DISTRESS MANAGEMENT IN CANCER PATIENTS: EVALUATION OF PROJECT TO IMPLEMENT A POLICY AND PROCEDURE

Monique Swiecichowski, RN, BSN, MSN (c), CCRC, OCN, Aurora Health Care, Milwaukee, WI. 414-219-7458 or Monique.swiecichowski@aurora.org.

Poster Presentation

Background: 45% of cancer patients do not report high distress levels; therefore the Commission on Cancer (CoC) and the Quality Oncology Practice Initiative (QOPI) have added distress management to their accreditation standards. Cancer Nurse Navigators (CNN) in a large Midwestern health system have been assessing distress using a tool endorsed by the National Comprehensive Cancer Network (NCCN), the Distress Thermometer (DT), since 2010. In late 2012-early 2013, the DT was imbedded into the electronic health record (Approval granted by NCCN.) The same large Midwestern health system developed a policy and procedure for distress management. Oncology nurses develop a unique relationship with their patients and are often able to identify emotional changes in their patients. They are instrumental in acknowledging and assessing for distress and then mobilizing resources in the management of distress. There are > 6000 new cancer patients/year, 24 CNN’s, and >26 outpatient oncology clinics in the stated health system extending from Marinette to Kenosha/Racine. A collaborative effort with all oncology nurses for distress management is needed.

Project question: Can a large health system with greater than 100 oncology nurses implement distress screening more successfully than with 23 CNNs? The goal was to pilot the implementation and workflow of the psychosocial distress screening. The objectives were to obtain an 80% completion screening rate and identify the barriers and facilitators perceived by the nursing staff.

Population: Two ambulatory oncology units; a medical oncology clinic and a radiation oncology clinic were the pilot sites.

Frameworks: Michel’s Uncertainty in Illness Theory (UIT), Azjen’s Planned Behavior Theory, and the Oncology Nursing Society Stages of Incorporating Evidence-Based Practice guided this project.

Method: The pilot was approved by the institution’s Beacon Governance Council. Staff at the two pilot sites was provided education including: the NCCN Distress Management Guidelines, the new policy and procedure, patient benefits, application of the DT tool, and documentation into EPIC. The process included a power point presentation, paper copy of slides, live demonstrations, and a quick reference guide.

Results: Charts were reviewed for verification of distress screening and the nurses were asked to complete a questionnaire about the process. The DT completion performance rate for 6 months was 75% for radiation oncology and 90% for medical oncology; an average of 82%. Facilitators included successful interventions and nurses recognizing the benefits to patients. Barriers were an inadequate workflow, unspecific referral pathway, and inadequate education for staff that were not at the formal sessions.

Conclusions/Implications: The results of this pilot show that an 80% performance rate goal is achievable and it identified a workflow for radiation oncology units and medical oncology units. Prior to other site implementations, site managers may consider introducing the initiative at staff meetings and with a display using the ‘ADIP’ poster, and identifying champion. Formal staff education and demonstrations will be offered and a learning module in Learning Connection made available with consideration to making it mandatory. Each site should create a referral pathway with contact numbers specific to that site. The reportable data on a newly created Clarity Report will better identify and assess measurable outcomes. The process will continue to be evaluated and performance rates monitored. Additional data will be collected and evaluated for identification of patient outcomes and compliance to the CoC and QOPI standards.