcomes for patients with cancer.

Purpose Statement

The purpose of this staff education project was to address the gap in practice of the lack of knowledge of screening for distress in cancer patients by providing education to oncology nurses on how to identify and manage cancer-related psychological distress in patients with cancer. In the project setting, screening for distress was not part of the care of patients with cancer, and there was no formal education in place to address this gap in nursing practice. If screening is not being done, patients experiencing distress cannot be identified and treated. The gap in practice that this project addressed was the lack of knowledge among oncology nurses on how to screen and manage cancer-related distress. To identify distress, screening should be done, and this can be accomplished using the distress thermometer (DT) or Edmonton Symptom Assessment System (ESAS), and Canadian Problem Checklist (CPC) (Canadian Partnership Against Cancer [CPAC], 2012; NCCN, 2019). The significance this project holds for practice is that patients will receive more comprehensive or holistic care along their cancer journey, and this may aid in preventing or decreasing their distress and suffering and may result in better QOL.

A landmark report by the Institute of Medicine (IOM, 2008), now the National Academy of Medicine, found that patients and health care providers felt that education on psychosocial care was the exception rather than the rule and recommended screening for distress and development of a plan of care with referrals as needed. Evidence has shown that addressing psychosocial concerns can decrease distress, depression, and anxiety and enhance QOL of cancer patients (Mahendran et al., 2015). Nurses are well positioned to provide education, support, and referrals to patients if they are knowledgeable on how to screen and manage distress in patients with cancer.

Nature of the Doctoral Project

The nature of this staff education program was to improve oncology nurses' knowledge of how to screen and manage cancer-related distress. The knowledge change was measured by using a pre- and posteducation approach that included oncology nurses from an outpatient setting who provided care to patients diagnosed with several types of cancers. Participants were asked to complete a pre- and postprogram questionnaire. The program educated nurses on how to identify, assess, and manage distress in patients with cancer based on the patient's specific needs and concerns. This can be considered personalized care because each person’s needs are different and intervention should be tailored based on the person’s needs (Smith et al., 2018).

The focus of this staff education project was to address a gap in nursing practice. By addressing this gap in practice, oncology nurses may obtain the knowledge needed to screen and manage distress in patients with cancer. The fact that distress was not being monitored and addressed on the project unit indicated that it may not be a priority or nurses do not know how to address distress or see this as part of their role. As health care providers, nurses should see this as a responsibility and recognize that managing distress is a critical component of comprehensive cancer care. The goals of psychosocial care are to relieve emotional distress, improve well-being and QOL for those diagnosed with cancer (Cancer Care Ontario [CCO], n.d.). Nurses have a significant role to play in this endeavor. Patients will also benefit because the knowledge gained by nurses can be integrated into a patient’s routine plan of care.

A comprehensive search of the literature was completed using keywords such as *cancer related distress or distress*, *gynecological cancers*, *managing cancer related distress*, *oncology nurses*, *educational needs*, *psychosocial care*, and *distress screening and management*. The search was done using Walden University Library Database including CINAHL, PubMed, MEDLINE, ProQuest Health, PsycINFO, and Google Scholar. The search included peer-reviewed articles of reviews, completed studies, or trials related to distress and its management and recommendations for distress screening and practice guidelines. I targeted literature published within the last 5 years with the inclusion of patients with gynecological and other cancers. Guidelines from the NCCN, CCO, NCI, Cancer Care Nova Scotia, CPAC, and Canadian Association of Psychosocial Oncology (CAPO) were used in the development of the education program.

Significance

This project will contribute to nursing practice by addressing areas for improvement and applying best practices for distress management. When cancer patients receive care that is evidence based and comprehensive, they will have better health outcomes and enhanced QOL. This project will also have importance to other stakeholders who provide care for cancer patients. These include oncology nurses, advanced practice nurses (APNs), nurse educators (NEs), physicians, social workers, and other members of the oncology health care team.

The APN and NE played a vital role because these individuals assisted in reviewing the program and can assist in arranging in-services for the oncology nurses. The APN and NE can also be instrumental in the sustainability and reinforcement of the education program. The knowledge gained by nurses in the project setting will be applicable in other areas that provide care to patients diagnosed with several types of cancer. Therefore, the knowledge gained will be a transferable skill for nurses, and this can be of benefit to other patients with cancers.

Summary

Cancer is a devastating condition that can cause distress in people affected by the disease. Distress can be debilitating, thereby impacting an individual’s well-being and QOL. Distress in many patients with cancer is often not identified and therefore not treated. This adds to additional suffering. At the time of this project study, there was no formal education in place in the project setting to detect and manage distress in patients with cancer. Evidence has shown that identifying and managing distress has positive outcomes for patients and their families.

This staff education initiative addressed the identified practice gap by providing education to nurses on how to screen and manage cancer-related distress in the project setting. Findings will assist in preventing or decreasing distress in cancer patients who are experiencing distress. In the next section of this doctor of nursing practice (DNP) project, I discuss the background and context as well as the concept, model, and theory that were used for this project. Additionally, I provide information on the local setting, the relevance to nursing practice, and my role in the project.

Section 2: Background and Context

Cancer-related distress is a widespread problem experienced by many cancer patients. There was no formal education in place for nurses on the project surgical oncology unit regarding how to screen, assess, and manage cancer-related distress. The NCCN (2019) and the CPAC (2012) recommended screening and management of distress on initial visit and at various stages of the cancer trajectory. Additionally, these agencies recommended the development of education training programs to ensure that health care providers have the knowledge and skills to assess and manage distress. The CPAC in collaboration with the CAPO has developed an online screening for distress program for health care providers. It is imperative that nurses and other health care providers be educated in distress for cancer patients.

The project question asked whether oncology nurses show an improvement in knowledge on how to identify and manage patients with cancer-related distress after an education program. The purpose of this project was to educate oncology nurses on how to identify and manage distress in patients with cancer. In this section, I discuss the concepts, models, and theories that were used for the project. The relevance to nursing practice as well as the local background and context are also addressed. Lastly, my role as the DNP student and the project team's role are discussed, and a summary is provided.

Concepts, Models, and Theories

For this DNP project, the Roy adaptation model (RAM) was used as the guiding principle. RAM is a well-developed model based on adaptation and is frequently used in nursing to direct practice, education, administration, and research (Parker, 2006). The model views individuals, both singly and collectively, as holistic adaptive systems (Parker, 2006). The model assumes that a person is a bio-psychological being and is in constant interaction with a changing internal and external environment. To cope with a changing environment, a person must use innate and acquired mechanisms that are biological, psychological, and social (Alligood, 2018; Current Nursing, 2012). Being able to adapt promotes health, which is a process of being and becoming harmonized and complete (Parker, 2006; Polit & Beck, 2018).

Current Nursing (2012) defined the four modes of adaptation as being physiologic/physical, self-concept/group identity, role function, and interdependence. These adaptive modes provide mechanisms that assist in coping with changes and environmental stimuli (Polit & Beck, 2018). The physical mode is manifested in physical and chemical processes involved in the functions of a person’s life (Alligood, 2018). These include a person’s basic needs of oxygen, nutrition, elimination, activity, rest, and protection. Other processes involved in physical integrity include the senses, fluids and electrolytes, and neurologic and endocrine functions (Alligood, 2018; Ursavas et al., 2014).

The other three modes of self-concept/group, role function, and interdependence are viewed as psychosocial modes (Badr Naga & Al-Khasib, 2014). The self-concept/ group identity mode relates to how the person believes and feels about themself with the basic needs being psychic and spiritual integrity (Alligood, 2018). Some of the components in this mode include body sensations and body image, self-consistency, self-ideal, and moral-ethical-spiritual self (Alligood, 2018; Current Nursing, 2012). The group identity mode relates to how people in a group perceive themselves based on feedback from the environment with the basic need being integrity (Alligood, 2018; Ursavas et al., 2014).

The role function mode, considered a social mode, deals with the position the person has in society. The basic need in this mode is social integrity. A person has the desire to know who they are so behaviors can be in line with the position or role they hold (Alligood, 2018; Ursavas et al., 2014). The other social mode is the interdependence mode. This mode deals with relationships or how a person interacts with others, such as the giving and receiving of respect, love, nurturing, knowledge, skills, commitment, time, and talents. The basic need in this mode is relational integrity (Alligood, 2018; Ursavas et al., 2014).

A person with a life-threatening condition/disease such as cancer experiences many changes and challenges that can affect their emotional well-being. Such a person must adapt to a changing environment for positive outcomes to be realized. Nurses assess behaviors and responses and decide whether they are adaptive or not. The goal of nursing as it relates to the RAM is to promote adaptation and adjust stimuli that interfere with adaptation (Polit & Beck, 2018). Roy sees the role of nursing as assisting patients in meeting these modes of adaptation, thereby contributing to the person's health and QOL (Alligood, 2018). This can be achieved by interventions that increase, decrease, remove, or maintain internal or external stimuli that interfere with adaptation (Polit & Beck, 2018).

Nurses see patients diagnosed with cancer throughout the cancer trajectory and are well positioned to assist patients with challenging situations they encounter. The use of RAM provides nurses with an understanding of the coping process. Nurses must be able to understand what the person sees as the problem and use critical thinking and decision making to assist patients with adaptation and coping. The knowledge gained from this staff education project provided nurses with directions on how to assist patients with coping and adapting to the challenges related to their illness and treatment. Nurses who received the education on how to identify and manage cancer-related distress should be able to incorporate this knowledge into their daily practice. This means that they should be able to provide strategies and resources that will lessen or prevent distress in their patients.

Relevance to Nursing Practice

Distress in people diagnosed with cancer has been a long-standing issue. Up to 50% of patients diagnosed with cancer experience significant levels of distress throughout their cancer journey (Mehnert et al., 2018; NCCN, 2019; Zebrack et al., 2015). A systematic review of the literature using CINAHL, ProQuest Health, MEDLINE, PubMed, PsycINFO, and Google Scholar indicated that distress among cancer patients is common yet often is unrecognized and untreated (Pal, 2018; Zebrack et al., 2015). The NCCN (2019) and other cancer care agencies recommended screening and management of distress in cancer patients at various stages of the cancer journey. Evidence has shown that receiving psychosocial care or intervention can be of benefit to those experiencing distress (NCCN, 2019). Therefore, it is imperative that nurses and other health care providers receive education that pertains to distress management in cancer patients so that the knowledge gained can result in positive outcomes for cancer patients and their families.

Managing distress is considered standard of care for patients diagnosed with cancer (Bultz et al., 2011; CPAC, 2012). However, cancer-related distress is often undetected and untreated (Pal, 2018; Zebrack et al., (2015). This means that many individuals who can benefit from interventions to decrease or prevent distress do not receive it, and this may result in suffering. Nurses are frontline care providers for patients diagnosed with cancer. Nurses are in a unique position to screen, educate, and provide interventions or referrals to appropriate services that can assist patients experiencing distress.

As care providers, nurses are well positioned to lead initiatives in distress management. This project provided nurses the opportunity to increase their competencies and abilities and enhance their clinical skills, knowledge, and practice. This staff education project will also add to the body of knowledge and may influence change in practice. Additionally, the project may contribute to positive social change by reducing the financial cost and burden of distress experienced by those diagnosed with cancer and their families by enhancing their QOL.

Local Background and Context

Cancer is the leading cause of death in Canada and is responsible for 30% of all deaths (Canadian Cancer Society [CCS], 2020). In Canada, 229,200 new cases of cancer and 84,600 deaths occurred in 2021 (CCS, 2020). In a lifetime, it is expected that 1 in 2

Canadians will be diagnosed with cancer and 1 in 4 will die from the disease (CCS, 2020). In Ontario, 1 in 2 individuals will be diagnosed with cancer (CCO, n.d.). For the year 2020, an estimated 91,946 cases of cancer were diagnosed in Ontario (CCO, 2021). In 2016, there were 81,409 people residing in Ontario who were diagnosed with cancer (CCO, 2020).

Being diagnosed with cancer can be psychologically, emotionally, and physically challenging (Bultz et al., 2011; NCCN, 2019). Evidence has shown that up to 50% of patients diagnosed with cancer experience significant levels of distress (Mehnert et al., 2018; Zebrack et al., 2015). It is therefore reasonable to conclude that many of these individuals in Ontario who are diagnosed with cancer will experience some level of distress.

The project site is in Ontario and is a large teaching hospital that is fully affiliated with a university in Toronto. Within the hospital is a highly specialized comprehensive cancer program. The hospital serves an estimated 1.3 million patient visits per year. The cancer program has treated many of those patients diagnosed with several types of cancers including breast, genitourinary, gynecological, central nervous system, gastrointestinal, hematological, head, and neck. Many individuals diagnosed with cancer will be seen from diagnosis to treatment and beyond at the project site both as inpatients and outpatients.

The setting was a surgical oncology unit within the project organization. Patients seen on this unit have gynecological, genitourinary, breast, head, and neck cancers. Many of these patients may experience some level of distress. At the time of the project study, screening for distress was not being done on this unit and there was no formal education for nurses on how to screen and manage distress in patients with cancer. Due to nurses' lack of knowledge and skills on how to address this issue, many patients may leave the unit with undiagnosed and untreated distress. This can result in additional suffering for both patients and their families. Nurses see and care for patients with cancer daily and can play a significant role in relieving patients' distress and enhancing their QOL.

Role of the DNP Student

I am a specialized oncology nurse and a rapid diagnostic nurse navigator in the outpatient setting of the organization. My roles entail caring for patients diagnosed with breast cancer and helping those with abnormal breast findings navigate from diagnosis to surgery as needed. My DNP clinical placement was on the inpatient surgical oncology unit within the organization where I work. This unit services patients diagnosed with breast, prostate, head, and neck and gynecological cancers.

During my placement, there was no education for staff on how to identify and manage distress in those diagnosed with cancer. Nurses who are knowledgeable on how to assist cancer patients in managing their distress can have profoundly positive effects on patients' health outcomes and QOL. Although my project focus was on patients with gynecological cancers, this education intervention will be applicable to all patients diagnosed with cancer.

My role in this project was to plan, implement, and analyze this education program for nurses. Working with key stakeholders, I prepared the program objectives, developed the curriculum, developed the pre- and postintervention evaluation tools, implemented the program, and evaluated the outcomes. The objectives were formulated from an evidence-based literature review and focused on how recommended screening tools can be used to identify distress in patients with cancer.

Oncology nurses from the project setting were invited to participate in this education program once plans were finalized with the patient care manager, the APN, and the NE. However, due to the COVID-19 pandemic, plans with this group of participants did not materialize. Oncology nurses from the outpatient setting were then invited to participate in the pilot study.

Participants were asked to sign an informed consent form, participate in the education session, and complete the pre- and posteducation assessment tools. Convenient times were arranged for the delivery of the education program. The learning objectives were used as a guide to develop the content of the education program. Those in attendance were offered appropriate handouts that assisted them in navigating the referral process to other services. Immediately before and after the education session, participants were asked to complete the pre- and postintervention knowledge assessment and to return them sealed in envelopes that were provided. Participants were also given the opportunity to provide feedback about the program using a summative evaluation.

This program may be extended and used as an ongoing education program for other nurses caring for oncology patients. Providing nurses with the knowledge required and meeting best practices in oncology care would positively impact patients' health outcomes and QOL. The sustainability of this program is feasible because it promotes the standard of care for all patients diagnosed with cancer. On a long-term basis, senior leadership may want to evaluate the success of the program to determine how many patients are screened for distress and how many are referred to other support services and the outcomes.

Role of the Project Team

The project team included the patient care manager, the APN, and the NE for the project unit. Other stakeholders who were not directly involved included nurses, physicians, pastoral care services, ethics committee members, unit team leaders, other patient care managers, and APNs whose units may benefit from the program. The project team met to review the contents of the education program. Approval for the delivery of the program was obtained from the organization’s and Walden's Institutional Review Board (07-02-21-0254509).

The assessment tool that was used to evaluate the outcome was a self-reported pre- and postintervention questionnaire and developed by me and approved by the project team. The project team met to review the questionnaire for content validity, provided feedback, and made recommendations as needed. The team ensured that the questions were clear, easily understood, and linked to the assessment of knowledge. The project team used the objectives and education content to determine whether the tools were valid and reliable based on the stated objectives and education contents. The team took over 4 weeks to complete this process.

Summary

Patients diagnosed with cancer experience significant levels of distress. Evidence has shown that identifying and treating distress can prevent or decrease a person’s level of distress and improve their QOL. In the practice setting, there was no formal education for nurses on how to screen and manage cancer-related distress among those experiencing it. This project addressed an identified gap in nursing practice by providing education to oncology nurses on how to screen and manage distress in cancer patients. RAM was used as a guiding principle for this DNP project. In Section 2, the relevance to nursing practice and the local background and context were discussed as well as the role of the DNP student and project team. In Section 3, the practice problem, sources of evidence, and analysis methods are addressed.

Section 3: Collection and Analysis of Evidence

In this section, the collection and analysis of evidence are addressed. A diagnosis of cancer and its treatment can lead to distress that can negatively affect cancer patients and their families (Bultz et al., 2011; NCCN, 2019; Yee et al., 2017). Up to 50% of patients diagnosed with cancer experience significant levels of distress, and much of this distress is unrecognized and untreated (Mehnert et al., 2018; Pal, 2018; Zebrack et al., 2015).

Many regulatory bodies, including the NCCN, recommended that cancer-related distress be identified, monitored, and documented throughout the cancer journey (CPAC, 2012; CCO, n.d.; IOM, 2008; NCCN, 2019; Zebrack, 2015). Additionally, the NCCN (2019) recommended that education programs be developed to ensure that health care providers have the knowledge and skills needed to screen and manage distress in patients with cancer. The current project's education intervention fulfilled one of the NCCN's recommendations by providing education to oncology nurses that would enhance their knowledge of distress screening and management of patients with cancer.

Despite recommendations by regulatory bodies to identify and manage distress in patients with cancer, this is not being implemented consistently throughout many cancer care agencies (Lazenby et al., 2018; NCCN, 2019; Pal, 2018). For example, there was no screening for distress being done on the project site's surgical oncology setting. When distress is not identified, it may not be treated and this may result in non-adherence to treatment, poor health outcomes and QOL, and suffering (Grassi et al., 2017; Travado et al., 2017; Yee et al., 2017). The purpose that this project was to address the gap in nursing knowledge of screening for distress by educating oncology nurses on how to screen and manage distress in patients with cancer. In Section 3, the practice-focused question, sources of evidence, and analysis and synthesis are provided, as well as the evidence and recommendations that supported this project. Finally, a summary is provided.

Practice-Focused Question

Significant levels of distress occur in approximately 50% of individuals diagnosed with cancer, and much of this distress is unrecognized and untreated (NCCN, 2019; Mehnert et al., 2018; Pal, 2018; Zebrack et al., 2015). This may result in non-adherence to treatment, poor health outcomes, and reduced QOL (*BuschBasch* to treatment, poor health outcomes, and reduced QOL (Basch et al., 2017; Grassi et al., 2017; Yee et al., 2017). When distress is not identified, it may not be treated, and this can result in much suffering, poor health outcomes, and reduced QOL (Grassi et al., 2017; Travado et al., 2017).

The practice setting was a surgical oncology unit that services patients with gynecological, genitourinary, breast, head, and neck cancers. At the time of the project study, there was no mechanism in place or formal education for nurses on how to screen and manage distress in patients with cancer. Therefore, the purpose of this DNP project was to address a gap in practice regarding the lack of nursing knowledge of screening for distress in cancer patients by providing education to oncology nurses on how to identify and manage distress.

The practice-focused question was the following: Will oncology nurses show an improvement in knowledge on how to identify and manage distress in cancer patients after an education program? My role was to develop, implement, and evaluate the education program for oncology nurses. The effectiveness of the program was evaluated to determine whether the stated goals and objectives of the program were met.

It is essential that nurses be equipped with the skills and knowledge needed to identify and manage distress in patients with cancer. When patients are identified as having distress, steps can be taken such as providing emotional support, showing empathy, education, and referral to the appropriate services. Nurses are in a unique position to provide timely interventions in the areas of information, education, support, and referral to the resources that will assist patients in managing their distress. This can be accomplished only when oncology nurses have the knowledge and skills on how to identify and manage patient cancer-related distress.

Sources of Evidence

For this DNP project, an extensive search of the literature was conducted using the Walden Library Databases: CINAHL, PubMed, MEDLINE, ProQuest Health, PsycINFO, and Google Scholar. The search involved peer-reviewed articles, completed studies, or trials and recommendations related to distress and its management. Guidelines from the NCCN, Cancer Network, CCO, NCI, Cancer Care Nova Scotia, CPAC, and CAPO were used in the development of the education program.

The review and evaluation of the evidence supported the need to address this clinical practice question. Some of the key terms that were used in the search were *distress*, *cancer related distress*, *distress screening*, *managing distress*, *distress intervention*, *psychosocial care*, *oncology nursing*, *psychological distress*, and *nursing education*. A total of 234 articles were reviewed, and a total of 9 were included in the literature review. The most current articles and guidelines were used for the development of the education program. Most of the articles were published within the last 5 years. Articles included were from peer-reviewed journals that looked at research findings and explored clinical practice guidelines and distress experienced in patients diagnosed with cancer.

At the time of the project study, there was limited information regarding the role nurses played in distress screening and management, especially in hospitalized patients. Evidence suggested that the interest in distress screening was growing, and more emphasis was on the role of oncology nurses and how distress screening fits into their everyday practice (Fitch et al., 2012). Because all patients must be considered at risk for developing distress, it is critical that nurses have a sound understanding of the screening processes and management of distress in patients with cancer.

Although screening for distress is essential, it is also helpful to know what strategies patients use to manage their distress and what they feel would be helpful in managing their distress. Each patient is unique and may need a separate way of managing their distress. Stonelake-French et al. (2018) used a qualitative and quantitative method to look at self-reported distress in hospitalized patients with cancer. Participants were asked to complete the DT (a visual analog scale) and answer two open-ended questions while in the hospital: What are you currently doing to decrease your level of distress? What would you find helpful during your hospitalization to decrease your level of distress? Stonelake-French et al. found that the strategies used by patients were related to their QOL: relationship with health care team, taking charge, and accepting help. Stonelake-French et al. noted that there was limited understanding of distress in hospitalized patients that needed attention by health care providers. Additionally, Stonelake-French et al. concluded that the study had implications to improve patient care and put in place recommended psychosocial care and NCCN distress-screening standards. This study supported the need for education on screening and managing distress for health care providers, so that they can address distress in hospitalized patients with cancer. The study also provided some understanding of what patients find helpful for them.

Even though there has been growing interest in distress screening over the years, more needs to be done. Pal (2018) highlighted a keynote address by Dr. Deborah Mayer at the American Psychosocial Oncology Conference in 2018. Pal stated that Dr. Mayer pointed out that psychosocial issues are frequently underestimated and overlooked even though the signs are evident. Pal cited a 2017 study by the University of Michigan Comprehensive Cancer Center that looked at the health records of a few cancer centers in the United States and Canada. The study found that only 62% of patients received the required distress screening and follow-up (Pal, 2018). Pal stated that Dr. Mayer emphasized that cancer care agencies have the resources to make distress screening and management an essential component of cancer care and follow up. Pal highlighted that more needs to be done in distress screening and management, especially in hospitalized patients with cancer. When screening is not done routinely, signs of distress may be overlooked or may be assumed as something other than distress. As around-the-clock care providers, nurses are well positioned to play a pivotal role in this endeavor.

Distress screening in cancer patients has been mandated for years, yet screening is not being done in some cancer care settings (NCCN, 2019; Pal, 2018) including the project setting. In the project setting, nurses do not screen for distress, and this may be due to the lack of knowledge regarding distress and their role in distress screening and management. Chen et al. (2017) looked at nurses' perceptions and experiences related to the provision of psychosocial care. Nurses were asked about their views pertaining to psychosocial care, how they provide it, what the challenges are, and how to improve it among patients and families. Nurses reported that psychosocial care consisted of holistic care, spiritual care, support for patients and families, and showing empathy. Additionally, participants felt that psychosocial care entails communication among nurses, patients, families, and the health care team. Some of the barriers listed to providing psychosocial care were lack of time, language barriers, being focused on tasks, excessive documentation, lack of family involvement, and fear of complaints. Chen et al. claimed that nursing participants did not see the provision of psychosocial care as part of routine nursing care. Chen et al. claimed that the provision of this type of care can be accomplished by in-service education, discussions, and presentations by experienced nurses who have the knowledge. This study supported the need to address the lack of nursing knowledge in the project setting.

Patients interact daily with nurses and other health care providers. However, patients may not let other health care providers know they are experiencing distress or seek help. It is therefore essential that nurses who provide care to patients with cancer realize that distress is common in this group of patients and must be addressed. For several years in a row, nurses have been rated the highest in honesty and ethics (Reinhart, 2020). This finding reveals how nurses are viewed and how patients may be more willing to confide in them. Being a constant presence to patients puts the oncology nurse in a unique position to start the conversation about distress in patients diagnosed with cancer. However, nurses must be knowledgeable on how to start this conversation and the necessary next steps if a patient is experiencing distress.

Mahendran et al. (2015) found that patients were more willing to confide in nurses than to seek help and support from mental health care professionals. In a nurse-led psychosocial semistructured program, patients who participated in the intervention had reduced distress, depression, and anxiety and enhanced QOL. The findings indicated that positive outcomes can be realized when nurses are positioned to provide psychosocial care to patients with cancer. However, nurses must have the knowledge and skills needed to do so. The DNP project provided oncology nurses with the knowledge needed to identify distress and address concerns identified in patients with cancer.

These study findings confirmed that oncology nurses are well positioned to support those in distress but lack the knowledge on how to address psychosocial needs in those experiencing distress. Although nurses may have some understanding of what psychosocial care entails and may be providing some of that care, they do not see it as part of their daily role. This supported the need for education, additional training, and direction so that nurses can realize and embed this standard of care into their practice. It was necessary to address this gap in knowledge and practice by conducting the current project.

Internationally, many health care organizations have either mandated or endorsed the quality care standard of the whole person that is achieved through routine psychosocial distress screening. One of these organizations is the American College of Surgeons Commission on Cancer, who stipulated that every patient undergoing cancer treatment be screened for distress, and this is also a requirement for accreditation (Jacobsen & Lee, 2015; McCarter et al., 2018). Despite endorsements and recommendations, education and support regarding the implementation of routine distress screening have fallen short. The slow rate of compliance may be related to several barriers including limited administrative support, no set screening protocols, confusion about the appropriate screening tool, and uneducated staff (Lazenby et al., 2018). This DNP project provided education to oncology nurses on how distress screening fits into their practice and how to use validated and recommended screening tools such as DT, ESAS, CPC, and other available resources. These tools have been shown to be valid and reliable and are readily and easily available in the public domain (Bultz et al, 2011; Feldstain et al, 2014; NCCN, 2019).

The Union for International Cancer Control has endorsed distress as the sixth vital sign; in Canada distress is now considered the sixth vital sign in cancer care, and health care providers are expected to screen patients with cancer for distress (Bultz et al, 2011; Fitch et al., 2012). A tool kit containing ESAS and CPC has been developed, which is considered the minimum recommended measure (Bultz et al., 2011; Feldstain et al., 2014; Holland & Bultz, 2007). ESAS is a brief screening instrument that was developed for use in palliative care and has been validated in cancer patients (Hui & Bruera, 2017).

In addition to the NCCN clinical practice guidelines for the management of distress and the IOM proposed standards to address psychosocial care, the CAPO has developed national standards and practice guidelines for the management of distress. These include identifying procedures for screening and treatment, organizational structures for psychosocial services, and education and training of health care providers (Jacobsen & Lee, 2015). Additionally, the CAPO in partnership with the Interprofessional Psychosocial Oncology Distance Education developed a self-directed web-based course that supports the implementation of distress screening programs. The course provides health care professionals with knowledge on how to screen and manage distress (Interprofessional Psychosocial Oncology Distance Education, n.d.).

The NCCN also recommended the use of standard, valid, and reliable tools when screening for distress. The DT, ESAS, and CPC have been shown to be effective in identifying distress in patients. This DNP staff education project recommended the use of these reliable and validated tools as part of the education program. Blais et al. (2013) used the DT, ESAS, and CPC to screen patients for distress. The findings demonstrated that the use of these tools by a nurse navigator was successful in identifying patients with high levels of distress.

In 1997 the NCCN developed the DT. It is a single tool that is used to identify distress (see Appendix A). The DT is a graphic scale of a thermometer that ranges from 0 to 10, with 0 meaning no distress and 10 meaning severe distress. The DT is a quick and easy self-administered tool. Patients are asked to rate their level of distress over the last week. A cut off score of 4 has been shown to be the most sensitive and specific (NCCN, 2019). Cancer patients' whose score is 4 or more should receive further assessment and treatment as needed by specialized professionals (Cutillo et al., 2017). Tang et al. (2011) found that the DT is an accurate and reliable tool when screening for distress in cancer patients. The authors stated that the use of this rapid screening tool can assist health care providers in identifying psychological and psychiatric issues in cancer patients, and can be helpful in providing information, and referral to specialized psychosocial services.

Hui et al. (2017) found the ESAS (see Appendix B) a valid and reliable self-administered assessment tool. The tool is used to assess nine common symptoms experienced by patients with cancer, with the option of adding a tenth, patient-specific symptom. ESAS was initially developed for the Regional Palliative Care Program in Edmonton, Alberta and was adapted for use in cancer patients. Each patient rates their symptoms at the time of the assessment, on its severity, from 0 to 10, with 0 being the absence of symptom and 10 being the worst possible severity of symptom (CCO, 2005). It is recommended that ESAS be used as one component of a complete clinical assessment (CCO, 2005). There is the accompanying CPC that consists of six categories of practical issues that allow patients to select from the areas they are having difficulties. The DT, ESAS, and CPC are available in the public domain and do not require permission for their use in the assessment and management in the care of patients.

The literature review provided recommendations for evidence-based practice guidelines. These served as guiding principles in the development and implementation of the education program. The literature review supported the use of RAM as an appropriate framework for this project. The model is based on adaptation, and is used in nursing to direct care, practice, education, administration, and research (Alligood, 2018 & RAM, 2012).

Analysis and Synthesis

In this section, I discuss the analysis and synthesis that were used for the project. The data collection started before the education session. The pre-intervention assessment was completed by all participants prior to the education session. This established a baseline of each participant's knowledge, related to distress screening and management. There was no reliable and validated pre- and postintervention assessment tool. Questionnaires to assess pre- and postimplementation impact of the education program was developed by me and evaluated by the project team members. A Likert type scale was used to answer the questions that were based on the objectives, stated goals, and education content.

The sources of evidence that were used to answer the project question were basic demographics data, and pre- and posteducation knowledge assessments. Participants completed the demographic and pre-intervention self-reported questionnaire before the educational session. The posteducation, self-reported questionnaire was completed by all participants after the education session. Before the tools were used, they were evaluated for content validity by the project team members, who are specialized in cancer care.

The data collection included the pre- and postintervention knowledge assessment. The pre- and postassessments were compared. I looked at the total number of participants, their responses, trends, errors, and omissions from each respondent. The responses from each participant were entered into an Excel spread sheet by a student volunteer prior to the entry into the statistical analysis software. These entries were double checked by me to ensure the accuracy of the contents and data entries. Hard copies of the de-identified data are stored in my office in a locked file cabinet, in a locked room in the institutions' building and will be kept for 6 months. Data stored electronically can be accessed by team members using a protected password. To minimized missing information, the questionnaire was clear and easily understood. Participants were encouraged to answer all the questions on the questionnaire before and after the education intervention.

The differences between the nurse's knowledge before the intervention and after intervention were compared using inferential statistics. For the statistical data analysis, the International Business Machine (IBM) Statistical Package for Social Sciences (SPSS) version 27 was used. This package was used to identify outliers and corrected them as needed. The paired-sample *t* test was used to analyze the project findings. I addressed assumptions of the *t*-test by ensuring a random sample of participants that were representative of the oncology nursing population. Additionally, I assumed that the observations are independent of each other and the differences between the pairs are normally distributed.

Summary

In this section, I provide an introduction, the problem, and how it aligned with this project. The purpose of this project and how it aligned with the practice-focused question was also addressed. Additionally, the sources of the evidence that was used, how the analysis and synthesis was completed, and the supporting evidence for this project were provided. Finally, a summary, including all these tasks, is presented. In the next section, the project findings and evaluation is given.

Section 4: Findings and Recommendations

Globally, cancer is the leading cause of death with almost 10 million deaths in 2020 (WHO, 2022). A diagnosis of cancer is a life-changing and devastating experience that can affect many aspects of a person's life. Evidence has shown that up to 50% of patients diagnosed with cancer may experience significant levels of distress (Mehnert et al., 2018; Zebrack et al., 2015). The NCCN (2019) recommended that at various stages of the cancer journey, cancer-related distress should be identified, documented, monitored, and treated. Distress screening and management is a standard of care for patients diagnosed with cancer. Therefore, if screening is not being done, distress cannot be managed.

The purpose of this study was to address a gap in practice regarding the lack of screening for distress in patients with cancer. On the targeted unit, distress screening was not being done with patients diagnosed with cancer, and there was no formal education to address this gap in practice. The practice-focused question asked whether oncology nurses showed an improvement in knowledge on how to identify and manage patients with cancer-related distress after an education program. Through the education program, oncology nurses may have gained the knowledge needed to screen and manage distress in patients with cancer. The study commenced following approval from the project site's research ethics board and Walden University's IRB. Project team members were then asked to review the content of the education program and provide feedback and recommendations. Changes were made to the program as recommended.

Prior to the implementation of the program, nurses from the project unit were invited to participate in the study. Due to difficulties and restrictions caused by the COVID-19 pandemic, there were several challenges in accessing the targeted population; therefore, the project was changed to a pilot study. Oncology nurses who agreed to participate in the pilot study were asked to read and sign an informed consent form before participating in the study. Participants were asked to complete an anonymous pre- and postsession questionnaire before and after the education program (see Appendix C and D).

The education program included a PowerPoint presentation that was delivered over three sessions via the Zoom platform. Participants were provided with opportunities to be engaged, allowing for enhancement of the learning experience. They were also provided with the opportunity to ask questions following the presentation.

Findings and Discussions

A total of six oncology nurses from an outpatient setting at a teaching hospital participated in the study. All participants (100%) were female registered nurses with an age range of 30 to over 60. Eighty-three percent of the participants had a bachelor’s degree in nursing while 17% had a diploma in nursing. Thirty-three percent had between 6 and 15 years of nursing experience, 17% had between 16 and 25 years, and 50% had over 26 years in nursing. As oncology nurses, 66% had between 6 and 15 years of experience, 17% had between 16 and 25 years, and 17% had over 26 years of oncology experience. Fifty percent of the participants had certification in oncology while 50% did not (see Table 1).

Table 1

Participant Demographics

Demographic	Category	Number	Percentage
Gender	Female	6	100%
Age	30–39	2	33%
	40–49	1	17%
	50–59	2	33%
	60+	1	17%
Status	RN	6	100%
Education level	Diploma	1	17%
	Bachelor's degree	5	83%
Years in nursing	6–15	2	33%
	16–25	1	17%
	26–35	3	50%
Years in oncology	6–15	4	66%
	16–25	1	17%
	26–35	1	17%
Oncology certification	Yes	3	50%
	No	3	50%

I conducted a paired-samples *t t*est to analyze the impact of the education intervention on knowledge. Preintervention results (*M* = 32.33, *SD* = 3.82) post-intervention results (*M* = 38.83, *SD* = 7.46), paired differences (*M* = -6.5, *SD* = 7.61), and *t* = -2.09, *df* = 5, *p* = .091 (2-tailed) showed no statistically significant improvement in knowledge postintervention. The small sample size of six contributed to the study findings. Therefore, no firm conclusions or generalizations could be made. The null hypothesis was therefore retained.

I looked at the answers from participants, and two questions were answered incorrectly by most of the participants before and after the education session. This may indicate a gap in how the information was presented, or the questions may not have been properly worded. There may also have been the need to elaborate more when addressing those two areas.

Second, 34% of participants had over 16 years of oncology experience. Fifty percent had certification in oncology. These nurses had a sizable number of years in nursing and oncology. They may have had experience or knowledge on how to manage distress in patients diagnosed with cancer. Therefore, the findings of this study may be due to chance and cannot be generalized. Further research is needed with a larger number of participants to address the small sample size and to include more nurses who have little or no experience in oncology nursing.

In addition to the pre- and postsession questionnaire, participants were asked to evaluate the program using Likert type answers (see Appendix E). All participants strongly agreed or agreed that the program increased their knowledge of cancer-related distress. Five of the six participants strongly agreed or agreed that they would recommend this program to their peers. All six participants strongly agreed or agreed that they would apply the knowledge gained in their practice.

Recommendations and Implications

There is a need to incorporate distress screening and management into daily practice because this would provide cancer patients with better QOL and health outcomes. Despite the many barriers and findings, this type of project could have significant benefits for nurses and patients. The literature supported the need for this type of intervention. Distress screening and management is part of the standard of care for patients diagnosed with cancer. The study was suited for the intended participants and will be delivered at a time that is convenient for these nurses. This program may also be suited for nurses who are new to oncology nursing and can be incorporated into their orientation program.

Nurses need the knowledge and skills to engage in screening, assessment, and management of cancer-related distress. This program was intended to provide the knowledge that was needed to identify and manage cancer-related distress. This program may allow oncology nurses to practice to their full scope of practice in cancer care. A study such as this has the potential to influence change in nursing practice and patient outcomes. Nurses will have transferrable skills, and patients will benefit by achieving better QOL and health outcomes. However, further research is needed to address this area of nursing practice.

Strengths and Limitations of the Project

Despite the outcome, there were strengths that were identified throughout this project. There was positive feedback from the participants indicating a need for this type of program (see Table 2). Participants can be given the questionnaire ahead of time in sealed envelopes and asked to complete it before the session and after the education session. This will save time for busy nurses who are pressed for time. The actual presentation of the content took approximately 20 minutes.

Table 2

Summative Evaluation Results

Item	Strongly agree	Agree	Neither agree nor disagree
The program met the stated objectives	66%	34%	
The educational program improved/increased my knowledge of cancer-related distress screening	83%	17%	
I would recommend this educational session to my peers	66%	17%	17%
I will apply the knowledge gained to my practice	66%	34%	

Note. Feedback comments included the following: "Great presentation. Distress is often not discussed with cancer patient. Great resources and information provided. This educational session was very informative and a useful tool for assessment, screening and management of patient with cancer related distress. This should be shared with our colleagues. This is an area that has been overlooked. The only thing I would change is to make it interactive throughout. Excellent presentation. All nurses and allied health should attend this program so that we can help patients in need."

Another strength was the flexibility and portability of this project. The Zoom platform was a way of reaching and accommodating participants. This medium can also be used for the targeted population. Participants were provided with opportunities to be engaged, allowing for enhancement of the learning experience. They were also provided the opportunity to ask questions following the presentation and complete an evaluation of the program (see Appendix E).

Nurses who participated in the project can now incorporate this information into their practice. The evaluation at the end of the program gave participants the opportunity to provide feedback (see Appendix E). Feedback, recommendations, and lessons learned from the pilot study will be incorporated into the program to enhance the learning experience for the target population and others. The pilot study demonstrated that this program is efficient and can be implemented using a different medium and at a convenient time for participants.

There were several limitations to this project. The study population was small (a sample size of six), so generalization cannot be made. Another limitation was that participants were not from the targeted population. There was also no assessment or evaluation tool available, so these had to be created. There were a few challenges throughout this process. The COVID-19 pandemic played a role in several delays and getting this project implemented with the intended participants. There were illnesses, staff shortages, accreditation issues, and staff turnovers. These and other factors made it impossible to implement the program with the targeted population. I was told that the nurses were overwhelmed with the present situation; they had no time and were not able to participate in the study at this time. The small sample size may have contributed to the findings of this study.

Another limitation was that team members were not available to be actively engaged in the pilot study. Changes had to be made from the in-person program to virtual via the Zoom platform. This was a new medium for me. The lack of an in-person presentation can also be seen as a limitation. There was no direct face-to-face interaction or connectivity. Other adjustments had to be made regarding the completion and return of the pre- and postsession questionnaires. Participants were given questionnaires in sealed envelopes with their ID numbers known only to them to maintain anonymity. Participants were asked to return the completed questionnaires in sealed envelopes addressed to me. These were opened only when all were received. There were changes that had to be made to the recruitment letter for the pilot study. In Section 5, I describe the plan for dissemination and provide an analysis of myself.

Section 5: Dissemination Plan

Dissemination of research findings is essential for findings to be translated into practice. Dissemination is also expected for a scholar practitioner. There is no benefit to the profession if researchers keep findings to themselves. My plan for dissemination is to share the findings internally with my nursing colleagues. My target audiences will be nurses and other health care providers within my organization.

Second, my plan is to submit an abstract for either a poster or oral presentation to the Canadian Association of Nurses in Oncology annual national oncology conference. Canadian Association of Nurses in Oncology (2022) is a national organization in Canada whose mission is to advance oncology nursing excellence through practice, education, research, and leadership. This is for the benefit of all Canadians and with a vision to being an international nursing leader in cancer control. The association is run by its members and takes direction from the membership to formulate its activities and initiatives. Additionally, I would also like to present the study findings at one of the international conferences, either the Oncology Nursing Society or International Conference on Cancer Nursing.

Analysis of Self

Coming from a beautiful, tiny island in the Caribbean known as Nevis, I feel honored to have reached this milestone. I was inspired when I attended a conference in Toronto and saw nurses who looked like me with higher levels of education including the doctoral level. Working as an oncology nurse for over 2 decades, I wanted to ensure that oncology patients received the best care possible. I did not see that when I was doing my practicum experience on the oncology unit. I noticed a gap in practice in the identification and management of distress in patients diagnosed with cancer. I took the initiative to try to fill that gap.

The process of higher learning excited me, and I always wanted to be a lifelong learner. This doctoral program has been a learning experience that I will always cherish, though it was not without its challenging moments. I developed skills in knowing how to search the literature more effectively to find evidence-based solutions. As a scholar practitioner, I was able to identify a practice gap, determine what was needed, and take the necessary steps to address that gap.

Throughout this process, I learned how to assess, plan, execute and analyze an education program. The journey did not always go as I had planned, but I was determined to persevere. I developed skills in patience, adaptability, and accepting situations that I cannot control. I realized the importance of collaboration and engaging in meaningful communication to achieve successful outcomes.

My immediate goal is to seek a part-time teaching position as an educator in the BSN or MSN program in a college or university. This will allow me to continue my lifelong learning and to impart the knowledge and skills that I have acquired to the next generation of nursing scholars. My long-term goal is to return to my beautiful island of Nevis to set up a program for seniors that would ensure they receive the necessary care they deserve and need. I can now say that I am a more rounded scholar practitioner and nurse. Throughout this process, I have grown personally and professionally and feel well positioned to share my knowledge with others that will result in positive outcomes for patients and the community.

Summary

Cancer is a devastating disease that accounted for around 10 million deaths worldwide in 2020. Many of these individuals would have experienced cancer-related distress. There was a gap in practice regarding the screening and management of cancer-related distress. I sought to address this gap to prevent or decrease patient suffering. The literature supported the need for an education intervention. Nurses are in an ideal position to limit or prevent patient suffering. However, I was not able to conduct this study with the intended participants. The plan is to implement this program when it is convenient for this population of nurses.

This pilot study allowed me the opportunity to be engaged in research. Although there were many challenges encountered throughout this process, I was able to develop and implement a program and analyze the results. This allowed me to contribute to the nursing profession. Nurses can be the beneficiaries of this program through their increased knowledge and transferrable skills in screening and managing cancer-related distress. The impact in terms of social change can be enormous for patients diagnosed with cancer. If their distress is managed, they may have better QOL and health outcomes.

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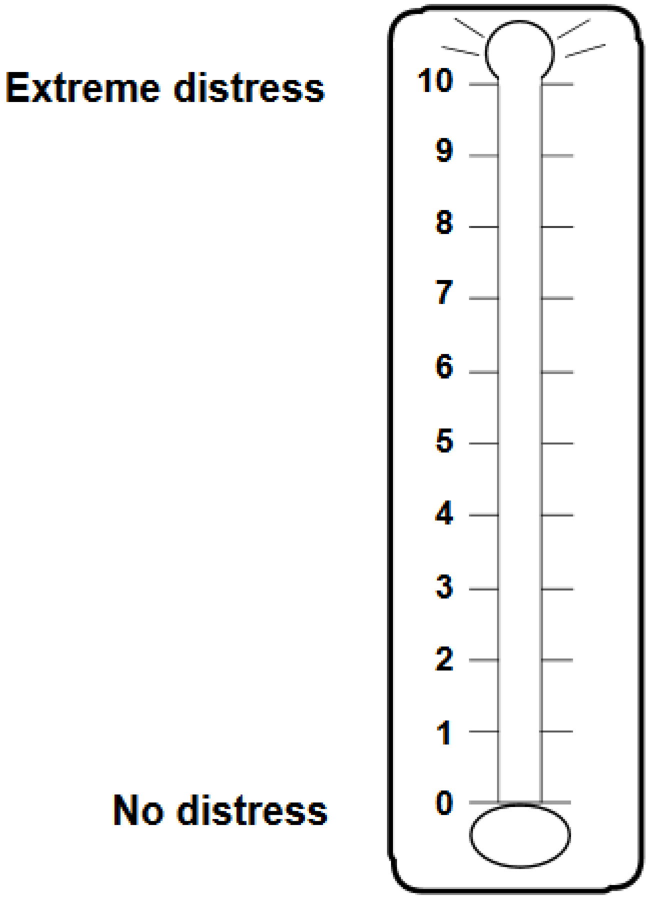
Appendix A: NCCN Distress Thermometer

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing i the past week including today.



NCCN Distress Thermometer and Problem List

Thank you for your interest in the NCCN Distress Thermometer and Problem List, Figure (DIS-A), from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Distress Management.

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By downloading this page you agree that you are a healthcare professional, researcher, hospital, or medical practice who will be using the NCCN Distress Thermometer and Problem List strictly for your personal use, which you represent and warrant being for non-promotional, educational use only.

NCCN has verified translations of the NCCN Distress Thermometer and Problem List in select languages. Approved international adaptations of the Distress Tool can be found at the International Adaptations & Translations section of NCCN.org.

If you would like to request permission to use the tool for any purpose other than direct treatment of patients or use in grants or research, please visit the NCCN Permissions Request Form.

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Appendix B: Edmonton Symptom Assessment System and Problem Checklist

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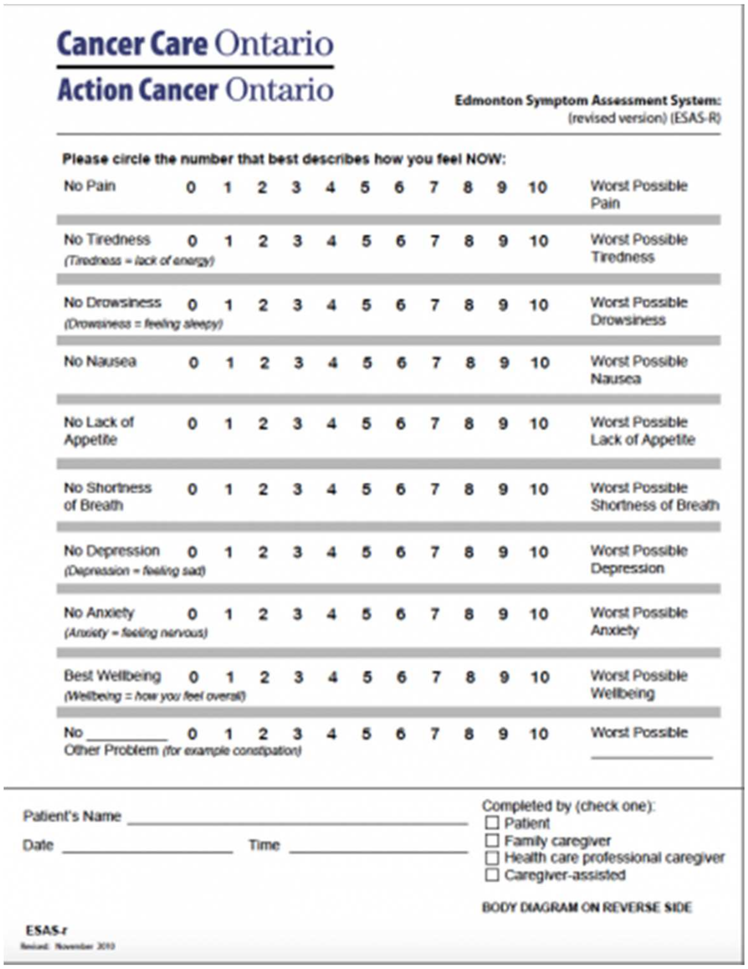


Cancer Care Ontario
Action Cancer Ontario

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No ________ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible ________

Patient's Name ________________________

Date ____________ Time ____________

Completed by (check one):
☐ Patient
☐ Family caregiver
☐ Health care professional caregiver
☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

Appendix C: Pre-Session Questionnaire

Participant Number: ____________ **Date:** _______________

Please complete the following by circling your answers:

Gender:
- Female
- Male

Age Range:
- <20
- 20-29
- 30-39
- 40-49
- 50-59
- 60+

Status:
- RN
- RPN

Education Level:
- Certificate
- Diploma
- Bachelor’s Degree
- Master’s Degree
- Doctorate Degree

Years Experienced as RN or RPN:
- <1
- 1-5
- 6-15
- 16-25
- 26-35
- >35

Years as an Oncology Nurse:
- <1
- 1-5
- 6-15
- 16-25
- 26-35
- >35

Oncology Certification:
- Yes
- No

Appendix D: Postsession Questionnaire

Participant Number: ___________ **Date:** ________________

Please complete the following by circling your answers

Question	**Rating: Please Select One of the Answer** **Rating Scale:** 1=Strongly Disagree; 2=Disagree; 3=Neutral; 4=Agree; 5=Strongly Agree				
I understand the meaning of cancer related distress	1	2	3	4	5
I am able to identify at least three risk factors for those experiencing cancer related distress	1	2	3	4	5
I know how to screen for cancer related distress in patients with cancer	1	2	3	4	5
ESAS-r stands for Edmonton System Assessment Symptom (revised version)	1	2	3	4	5
Psychosocial care is considered the 6th vital sign	1	2	3	4	5
Cancer related stress is always psychological/emotional	1	2	3	4	5
The distress thermometer is used to identify the source of distress	1	2	3	4	5
Men are more likely to experience distress than women	1	2	3	4	5
I am confident in my ability to identify and manage cancer related distress	1	2	3	4	5

I know when a patient should be referred to specialized services	1	2	3	4	5

Appendix E: Evaluation of Educational Program

Please complete the following by circling your answers:

The program met the stated educational objectives

a) Strongly Agree
b) Agree
c) Neither Agree nor Disagree
d) Disagree
e) Strongly Disagree

The educational program improved/increase my knowledge on cancer related distress screening

a) Strongly Agree
b) Agree
c) Neither Agree nor Disagree
d) Disagree
e) Strongly Disagree

I would recommend this educational session to my peers

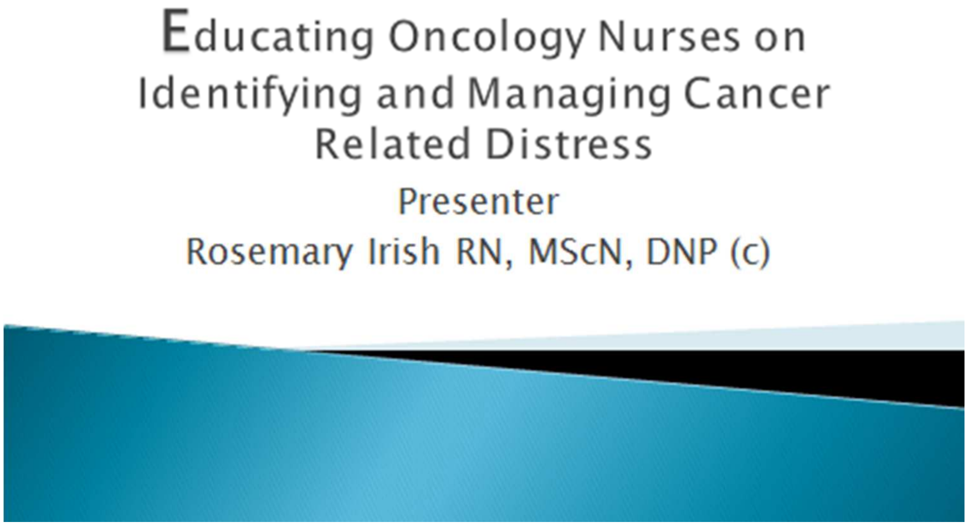
a) Strongly Agree
b) Agree
c) Neither Agree nor Disagree
d) Disagree
e) Strongly Disagree

I will apply the knowledge gained to my practice

a) Strongly Agree
b) Agree
c) Neither Agree nor Disagree
d) Disagree
e) Strongly Disagree

Please provide any comments/feedback you feel will improve the program:

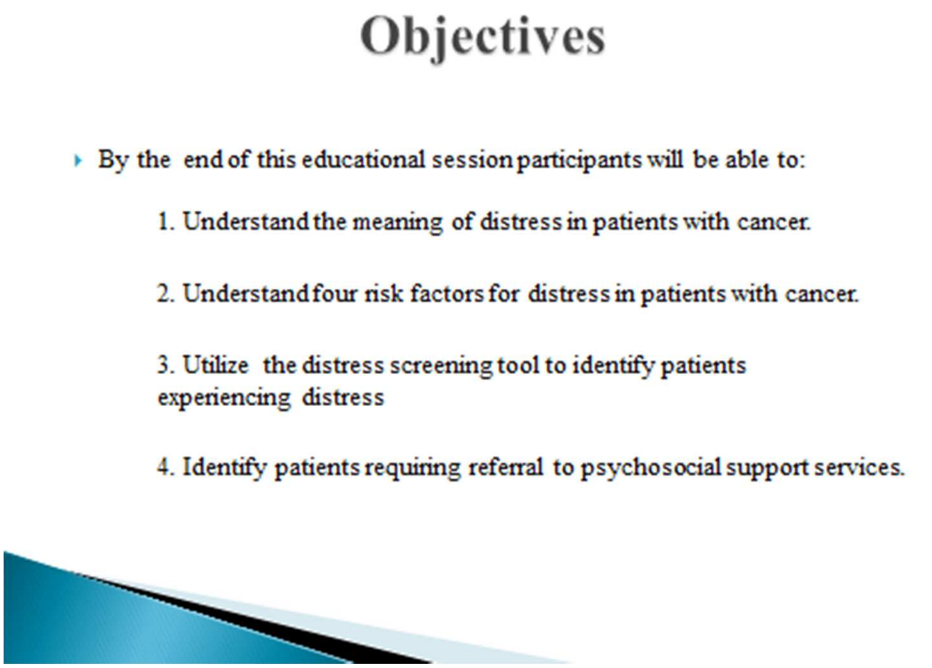
Appendix F: PowerPoint



Educating Oncology Nurses on Identifying and Managing Cancer Related Distress

Presenter

Rosemary Irish RN, MScN, DNP (c)



Objectives

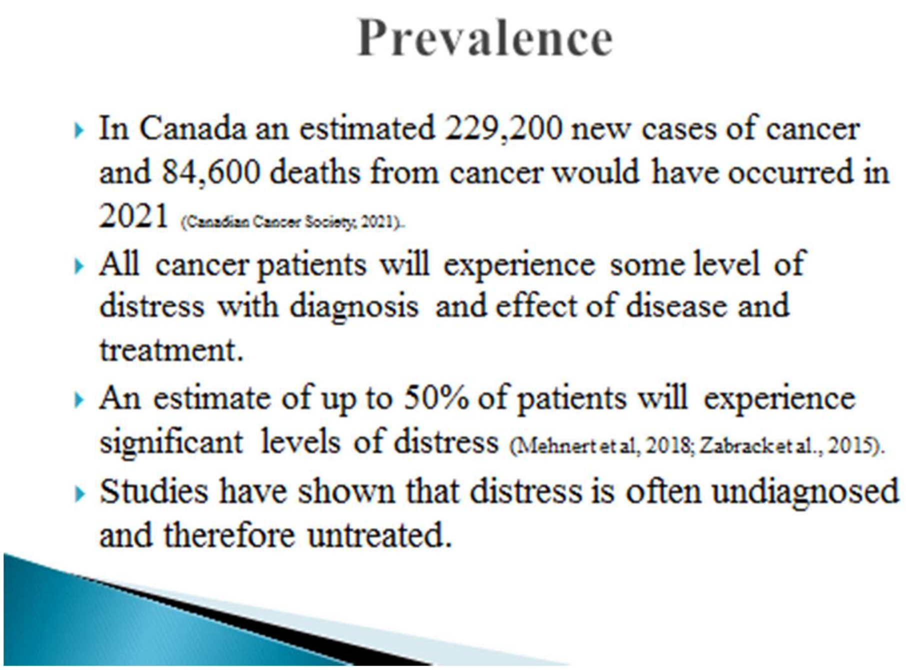
- By the end of this educational session participants will be able to:

  1. Understand the meaning of distress in patients with cancer.

  2. Understand four risk factors for distress in patients with cancer.

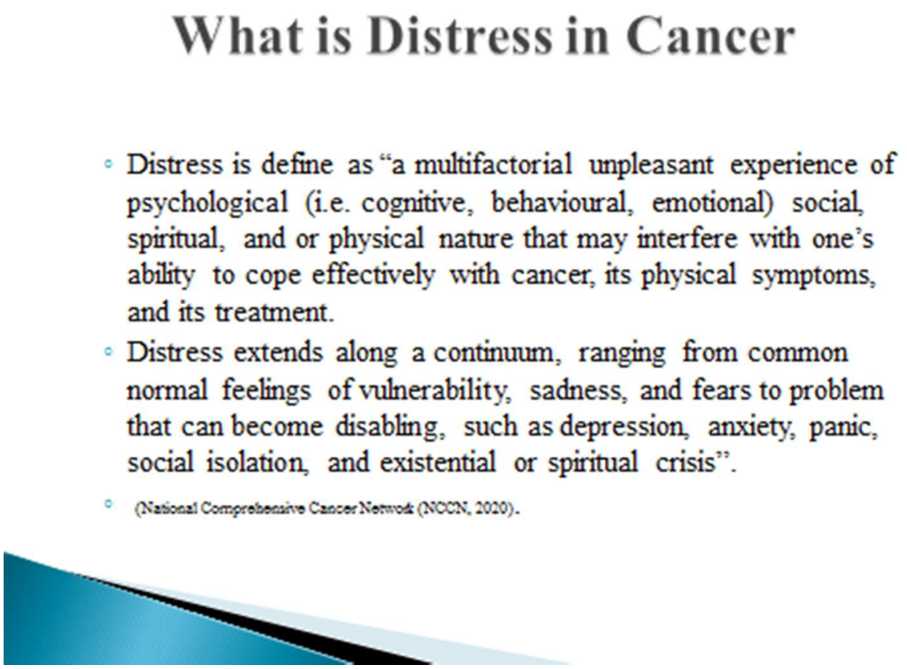
  3. Utilize the distress screening tool to identify patients experiencing distress

  4. Identify patients requiring referral to psychosocial support services.



Prevalence

- In Canada an estimated 229,200 new cases of cancer and 84,600 deaths from cancer would have occurred in 2021 (Canadian Cancer Society, 2021).
- All cancer patients will experience some level of distress with diagnosis and effect of disease and treatment.
- An estimate of up to 50% of patients will experience significant levels of distress (Mehnert et al, 2018; Zabrack et al., 2015).
- Studies have shown that distress is often undiagnosed and therefore untreated.



What is Distress in Cancer

- Distress is define as "a multifactorial unpleasant experience of psychological (i.e. cognitive, behavioural, emotional) social, spiritual, and or physical nature that may interfere with one's ability to cope effectively with cancer, its physical symptoms, and its treatment.
- Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problem that can become disabling, such as depression, anxiety, panic, social isolation, and existential or spiritual crisis".
- (National Comprehensive Cancer Network (NCCN, 2020).

Risk Factors

- Age and gender (younger persons and females)
- Comorbid disease
- Language barriers
- Psychiatric disorder, depression, substance abuse
- Spiritual and religious concerns

Triggers of Distress

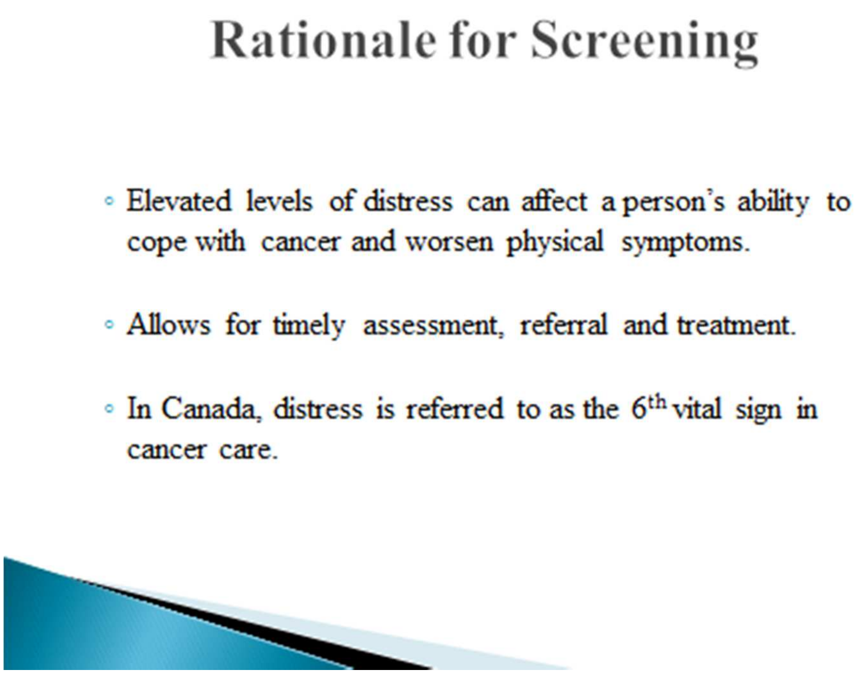
- Waiting for treatment to start
- Learning cancer has worsened or spread
- Being admitted or discharged from hospital
- Transitions in care i.e. finishing treatment, extending follow ups

Standard of Care (NCCN)

- Distress should be recognized, monitored, treated promptly and documented at all stages of disease and in all settings (NCCN, 2020).

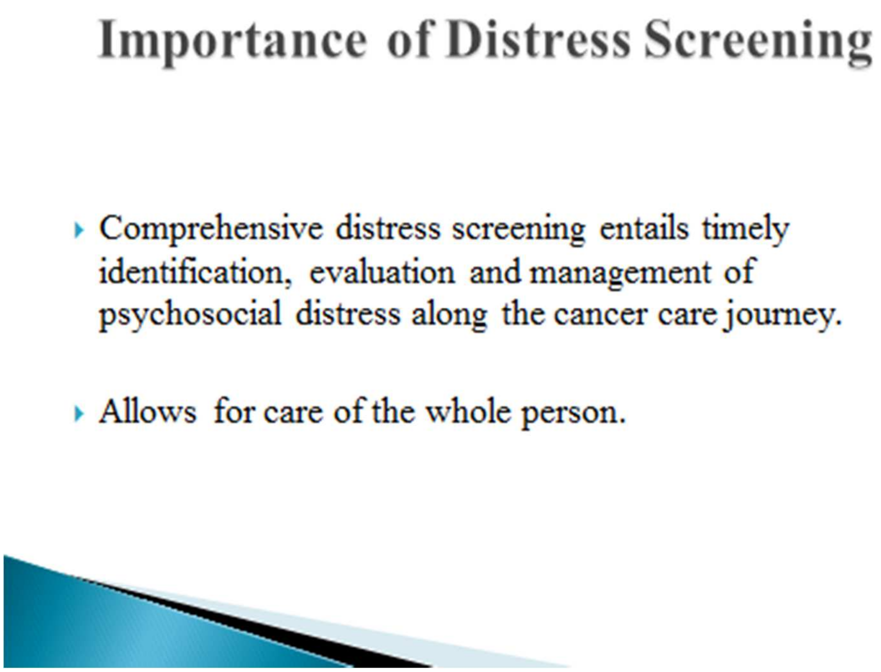
CANO Standards of Care

- Domain #1:Individualized and holistic
  (entails comprehensive psychological and physical assessment from diagnosis through treatment and beyond)
- Domain #5:Coordinated and Continuous
  (Includes prevention, screening, early detection and treatment)
- Domain # 6: Supportive, Therapeutic Relationship
  (knowledgeable, caring care along the cancer journey)
- Evidence Based Care
  (care based on physiological and psychosocial sciences and best practices)



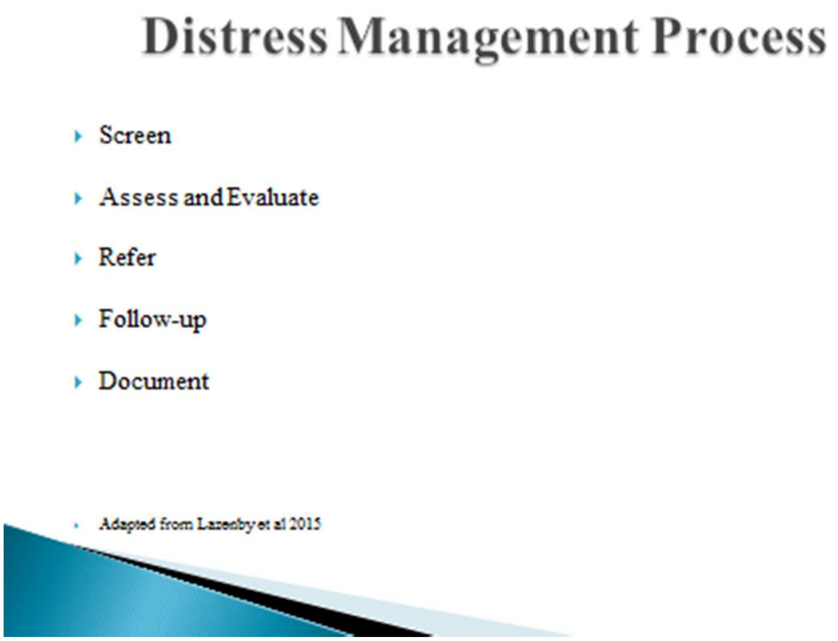
Rationale for Screening

- Elevated levels of distress can affect a person's ability to cope with cancer and worsen physical symptoms.
- Allows for timely assessment, referral and treatment.
- In Canada, distress is referred to as the 6th vital sign in cancer care.



Importance of Distress Screening

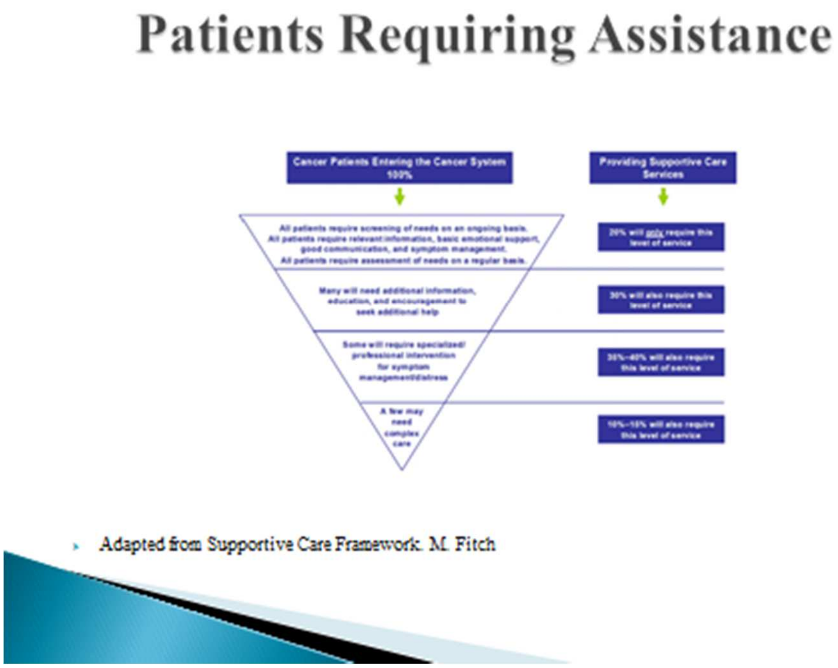
- Comprehensive distress screening entails timely identification, evaluation and management of psychosocial distress along the cancer care journey.
- Allows for care of the whole person.



Distress Management Process

- Screen
- Assess and Evaluate
- Refer
- Follow-up
- Document

- Adapted from Lazenby et al 2015



Patients Requiring Assistance

Cancer Patients Entering the Cancer System 100%

Providing Supportive Care Services

All patients require screening of needs on an ongoing basis.
All patients require relevant information, basic emotional support, good communication, and symptom management.
All patients require assessment of needs on a regular basis.

20% will only require this level of service

Many will need additional information, education, and encouragement to seek additional help

30% will also require this level of service

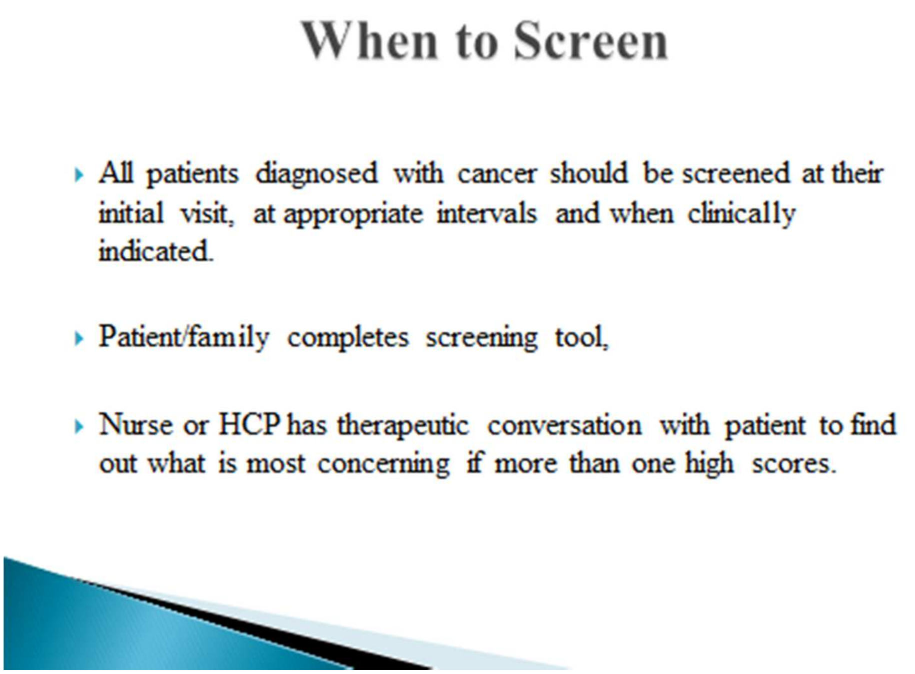
Some will require specialized/ professional intervention for symptom management/distress

35%–40% will also require this level of service

A few may need complex care

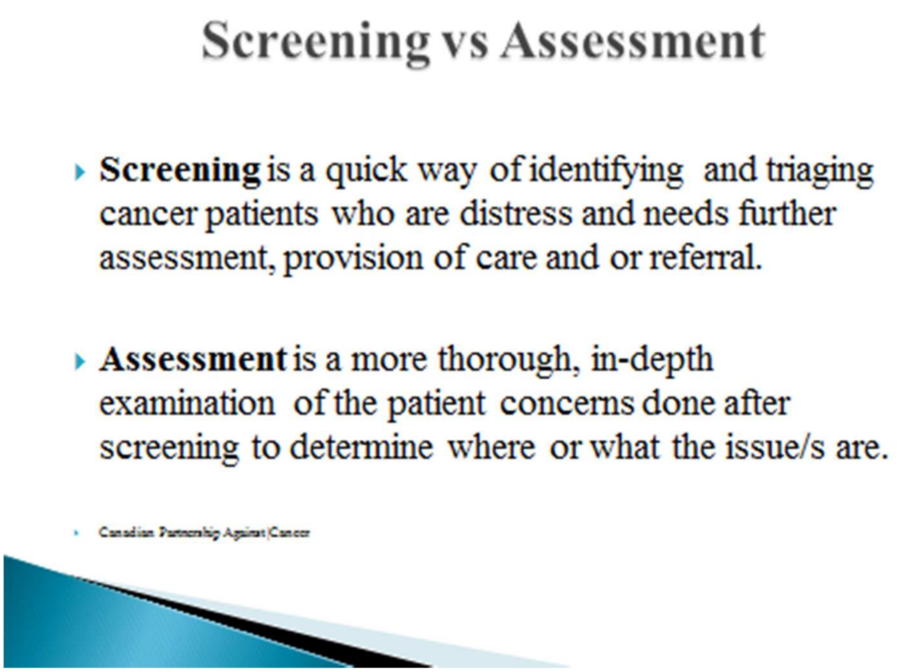
10%–15% will also require this level of service

- Adapted from Supportive Care Framework. M. Fitch



When to Screen

- All patients diagnosed with cancer should be screened at their initial visit, at appropriate intervals and when clinically indicated.
- Patient/family completes screening tool,
- Nurse or HCP has therapeutic conversation with patient to find out what is most concerning if more than one high scores.

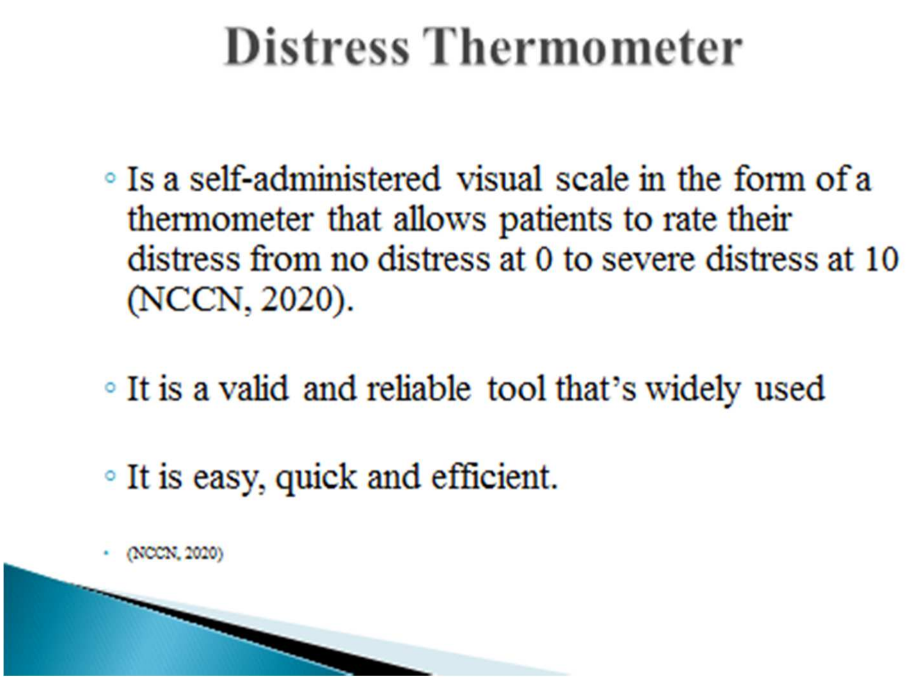


Screening vs Assessment

- **Screening** is a quick way of identifying and triaging cancer patients who are distress and needs further assessment, provision of care and or referral.
- **Assessment** is a more thorough, in-depth examination of the patient concerns done after screening to determine where or what the issue/s are.
- Canadian Partnership Against Cancer

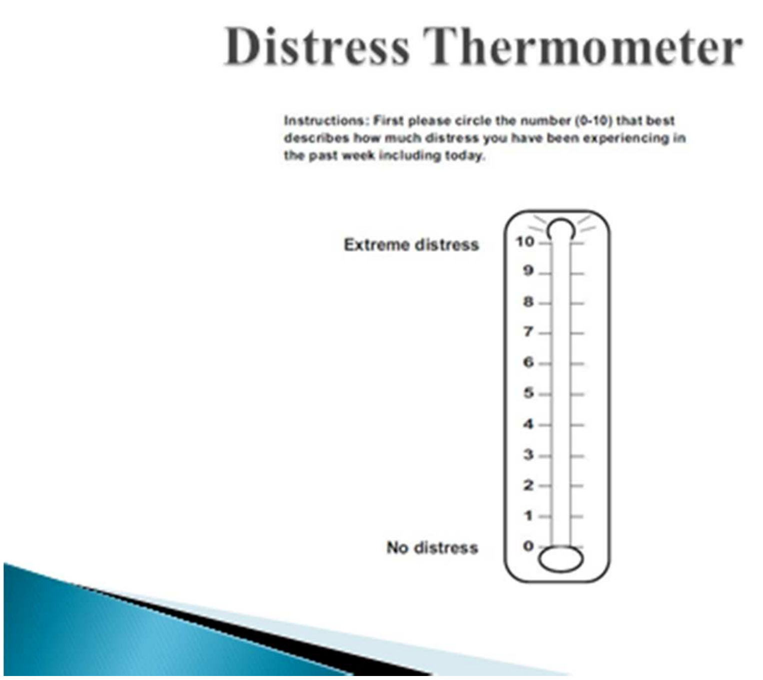
Tools for Distress Screening

- Distress Thermometer
- Edmonton Symptom Assessment System-r
- Canadian Problem Checklist



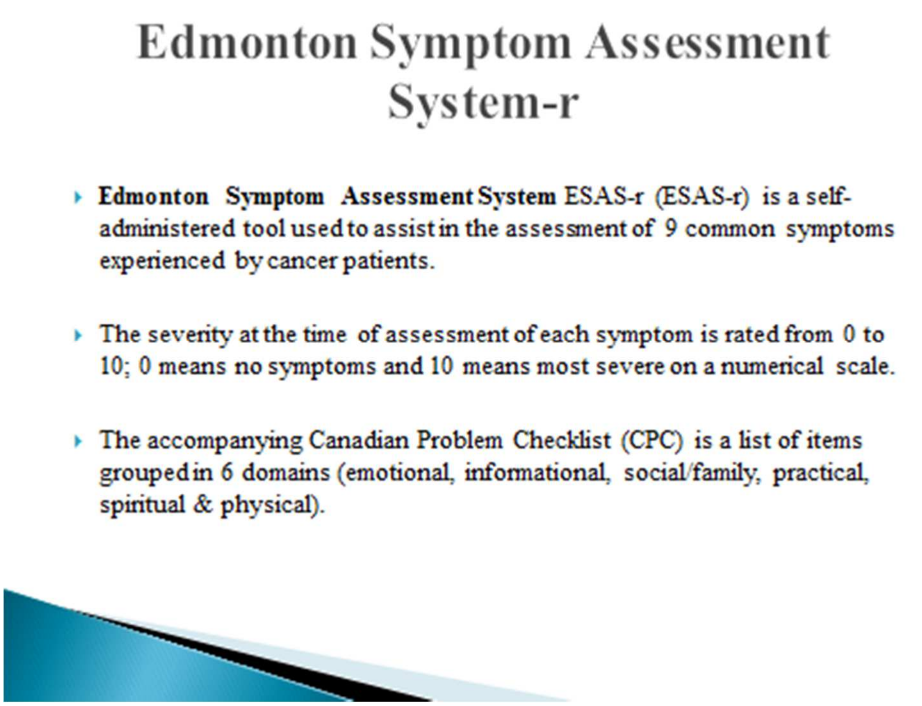
Distress Thermometer

- Is a self-administered visual scale in the form of a thermometer that allows patients to rate their distress from no distress at 0 to severe distress at 10 (NCCN, 2020).
- It is a valid and reliable tool that's widely used
- It is easy, quick and efficient.
- (NCCN, 2020)



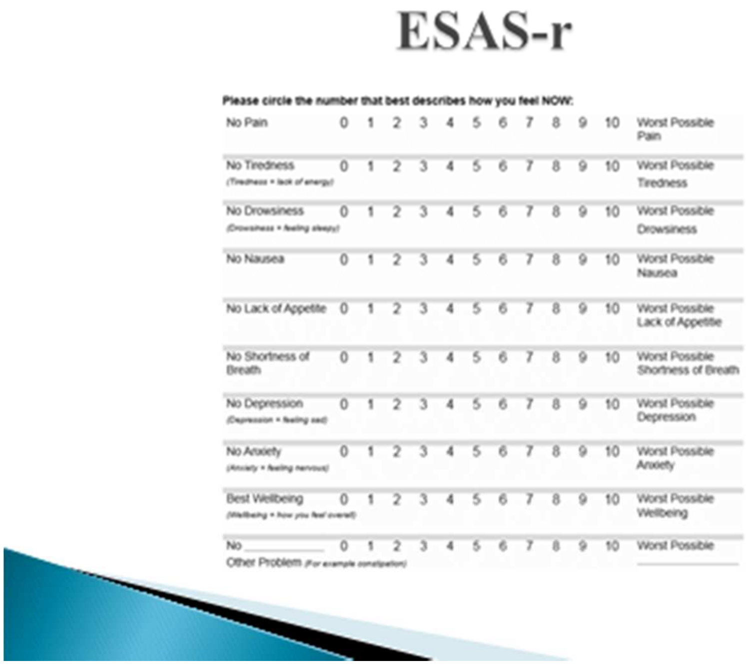
Distress Thermometer

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Edmonton Symptom Assessment System-r

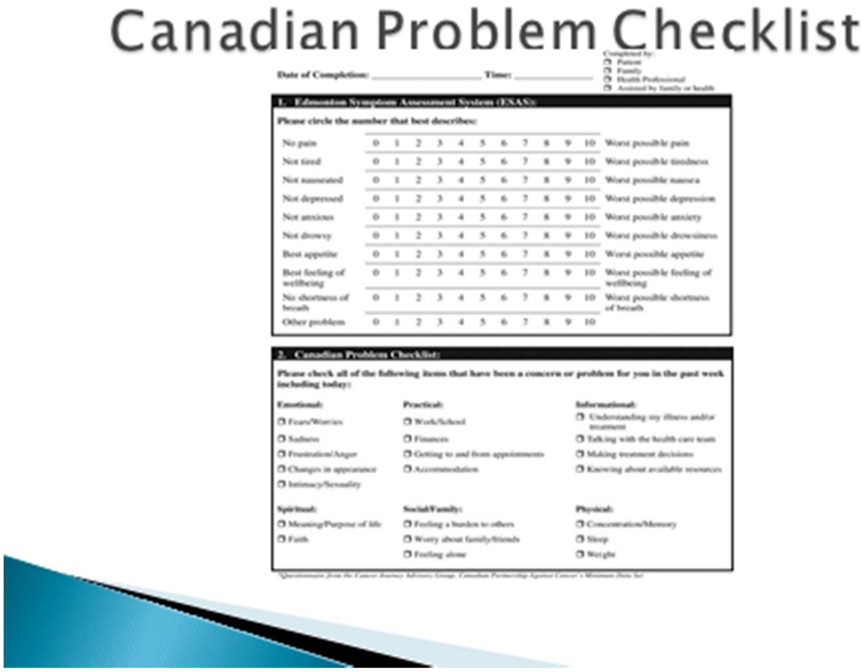
- **Edmonton Symptom Assessment System** ESAS-r (ESAS-r) is a self-administered tool used to assist in the assessment of 9 common symptoms experienced by cancer patients.
- The severity at the time of assessment of each symptom is rated from 0 to 10; 0 means no symptoms and 10 means most severe on a numerical scale.
- The accompanying Canadian Problem Checklist (CPC) is a list of items grouped in 6 domains (emotional, informational, social/family, practical, spiritual & physical).



ESAS-r

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No __________ Other Problem *(For example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible __________



Canadian Problem Checklist

Date of Completion: ________________ **Time:** ____________

Completed by:
☐ Patient
☐ Family
☐ Health Professional
☐ Assisted by family or health

1. Edmonton Symptom Assessment System (ESAS):

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

2. Canadian Problem Checklist:

Please check all of the following items that have been a concern or problem for you in the past week including today:

Emotional:
☐ Fears/Worries
☐ Sadness
☐ Frustration/Anger
☐ Changes in appearance
☐ Intimacy/Sexuality

Practical:
☐ Work/School
☐ Finances
☐ Getting to and from appointments
☐ Accommodation

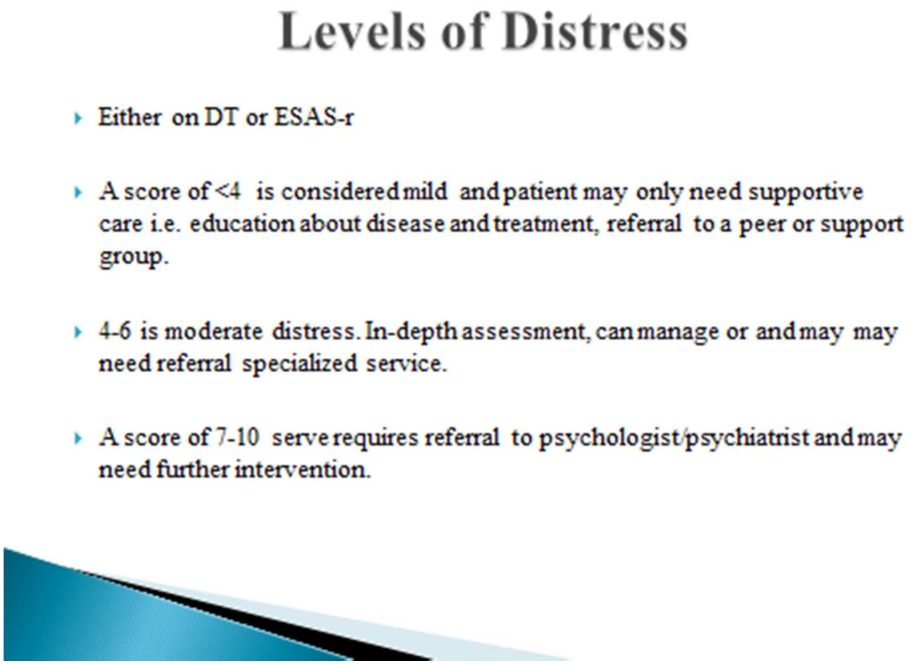
Informational:
☐ Understanding my illness and/or treatment
☐ Talking with the health care team
☐ Making treatment decisions
☐ Knowing about available resources

Spiritual:
☐ Meaning/Purpose of life
☐ Faith

Social/Family:
☐ Feeling a burden to others
☐ Worry about family/friends
☐ Feeling alone

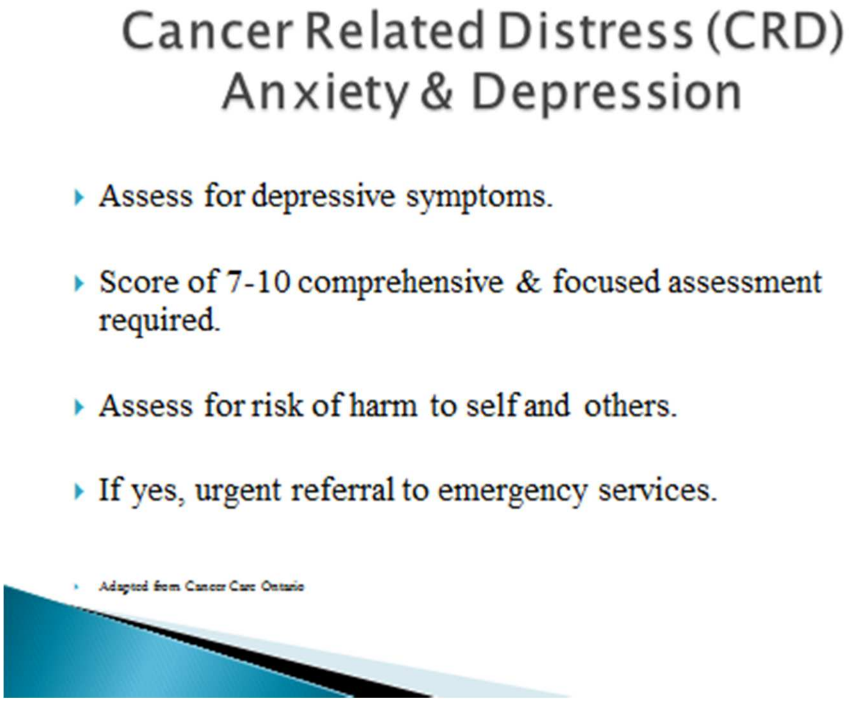
Physical:
☐ Concentration/Memory
☐ Sleep
☐ Weight

**Questionnaire from the Cancer Journey Advisory Group, Canadian Partnership Against Cancer's Minimum Data Set*



Levels of Distress

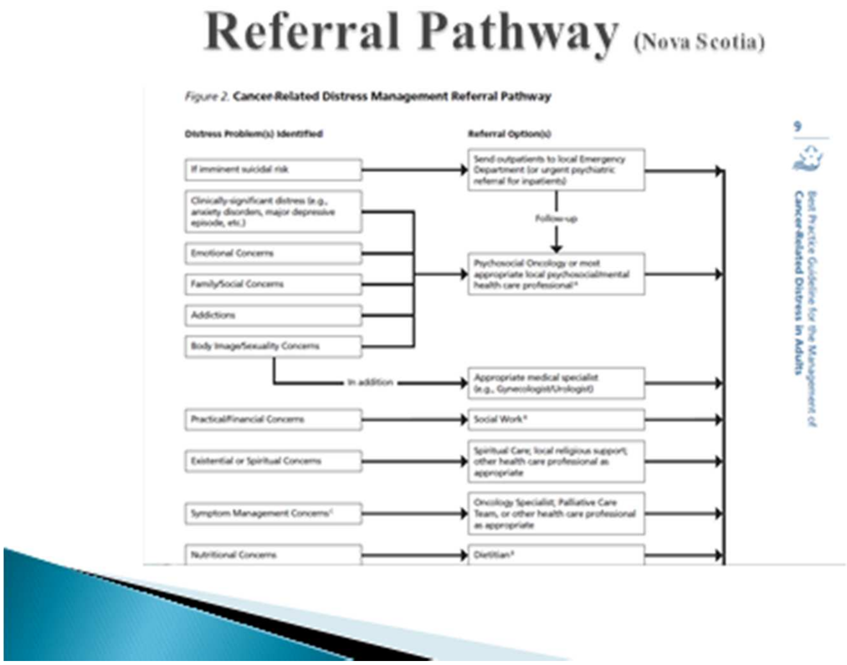
- Either on DT or ESAS-r
- A score of <4 is considered mild and patient may only need supportive care i.e. education about disease and treatment, referral to a peer or support group.
- 4-6 is moderate distress. In-depth assessment, can manage or and may may need referral specialized service.
- A score of 7-10 serve requires referral to psychologist/psychiatrist and may need further intervention.



Cancer Related Distress (CRD) Anxiety & Depression

- Assess for depressive symptoms.
- Score of 7-10 comprehensive & focused assessment required.
- Assess for risk of harm to self and others.
- If yes, urgent referral to emergency services.

- Adapted from Cancer Care Ontario



Referral Pathway (Nova Scotia)

Figure 2. **Cancer-Related Distress Management Referral Pathway**

Distress Problem(s) Identified

Referral Option(s)

If imminent suicidal risk → Send outpatients to local Emergency Department (or urgent psychiatric referral for inpatients)

Follow-up

Clinically-significant distress (e.g., anxiety disorders, major depressive episode, etc.) → Psychosocial Oncology or most appropriate local psychosocial/mental health care professional*

Emotional Concerns

Family/Social Concerns

Addictions

Body Image/Sexuality Concerns

In addition → Appropriate medical specialist (e.g., Gynecologist/Urologist)

Practical/Financial Concerns → Social Work*

Existential or Spiritual Concerns → Spiritual Care; local religious support; other health care professional as appropriate

Symptom Management Concerns[1] → Oncology Specialist, Palliative Care Team, or other health care professional as appropriate

Nutritional Concerns → Dietitian*

Key Points

- Up to 50% of cancer patients experience CRD.
- Distress screening is a standard of care for patients with cancer.
- All cancer patients should be screened for distress @ pivotal points and receive basic information & emotional support.
- Screening alone does not improve patient outcomes
- Patients experiencing high levels of distress should be referred to appropriate services.
- Untreated distress contributes to poor health outcomes and QOL.

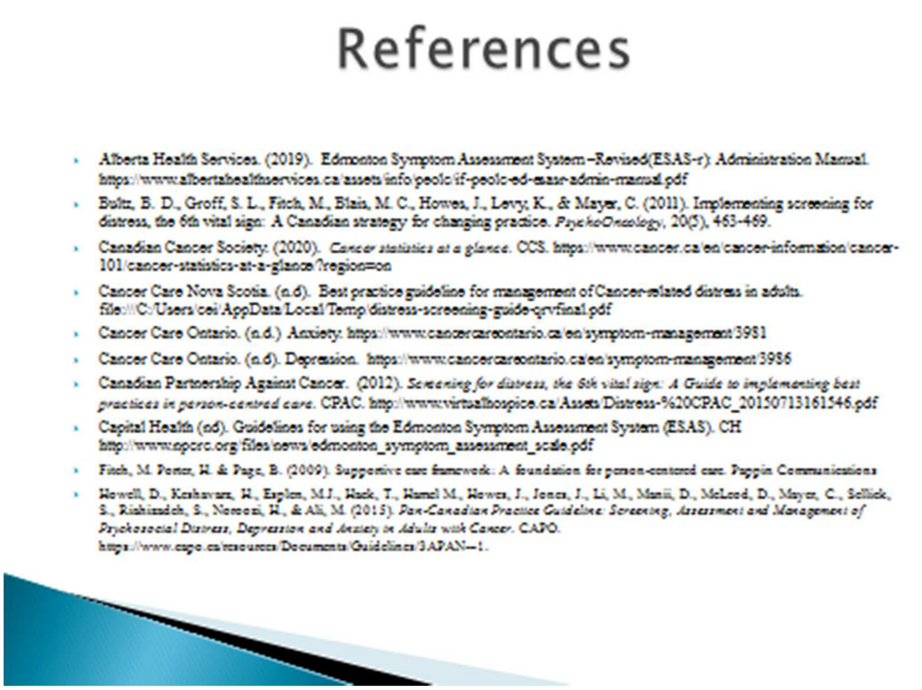
Nursing Implications

- Screening and assessment
- Providing education and support to patient and families
- Referrals to other members of the healthcare team as needed
- Follow up and documentation (all distress screening process should be documented)

Thank You

For your Participation

Questions?



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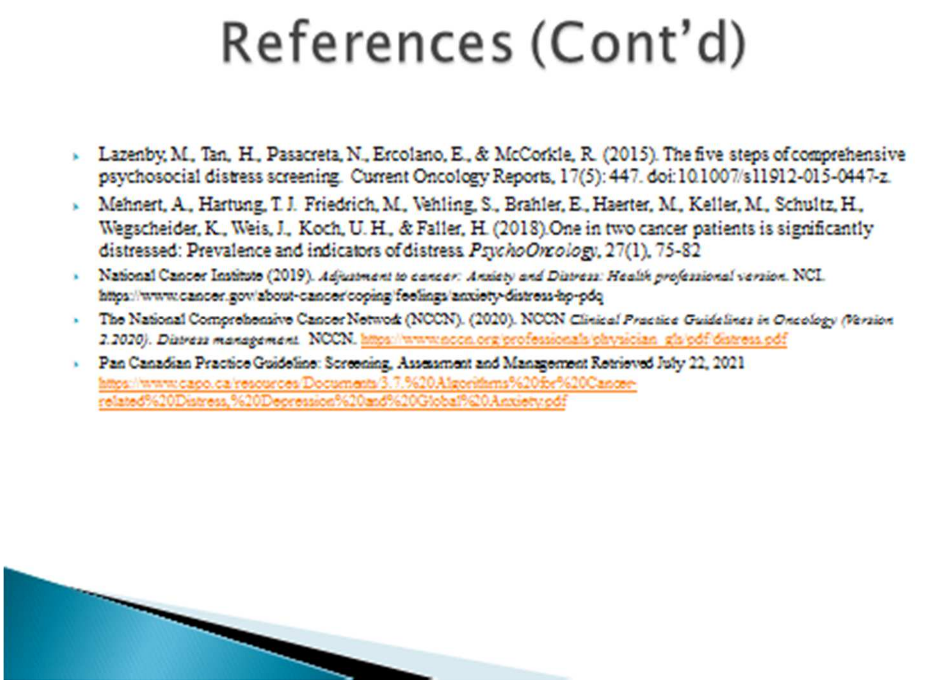

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