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Incorporating Supportive Care Into Routine Cancer Care: The Benefits and Challenges to Clinicians' Practice

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Patients with cancer experience significant symptom burden (Butt et al., 2008), unmet psychosocial needs (Boyes, Girgis, & Lecathelinais, 2009; McIlmurray et al., 2001), and psychiatric morbidity (Strong et al., 2007; Zabora, BrintzenhofeSzoc, Curbow, Hooker, & Piantadosi, 2001). Current psychosocial guidelines recommend routine screening of all patients with cancer for distress and unmet psychosocial needs to prevent development of more significant disorders (National Comprehensive Cancer Network [NCCN], 2011) and improve patient physical and psychosocial outcomes (Boyes, Newell, Girgis, McElduff, & Sanson-Fisher, 2006; McLachlan et al., 2001).

The need for routine supportive care screening is supported by previous research indicating that clinician identification of patient physical and psychosocial needs is less than optimal (Fallowfield, 2001; Keller et al., 2004). Additional studies have indicated patient reluctance to raise supportive care concerns during clinic visits or to discuss them only at the initiative of the clinician. Clinicians also generally defer to the wishes of their patients when discussing emotional and psychosocial concerns (Detmar, Aaronson, Wever, Muller, & Schornagel, 2000) and note that issues patients most want assistance with are not necessarily those they feel most able to address (Snyder et al., 2007).

While acknowledging the need for supportive care screening, a range of barriers has been identified that are relevant to clinical implementation (Botti et al., 2006; Schofield, Carey, Bonevski, & Sanson-Fisher, 2006), including personal knowledge and perceived value of supportive care, practice (time, role-definition, resources), and organizational (feedback, rewards) barriers. Those barriers, alongside patient and clinician expectations for discussion of psychosocial issues, highlight the need for clinician training in supportive care provision in combination with appropriate clinical support.

Purpose/Objectives: To investigate clinicians' experiences with supportive care screening and referral, and identify perceived barriers and benefits associated with implementation into the clinical setting.

Design: Qualitative, exploratory approach based on interviews.

Setting: A large regional hospital in Victoria, Australia, that provides chemotherapy and radiotherapy services to patients with cancer.

Sample: 5 chemotherapy nurses and 1 radiation therapist.

Methods: Semistructured interviews were conducted, documented, and analyzed with qualitative techniques.

Main Research Variables: Clinical benefits of supportive care screening and referral, and barriers to clinical implementation.

Findings: Clinicians perceived that supportive care screening benefited their practice by improving communication and rapport with patients. Clinicians supported each other during screening implementation, and although they initially were hesitant about the process, they ultimately endorsed screening for wider implementation. Time constraints and scope of practice were identified as significant barriers.

Conclusions: Supportive care screening was endorsed as part of future clinical practice, but barriers to implementation need to be addressed.

Implications for Nursing: With current psychosocial guidelines recommending routine supportive care screening of patients with cancer and statewide mandatory screening targets set in Australia, healthcare organizations need to carefully consider implementation processes. Although nurses are ideally placed to complete screening, organizations need to ensure that appropriate training and support mechanisms have been developed, as well as adequate resources, to enable integration into routine practice.

In Australia, recommendations for routine supportive care screening of all patients with cancer have not been translated routinely into clinical practice. Victoria's Cancer Action Plan 2008–2011 seeks to

address that by setting mandatory statewide targets for screening in hospitals (Victorian Government Department of Human Services, 2008). In response, a supportive care resource kit was developed to provide cancer clinicians with the necessary knowledge, skills, tools, and resources to enable supportive care screening and evidence-based actions and referrals. The kit contains nine sections: (a) Screening and Referral, which provide an overview of the screening and referral processes; (b) Practical, Family, Emotional, Spiritual, and Physical supportive care needs, which provide evidence-based referral protocols based on current clinical practice guidelines (National Breast Cancer Centre & National Cancer Control Initiative, 2003) with input from an advisory group; and (c) Information and Resources, which give clinicians validated screening tools—the Distress Thermometer and Problem List (Hoffman, Zevon, Darrigo, & Cecchini, 2004; National Comprehensive Cancer Network, 2008) and the Kessler Psychological Distress Scale (K10) (Andrews & Slade, 2001)—documentation tools to record screening outcomes, a supportive care training manual, and a services directory that contains information on supportive care practitioners and services in the region.

To enable screening, clinicians needed to complete the training module. Patients were asked to complete the screening tools at clinic visits. Clinicians and patients also undertook a screening discussion that aimed to clarify the issues identified by the patients on the screening tools and to provide information, suggestions, and referrals using the evidence-based referral protocols.

Although the benefits of screening patients for their supportive care needs clearly is recognized, how to implement routine screening into clinical practice is still an area where more research is needed. This article examines clinicians' experiences of incorporating supportive care screening, using the kit, into their clinical practice with a particular focus on the perceived benefits and specific barriers encountered.

Methods

Setting

The study was undertaken in the chemotherapy and radiotherapy units of a large regional hospital in Gippsland, Victoria, Australia. The hospital is the largest cancer treatment center in the region, and although chemotherapy treatment is available in five of Gippsland's six local government areas, radiotherapy is only available at this location. A previous audit of supportive care practice indicated no clinician training in supportive care was available within the region and no formal mechanisms facilitating supportive care screening were in place.

Participants

Potential participants were staff working in either the chemotherapy or radiotherapy departments or as specialized cancer care coordinators in the hospital. Unit managers initially identified clinicians who potentially could participate in the study. To be eligible, each clinician needed to be older than 18 years, a qualified practicing nurse or radiotherapist, and identified by the unit manager as possessing the clinical experience necessary to ensure the capability to undertake patient supportive care screening and referral. The researchers sent the clinicians a letter outlining how they were identified, an invitation to participate in the study, an information sheet detailing the study, and an informed consent form to read, sign, and return to the researchers. Ten clinicians consented to participate in the study: five from chemotherapy, four from radiotherapy, and one cancer care coordinator. At the conclusion of the study, six completed the interview (five nurses and one radiation therapist).

Procedure

Participating clinicians completed a four-hour workshop in which they were trained in the use of the kit and four topic areas: supportive care, screening, referral, and research participation. Readings, activities, and a case study were used to illustrate the principles of supportive care screening and referral (see Table 1). Supportive care screening was undertaken with 40 patients from the chemotherapy ($n = 20$) and radiotherapy ($n = 20$) units. Patients screened were older than 18 years, about to start or currently receiving chemotherapy or radiotherapy treatment for cancer, and considered by clinicians as capable of

Table 1. Overview of Supportive Care Resource Kit Training Workshop

Topic	Content
What is supportive care?	What are the common supportive care needs of patients with cancer? Why is supportive care important? How can supportive care be improved?
Screening	When to screen How to screen What tools to use for screening
Referral	Using the referral protocols Using the service directory Scoring the Distress Thermometer and Problem List Using the Kessler Psychological Distress Scale Completing the documentation
Research participation	What are the aims of the project? Who will be involved? Roles and responsibilities

completing screening tools. Patients completed the screening tools while waiting for treatment (i.e., in the waiting room or in a private room, if available), sitting in the treatment chair (usually for patients receiving chemotherapy), or at home prior to returning the following day for their scheduled appointment (usually for patients on radiotherapy). A screening discussion with each patient usually occurred on the day of a clinic visit or within three days after the visit. During the discussion, clinicians were required to score and assess the Distress Thermometer and Problem List. The Distress Thermometer is a single-item, self-report measure of distress consisting of an 11-point scale with endpoints labeled 0 (no distress) and 10 (extreme distress). The Problem List contains 36 checkboxes grouped into five categories of need: practical, family, emotional, spiritual, and physical. A score of less than 4 indicates mild distress (considered within the acceptable range of distress for patients with cancer), whereas a score of 4 or greater indicates moderate-to-severe distress and action needs to be taken. For patients who scored 4 or greater on the Problem List, the clinician used the K10 as a additional screening tool to determine if the patient's distress was related to emotional issues and/or psychological distress. The K10 is a 10-item scale measuring nonspecific psychological distress and is used widely in Australia. Patients respond to items on a five-point scale ranging from 1 (none of the time) to 5 (all of the time), with scores ranging from 10–50; a score of greater than 16 reflects an increased risk of anxiety and depressive disorders. This two-stage system is recommended to increase the specificity of screening for distress so that inappropriate and unnecessary referrals to limited psycho-oncology services are minimized. The clinician provided actions and referrals (using the kit) and then documented the discussion and outcomes.

Data Collection

At the end of the three-month patient recruitment period, semistructured interviews were conducted with the clinicians to gather their feedback on the supportive care screening process. Interviews took 15–20 minutes to complete, and the researchers took notes to record the participants' feedback. The interview questions were structured around four key areas (see Table 2).

Data Analysis

A thematic analysis was conducted on the data (O'Leary, 2004; Patton, 2002). Thematic analysis draws much of its approach from Glaser and Strauss' (1967) work in grounded theory. Thematic analysis is an inductive process of identifying common experiential themes, topics, meanings, and patterns by coding, sorting, and

organizing data. Initially, the data were organized and coded using the four topic areas of the interview questions. The researchers created categories by reading and grouping the participants' individual words, phrases, and concepts for each question. Categories were collapsed or expanded, or new categories were created, which then provided provisional concepts (Corbin & Strauss, 2008). The final stage in the development of the themes involved identifying relationships, making comparisons, and contrasting emerging themes within and between categories.

Findings

The clinicians identified a number of positive outcomes in using the kit, as well as a number of challenges in the clinical setting. Benefits included enhanced communication with patients, rapport building, transition of clinicians' thoughts about supportive care, and the collegiality and peer support in providing supportive care. Challenges included time to complete the screening while caring for other patients and issues related to their scope of practice, particularly in dealing with emotional and psychological issues.

Positive Outcomes

Patient communication: Clinicians found communication with their patients improved in several ways. First, they found that initiating discussion with patients was easier with a completed screening tool enabling straightforward identification of issues. Patients expected that screening discussions were intended to problem-solve issues of concern, meaning that sessions were focused. Once the discussion was initiated, clinicians easily could ask patients to elaborate or clarify issues identified or to ask additional exploratory questions. One clinician said, "The screening tools were worded very well; the patients didn't feel interrogated. It was worded just right to get them talking but not upset."

Second, problem solving was enhanced in specific areas. Topics usually not raised with patients (e.g., sexual issues) were brought up, and some of these perhaps more difficult issues were initiated by both patients and clinicians and discussed openly. Participating in screening and discussion with a clinician seemed to break down barriers for patients. According to the clinicians, many patients commented that they disclosed issues they usually would not because they perceived clinicians were too busy to deal with them. In short, this process gave patients permission to discuss a wide range of issues with a member of their treatment team. One clinician said the screening tool "opened the pathway for more conversation, things we wouldn't always think to ask."

Table 2. Areas of Focus in Interviews and Analysis of Clinicians' Use of the Supportive Care Resource Kit

Area	Discussion Points	Themes
Feedback on the screening tool	Ease of use and interpretation Value in identifying patient needs and opening communication	Patient communication Rapport building
Feedback on the components of the kit	Ease of use Use of referral protocols, service directory, and documentation process	Peer support and collegiality Time
Views on the discussion and referral process	Length of screening discussion Impact on patient rapport How the process fit in with current practice Potential for future use	Patient communication Rapport building Transition of thoughts Time Scope of practice
General feedback	Other comments on screening and referral process	Patient communication Rapport building Transition of thoughts Peer support and collegiality Time Scope of practice

That led clinicians to reflect on their caregiving, particularly when difficult issues or questions arose.

Made me think about what I asked people, made it a lot easier to ask harder questions. Some things I may usually skim over; this made me go through them, made me feel like I gave better care because of it.

In some cases, other issues emerged that the screening tool had not identified. A clinician noted, "The more they talk, the more they elaborate; the checklist doesn't get to the heart of the problem." At other times, the discussion was useful for emphasizing old information or providing new information. According to one clinician, "Sometimes it was reinforcing information they already had, other times it was opening a can of worms—a good thing."

Rapport building: Clinicians found that the process of problem solving with their patients during the screening discussion built a rapport that was not previously evident. That was highlighted by reports of patients continuing to approach clinicians about other issues. Patients and clinicians reported gratitude for the opportunity to address relevant issues. According to a clinician, "Afterward, they would seek me out for problems and issues because they knew they could ask me anything." One clinician reported that the rapport developed with one patient, and the confidence that patient subsequently felt, led to a request for assistance with an end-of-life directive, which the clinician was honored to support.

Transition of thoughts: Clinicians initially were hesitant to implement a new process; however, once they used the kit with their patients, they saw benefits to the patients as well as themselves.

Overall, clinicians described the screening process as "worthwhile," "beneficial," "useful," and "fantastic." Seeing benefits such as improved communication and rapport resulted in the transition of attitude from one of hesitation to overall support for the kit and the screening process.

When I first started using the kit, I thought it was just extra stuff; I thought we were already doing it. But once I used it, I thought it was very good—the patients got to have a voice.

Peer support and collegiality: The implementation process also had the benefit of enhancing collegiality and peer support between clinicians. Although most clinicians felt comfortable with the amount of training they received in using the kit to undertake supportive care screening, the peer support and collegiality was cited as the reason that

clinicians were satisfied with the overall support during screening implementation. That support was particularly important during the early stages of kit use, while clinicians familiarized themselves with the screening process. One clinician said, "We had peer support; we checked how each other were going." Greater use of the kit and observed benefits, along with peer support from colleagues, inspired greater confidence with the processes involved.

Overall, the majority of clinician feedback was positive, and the screening process was similar to what clinicians already practiced, although formalized. Clinicians endorsed the implementation of supportive care screening with the kit into routine clinical practice.

Challenges

Time: The biggest challenge for clinicians related to the time taken to complete the screening, in particular, time taken to complete the screening discussion with the patient and time taken to complete documentation. On average, clinicians estimated spending 30 minutes completing the screening discussion with patients in response to issues identified with the screening tool. For more complex cases (i.e., patients with more issues of concern), discussion times were longer (up to one hour).

For chemotherapy staff, time for the discussion occurred in broken intervals throughout the day, which perhaps created the perception that the process took longer. Because patients came in for radiotherapy on successive days over a six-week period, scheduling the screening discussion was easier. Clinicians also talked about balancing their usual tasks with the screening discussion

and the clinical care of other patients. According to a clinician, "When still caring for other patients, [I] had to spend less time talking because of other work; conversation was often interrupted by care needed for others."

During the implementation of the screening process, time emerged as an issue for clinicians. In response, the clinicians, in consultation with the patients, triaged problems for discussion. Clinicians needed to clarify with patients the issues identified on the screening tool (i.e., to check for misunderstandings or issues that were not a current concern) and ask patients to prioritize those most important to them so they could be addressed immediately. Issues of a lower priority could be addressed at a future time. "Ideally all patients would have it, but in reality maybe only some because [it's] time consuming. Would need a system in place to cope with the time allocation."

Clinicians also commented on the time required to complete the documentation. Clinicians found they took as long to document the screening discussion and actions as they took to complete the discussion itself. For more complex cases, documentation was completed out of work hours. Time also was spent writing clinical notes in patient medical records.

Scope of practice: Scope of practice was identified as a challenge, particularly in responding to psychological and emotional needs. Clinicians recognized the Distress Thermometer and Problem List as being very beneficial in identifying distress and emotional issues and commented that these needs sometimes can go unidentified. According to a clinician, "[I] found it a really useful tool for social; we do physical well, we may think we do social well but, without the tool, just skimmed the surface."

Similarly, the benefits of using the K10 as an additional screening tool were acknowledged as a means to inform decision making around psychological issues and whether a referral was needed to specialist services. However, some clinicians reported hesitation and a lack of confidence in dealing with emotional issues: "We had to look at the counseling skills of the nurses using it; needs extra training for counseling (e.g., K10)." When dealing with the spectrum of supportive care needs, the clinicians were more confident with physical needs, which they usually were able to address immediately, whereas they were hesitant regarding action and referral for emotional issues. As one clinician described,

Gray area—counselors and psychologists, patients funny about it. I backed off on some referrals but not others. For example, dietitian—didn't back off. Didn't get good vibe from patients at mention of psychologist or counselor.

In some instances, clinicians were hesitant to handle psychological issues, as they felt uncomfortable coping with the stigma associated with these issues or referrals to psychologists or counselors.

Discussion

The current study confirms the importance of providing health professionals with the necessary knowledge, skills, and tools as a first step toward improved supportive care provision (Fulcher & Gosselin-Acomb, 2007; Maguire, 1999; National Breast Cancer Centre and National Cancer Control Initiative, 2003). Although these tools and skills provide a foundation for evidence-based practice, recognizing the benefits and overcoming challenges also are essential to implementation. The challenges identified by the clinicians in the current study—concerns about scope of practice and time limitations—were offset by the positive outcomes of improved patient communication, rapport building, and the peer support.

Improving clinician-patient communication is important because patients rate communication as an essential element of their care (Bakker, Fitch, Gray, Reed, & Bennett, 2001), yet evidence suggests that it is often ineffective (Arora, 2003; Bakker et al., 2001; Maguire, 1999). Poor communication leads to inaccessibility of information, misinterpretation of side-effect management, and decreased trust in the patient-clinician relationship (Bakker et al., 2001). As patients with cancer with greater concerns experience worse outcomes (Maguire, 1999), the importance of effective communication to elicit and facilitate resolution of those concerns is imperative. Conversely, effective communication between patients and clinicians has been shown to have a positive impact on patient adjustment to illness (Bakker et al., 2001), particularly because patients rely on clinicians for support with decision making, information, and dealing with social and interpersonal issues (Arora, 2003).

Clinicians involved in the current study attributed improved patient communication to the use of the screening tool, which clearly identified issues for discussion that neither patients nor clinicians usually would raise. Those findings concur with previous studies indicating clinician difficulty in accurately identifying patient supportive care needs, particularly in the emotional domain (Fallowfield, 2001; Ford, Fallowfield, & Lewis, 1996; Hedström, Skolin, & von Essen, 2004; Keller et al., 2004; Kruijver, Garssen, Visser, & Kuiper, 2006; Newell, Sanson-Fisher, Girgis, & Bonaventura, 1998), as well as the reluctance of patients to disclose those needs (Detmar et al., 2000; Maguire, 1999). Clinicians' inadequacy in detecting their patients' supportive care needs has been linked to a lack of training and, as such, training is recommended for health professionals on how to more effectively identify patients' needs and subsequently respond appropriately, including how and when to refer patients for specialist help (Maguire & Pitceathly, 2003; Schofield et al., 2006; Vitek, Rosenzweig, & Stollings, 2007).

Through participation in the study, the clinicians reflected on their overall communication. They reported that the screening process built and increased rapport with their patients. That rapport facilitated future communication between the clinicians and patients, encouraging future disclosure (Robinson & Roter, 1999). This reflection reinforced a new resolve to continue to address issues in all areas for their patients.

Clinicians also described the ongoing peer support they gave each other as they continued to test the screening process—a beneficial outcome, as a perceived lack of peer support by clinicians is related to an increase in blocking patient disclosure of need (Maguire, 1999), clinician burnout (Schofield et al., 2006), and a barrier to providing supportive care (Botti et al., 2006).

In the literature, time is reported as the greatest barrier to providing supportive care (Schofield et al., 2006), yet studies indicate that an additional 40 seconds spent by clinicians acknowledging patients' supportive care issues reduced anxiety (Fogarty, Curbow, Wingard, McDonnell, & Somerfield, 1999). Clinicians in the chemotherapy unit felt pressure to complete the screening process within the patient's visit because they may not see the patient again for several weeks. That, combined with the usual clinical care for the patient and care for other patients, was a challenge for their workload. At the same time, the process was valuable to patient care and should be routinely available. Clinicians informally provided supportive care, yet the formalization of the process was viewed as time consuming; however, some studies question whether time is an actual or a perceived barrier (Towers, 2007).

To achieve successful practice change, the logistical and practical application of the screening process needs to fit with the routines of the treatment facility (Kruijver et al., 2006; Redman, Turner, & Davis, 2003). One mechanism to improve fit with current routines may be to incorporate the practice of screening into other prescheduled appointments, such as those allocated to patient education or treatment reviews. In studies where the screening discussion was incorporated into prearranged appointments, little increase was reported in appointment length (Schofield et al., 2006). However, data concerning the documentation of supportive care are absent from those studies. The development of mechanisms for fast and simple documentation is, therefore, also a priority.

Challenges to clinicians' scope of practice commonly are identified as barriers to providing supportive care. Clinicians in the current study expressed higher confidence in addressing patients' physical and practical issues than in providing emotional care or responding to emotional distress (Kenny, Endacott, Botti, & Watts, 2007; Schofield et al., 2006; Sivesind et al., 2003; Towers, 2007). Although the kit and training provided clinicians with the knowledge base to understand supportive care and the necessary tools to provide it, a lack of confidence seems to exist in the skills base, particularly in relation

to emotional care. Schofield et al. (2006) argued that, although improving knowledge is important, self-efficacy that clinicians have toward the supportive care process must be assessed. Clinicians noted hesitancy in delving into patient emotional issues for fear of provoking feelings of despair or anger in the patient. Fear or hesitation about being drawn into the emotional world of the patient by asking questions about emotional well-being also is cited in the literature (Botti et al., 2006; Turner et al., 2007). Towers (2007) suggested that professionals may be uncertain about what to say in the situation and worry about upsetting patients. That process also is described as blocking, in which clinicians unknowingly maintain emotional distance to protect themselves from patient emotions (Kenny et al., 2007; Towers, 2007).

Despite initial trepidation about undertaking a new process, all clinicians provided positive feedback on the screening process following use with their patients and experiencing the clinical benefits. Such positive findings should be used to reinforce the process of practice change, problem-solve barriers to implementation, and convince clinicians of the value of supportive care screening.

Limitations

Although the results of the current study are supported by the existing literature, the authors acknowledge that the sample size was small. The results are, therefore, primarily based on the nursing experience. Future research to include a wider variety of practitioners (e.g., additional radiation therapists, social workers) to fully identify barriers and benefits of the screening process clearly is required. Barriers between practitioner types may vary; for example, social workers completing screening will have training and experience in dealing with emotional issues and are not likely to consider the currently reported scope-of-practice issues as a significant barrier. Further work also needs to be completed in other environments (e.g., surgical wards, palliative care, small community hospitals) to establish the benefits and identify any additional barriers across settings.

Implications for Nursing

With targets now set by the Department of Human Services, Victoria, Australia for patients with cancer to have documented supportive care screening and evidence of clinician training to be provided by 2012, health service administrations need to consider the implications of implementing these targets. Although the benefits for nursing practice and patient care have been clearly documented, the barriers around implementation need to be addressed so that nurses or other practitioners are not burdened with increased workloads. Providing supportive care is not the respon-

sibility of one clinician; it is shared by all members of the multidisciplinary team (Victorian Government Department of Human Services, 2008, 2009). In addition, supportive care is not an “added extra” in care provision. A system-wide approach is needed to successfully integrate supportive care into routine practice. For this to occur, supportive care must be promoted as worthwhile by hospitals, and institutional support needs to include clinician training, scheduled screening to fit with current clinical care (e.g., as part of prescheduled appointments), and adequate resources such as dedicated nursing time and identified referral networks. Positive feedback to clinicians and departments who undertake supportive care screening also is likely to result in successful practice change and improved patient care.

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