PART I

The Problem of Symptom Distress

Chapter 1

Evidence-Based Symptom Management

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The cancer experience, extending from screening and early detection to survivorship or death, involves a wide array of responses by the individual patient, his or her loved ones, and healthcare providers. The responses, most often referred to as symptoms, signs, or side effects, may have a positive, negative, or mixed impact on the person. When side effects of cancer or its treatment are negatively perceived, the person experiences distress. The experience of distress occurs in all patients with cancer,[1] making symptom management a clinical and ethical imperative.

Prolonged or ineffectual management of distress contributes to noncompliance with treatment, reduced quality of life, chronic psychosocial problems, and symptom worsening.[2] It is important to understand that distress is itself a symptom. Understanding distress and other symptoms and side effects of cancer and its treatment assists the oncology nurse caring for the patient to more accurately assess and diagnosis the patient problem and intervene appropriately. To optimize patient outcomes, nursing assessments and interventions should be based on reliable and valid evidence. This chapter discusses evidence-based practice and theory and their application to nurse-sensitive outcomes using the symptom of distress as an exemplar.

EVIDENCE-BASED PRACTICE

Evidence-based practice (EBP) provides the rationale for nursing actions. The concept of providing nursing care based on the best available evidence stretches back to Florence Nightingale, who collected meticulous data about each patient and care setting.[3] Evidence-based practice comprises research findings, clinician expertise, patient preference, and practice setting culture and resources.[4] When each of these factors is maximally incorporated into nursing care, optimal patient outcomes are achieved.[5]

The task of analyzing the best available evidence can be overwhelming. Fortunately, there are many resources providing detailed outlines, helpful tools, and training in the EBP process. The reader is encouraged to use the list of sources in Table 1-1 for detailed information on the various models and steps outlined in Table 1-2, the commonly identified steps in the EBP process.

Evidence-based practice guidelines are developed when adequate, reliable, and valid evidence supports particular interventions or actions. Comprehensive and meticulous reviews of evidence are completed, which requires an excellent understanding of research methodology and statistics. However, the clinical utility, practicality, and cultural appropriateness must be evaluated by those healthcare providers in the setting where the research findings are to be implemented into practice. Implementation of evidence-based practice guidelines helps ensure high-quality and cost-effective oncology nursing care. Practice guidelines are available online from several organizations, including the Oncology Nursing Society,[6] National Comprehensive Cancer Network,[7] Agency for Research and Healthcare Quality,[8] and Joanna Briggs Institute.[9]

The implementation of an evidence-based guideline may be difficult due to the differences between the controlled environment in which research is conducted

TABLE 1-1

Sources of Information about EBP Models and Processes

- Melnyk, BM & Fineout-Overholt, E. 2011 Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice, 2nd Ed. Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia.
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- Iowa Model: http://www.nnpnetwork.org/ebp-resources/iowa-model
- Oncology Nursing Society: http://www.ons.org/Research/EBPRA/Process

TABLE 1-2

Process of Evidence-Based Practice

- Develop the clinical practice question
  - PICOT acronym often used to clarify the specific question/problem
    - **P**atient or Population
    - **I**ntervention or Issue of interest
    - **C**omparison intervention or group
    - **O**utcome desired
    - **T**ime frame
- Find relevant evidence
  - Research findings
    - Common system used for rating levels of evidence
      - Level I Systematic review or meta-analysis of randomized controlled studies
      - Level II Randomized, controlled clinical trials
      - Level III Controlled trials without randomization
      - Level IV Case control or cohort studies
      - Level V Systematic review of descriptive or qualitative studies
      - Level VI Single descriptive or qualitative study
      - Level VII Authoritative opinion or expert reports
  - Quality improvement data
  - Patient data
- Evaluate the evidence for quality, quantity, and consistency
- Develop a plan to incorporate the evidence into practice
  - Policy changes
  - Educational requirements
  - Procurement of supplies
  - Budgeting

Evaluate of the practice change on outcomes

Phase	Description	Example
T_0	Identification of opportunities and approaches to health problems.	Art therapy as an intervention to decrease distress.
T_1	Takes approaches identified in T_0 and applies them to a specific situation or population	Testing the use of art therapy in the oncology setting, exploring the optimal number and frequency of sessions to achieve a decrease in distress.
T_2	Evaluates the approach and results in an evidence-based guideline	Evaluate all evidence on decreasing distress in people being treated for cancer and develop a guideline for managing distress in patients being treated for cancer.
T_3	Moves evidence-based guidelines into practice	Tests the distress management guideline in the practice setting for feasibility and efficacy.
T_4	Evaluates the outcomes in the clinical setting	Measures the impact of using the distress management guideline on operational, provider and patient outcomes

FIGURE 1-1

Phases in Translation Research.

Data from Khoury MJ, Gwinn M, Yoon PW, Dowling N, Moore CA, Bradley L. The continuum of translation research in genomic medicine: how can we accelerate the appropriate integration of human genome discoveries into health care and disease prevention? *Genet Med.* 2007;9(10):665–674.

and the complex and real-life nature of clinical practice settings.[10] Organizations do not always implement evidence-based practices. If such practices or guidelines are implemented, they are often done so inconsistently or in a manner different than designed, leading to suboptimal benefits. Issues with adopting evidence-based practices into routine clinical care have recently brought about an emphasis on the translation and diffusion of evidence into practice. A growing body of literature addresses the clinical application of research, also known as translational research.

Translational research is defined as research that "transforms scientific discoveries arising from laboratory, clinical, or population studies into clinical applications to reduce cancer incidence, morbidity, and mortality."[11] There are five phases of translational health research (Figure 1-1). When oncology nurses are implementing or changing practices due to evidence, they are most likely using level T_2 or T_3 study findings. If oncology nurses are involved in performance improvement activities related to the impact of using evidence in practice, level T_4 translational work is being conducted.

EVIDENCE-BASED PRACTICE AND DIFFUSION THEORY

The implementation of an evidence-based guideline may be difficult due to the differences between the controlled environment in which research is conducted and the complex and real-life nature of clinical practice settings.[11] Everett Rogers's Theory of the Diffusion of Innovation has been applied to understanding the adoption of clinical practice guidelines by several authors.[12–14] Rogers's theory identifies five areas that determine the rate and success of adopting evidence-based practices:1) perceived attributes of innovations; 2) type of innovation decision; 3) communication channels; 4) nature of the social system; and 5) extent of change agent's promotion efforts. In Rogers's theory, the speed at which evidence is incorporated into practice varies based on clinician and organizational perceptions of practice changes supported by the evidence. Adoption of evidence into practice is usually successful when positive perceptions of the change, involvement of stakeholders in key decisions, effective communication channels, and expectations are clear and a competent and respected person competently advocates for the changes.

NURSING IMPLICATIONS

Nursing is "the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations."[15] The results of nursing care relative to the patient and his or her healthcare problems are called nursing sensitive outcomes. Requisites for determining whether an outcome is nurse sensitive include the intervention existing within the scope of nursing practice, evidence supporting the nursing intervention as contributing to the outcome, and the

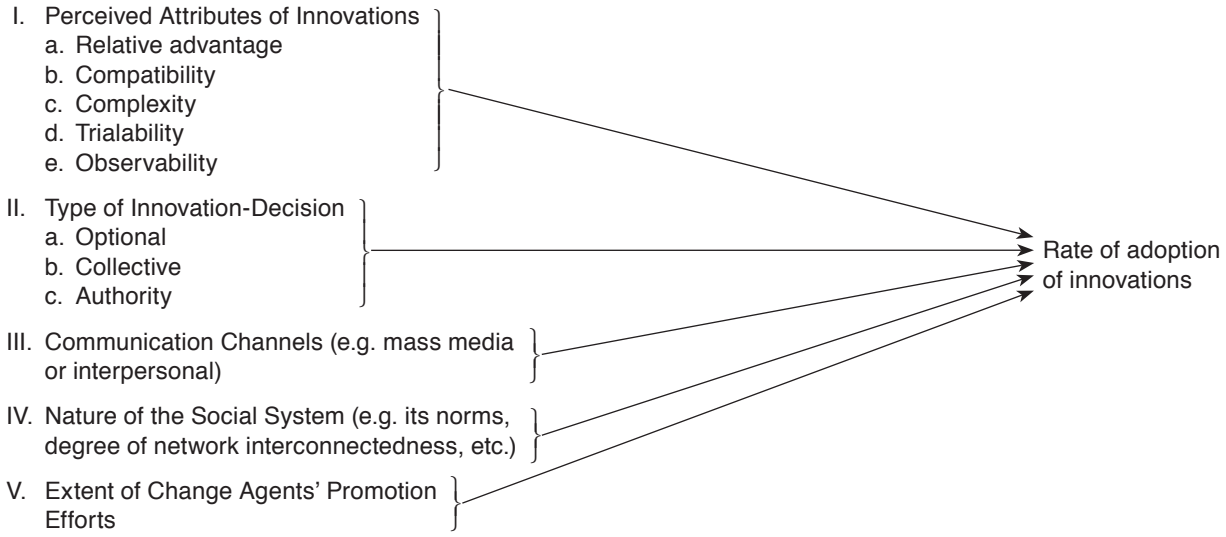

FIGURE 1-2

Variables Determining the Rate of Adoption of Innovation.

Reprinted with permission from Rogers EM. *Diffusion of Innovations.* 4th ed. New York: Free Press; 1995.

intervention being fundamental to the nursing process.[16] The Oncology Nursing Society identifies five categories of oncology nursing-sensitive outcomes: symptom experience, functional status, safety, psychological distress, and economic. The organization has used these categories as a framework for guiding the development of evidence-based practice guidelines and quality outcome initiatives.

Providing care using the best available evidence stretches back to Florence Nightingale, who collected meticulous data about each of her patients and that patient's care setting. Nursing care is based on the five steps of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. Research has been conducted addressing each of the five steps within the nursing process. Within the realm of nursing assessment, tools for screening and assessment have been developed that reliably assess for many oncology nursing-sensitive outcomes, many of which are discussed in later chapters of this text. The diagnostic step of the nursing process is supported by research such as the work on symptom clusters.[17–22] Nursing interventions are critical to improving nursing-sensitive outcomes. A growing body of evidence has identified nursing interventions that can effectively improve symptom distress,[23–26] improve quality of life,[27–29] and improve cancer screening.[30,31]

Finally, the evaluation of nursing care is synonymous with outcomes and asks the question, "Were the goals of care achieved?" Evaluation occurs at the individual level, at which the patient perspective must be taken into account. Patient satisfaction surveys and focus groups are often used to collect such data. Evaluation may also occur at the aggregate level. Outcome measurements are often conducted using quality assurance, quality improvement, and research methods.

Nurses provide assessments of the cancer symptom experience throughout the cancer trajectory. Knowledge of the signs and symptoms of the tumor, treatments, and associated complications accounts for the vast majority of oncology nursing expertise. The diagnosis and treatment of cancer-related symptoms require the nurse to remain current with the variations among tumor and treatment types as well as the nuances that occur at the individual level. This responsibility can often seem overwhelming given the constantly changing clinical environment and the vast quantity of research that has been published. Fortunately, several organizations (identified earlier in this chapter) provide comprehensive reviews of the evidence and issue practice guidelines that can be used by the practicing nurse.

CASE EXAMPLE: DISTRESS MANAGEMENT

You work in a community outpatient cancer clinic that is a department within the hospital. The center is accredited through the American College of Surgeons. The center has three medical oncologists, one radiation oncologist, and one nurse practitioner. Your clinic provides radiation and chemotherapy treatments for adult patients only. Nursing staff provide patient care during physician visits and chemotherapy administration. The center also has a dedicated social worker and dietician. Other professional resources, such as counseling, chaplaincy, and physical therapy, are available by referral.

The Institute of Medicine identified distress management as a critical element of care in the report *Psychosocial Care for the Whole Patient*.[32] The American College of Surgeons recently made distress assessment and management a requirement for accreditation.[33] The hospital where you work has chosen to follow the National Comprehensive Cancer Network Distress Management Guideline.[34] This guideline uses the Distress Thermometer (DT), a vertically drawn depiction of a thermometer on which patients rate their distress level over the past week on a scale from 0 (bottom of thermometer, indicating no distress) to 10 (top of thermometer, extreme distress). They mark items on the problem list next to the Distress Thermometer that they feel contribute to their distress. The guideline has a decision tree for referrals and interventions, dependent upon the source(s) of distress.

Your clinic uses an electronic medical record (EMR), with computers through which to access the EMRs being located in each exam room, in the accelerator control room, and throughout the chemotherapy administration area. Current nursing assessment data required in the EMR focuses on physiologic symptoms, but not psychosocial needs. However, the hospital computer support department recently integrated the Distress Thermometer[34] into the nursing assessment page used by the nurses in the outpatient oncology areas.

You are a nurse working with one of the medical oncologists. Your manager has assigned you the task of developing the policy and procedure for distress management in the outpatient cancer center. He gave you level 3 accountability, which means you need only to keep him informed of your progress. Upon reviewing the guideline and decision diagrams, you realize implementation should involve several disciplines.[35] Using Rogers's Diffusion of Innovation Theory, you anticipate that adoption of the guideline into practice will be more successful if the staff most affected by the decisions are involved. Thus you decide to use a team approach for this project.

Your team members include the cancer center's social worker and dietician, a radiation therapist, a chemotherapy infusion nurse, the nurse educator responsible for patient and nurse cancer education for the hospital, a staff member of the quality improvement department, and a staff member from the computer support team. The medical oncologist you work with has agreed to champion the project among the physicians but will not attend the meetings. She has requested that you keep her informed of the project's progress and decisions. She has agreed to a team presentation of the completed project during the monthly physician meeting.

Your team meets to review the project. You review the guideline with the group.[34] Although the DT and problem list are already available on the EMR, the team has questions about who is responsible for the screening and referral process and the frequency of screening. Because the DT and problem list are to be completed by the patient, another question arises about how the patient is to respond to the DT and problem list and how the responses should be entered into the EMR. After much discussion, the team identifies a need to review research related to the implementation of the guideline. You take the group through the PICOT process before requesting a literature search room the librarian at the hospital.

- **P**opulation: outpatient and/or office-based oncology clinic
- **I**ntervention/issue: implementation of a process for distress screening and management using EMRs
- **C**omparison intervention/group: none or pre/post implementation data
- **O**utcome desired: successful implementation of the guideline
- **T**ime frame: throughout the treatment phase of cancer

You take this information to the librarian at your hospital. She conducts a literature search and finds several articles.[36–43] She tells you there were very few research articles specific to your setting, so she broadened her search to include all clinical settings, reviews, and commentaries. The librarian notes that the entire April 2012 volume of the *Journal of Clinical Oncology* was dedicated to psychosocial care, with several articles covering distress management. You assign each team member to read and evaluate two articles each. You ask each team member to summarize each article using a table such as the one depicted in Table 1-3.

At the next team meeting, the summaries are reviewed and discussed for relevancy to your situation and setting. It is noted that the majority of articles found are anecdotal, case study, and quality improvement projects. The team summarizes the steps taken in each article that contributed to successful implementation as well as author recommendations. From this information you begin to develop a plan for implementing the National Comprehensive Cancer Network guideline. In your plan, you include education for all staff using several methods: self-study, online, and in-service programs. You work with the educator on the content and evaluation of learning. In addition, the educator helps draft the new policy using the required hospital format. This policy will be presented at the next Policy and Procedure Committee meeting for review and approval. The education effort requires a few resources such as paper, photocopying, and staff time. You work with your manager to develop the budget. You review the proposed policy and educational plan to the physician champion, and your team is scheduled to provide education and review of the project at the next physician meeting.

After the first week of implementing the policy for distress screening and management, your team meets again to celebrate the completion of this first phase of the project. The group also discusses how to monitor its ongoing use, resolve problems as they arise, and provide continual encouragement to the rest of the staff. At the meeting you suggest

TABLE 1-3

Example of Literature Review Summary Table

Reference info (title, author, journal)	Study Design	Study Sample	Study Methods	Summary of Findings/ Key Factors to Implementation	Level of Evidence
• Educational intervention in cancer outpatient clinics on routine screening for emotional distress • Grass, et al[40] • Psycho-Oncology	Observational study	Newly diagnosed cancer patient	Compared the Distress Thermometer scores of patients referred to psycho-social services with those who were not	• Differences were identified between patients not referred and those were. • Routine screening of all new patients resulted in more accurate referrals • Routine screening resulted in more referrals • Acceptance by staff and patients was low	VI-single descriptive study

that the group publish their experiences of implementation to help others facing the same situation. Everyone enthusiastically agrees. You lead a discussion to outline which information each member should continue to collect during the initial implementation phase. The group agrees to meet each month to review problems, resolutions, staff comments and organizational issues affecting the implementation of the guideline. This information will be used in the article.

Evidence-based practice provides a rationale for nursing actions. Research findings are just one facet of such evidence. Empirical findings, clinician experience and expertise, cultural issues, available resources, and patient preferences must also be factored into making decisions about nursing care. The dissemination of evidence and its translation into practice are the responsibility of all oncology nurses. Oncology nurses are in an ideal position to assess and manage the effects of cancer and its treatment on individuals and caregivers, thereby reducing distress. The remainder of this text reviews and applies an evidence-based approach to the assessment and management of symptoms commonly experienced by people with cancer.

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