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An Educational Program for Using the Distress Themometer

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Walden University

College of Health Sciences

This is to certify that the doctoral study by

Mabel Che-tuma

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2018

Abstract

An Educational Program for Using the Distress Thermometer

by

Mabel Che-Tuma

MS, South University, 2010

BS, Florida State University, 2003

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2018

Abstract

The distress thermometer (DT) is a screening tool designed to measure the level of stress in oncology patients. Clinical oncology nurses (CONs) at the local site lacked knowledge and training on how to administer and apply the DT. Because of this practice gap, patients were not receiving referrals to the necessary support services. The purpose of this project was to design and validate a CON staff education program on the use of the DT. The diffusion of innovation theory along with the theory of interpersonal relations served as the conceptual framework for the project. The project was organized into a 5-step process, consisting of interviewing stakeholders, conducting a literature review, developing a staff education module on the DT, validating the content of the DT module, and creating an implementation. Five local experts with at least 5 years of experience in oncology nursing participated in the validation of the staff education program. All the participants strongly agreed or agreed that the educational module provided CONs the necessary knowledge to use the DT to identify and refer patients in distress. Module changes made after expert responses were the following: separating the slides to ensure that the slides were not overwhelming for the readers, inserting screenshots of the questions from the electronic health record into the educational module, adding a distressed patient scenario, and adding test questions after each DT question. Implementation of these changes may help CONs to better understand module content. Stakeholders support the module implementation for all CONs in the oncology clinic, which may result in less distress among oncology patients. Module implementation has the potential to promote social change through increased staff knowledge on the use of the DT for the identification of patient distress and the required support service referrals.

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Dedication

This DNP scholarly project is dedicated to my parents, Mr. Che Barnabas Ngwa and Mrs. Margaret Bih Ngwa, who never had the opportunity to obtain an education higher than elementary education, but who have done everything possible for their children to obtain the highest level of education possible in any career path.

I would also like to dedicate this scholarly work to my uncle, Mr. Ngwa Zacchaeus Anye, and his wife, Elaine Kien, who have been instrumental in defining the path of our family when it comes to education.

Also, I would like to dedicate this scholarly project to my mother-in-law, Mrs. Monica Tuma, and my aunt, Mary Bih Ngwa, who did not have the opportunity to obtain an education, but have done everything possible for their children, nieces, and nephews to obtain a decent education.

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Section 1: Nature of the Project

Introduction to the Study

The purpose of this scholarly DNP project was to develop a standardized oncology nurse education program on the proper use of a distress thermometer (DT). This education program was developed for an oncology clinic in North Florida. The gap in practice involved the clinical oncology nurses' (CONs) lack of knowledge and education on the proper use of the DT. I developed this new DT education training program to train the CONs to identify patients who are in distress and in situations that require support services such as those of social workers, psychologists, pain specialists, and financial counselors. This DNP project has the potential to result in positive social change involving CONs as well as the identified distressed patient, which is congruent with the Walden University mission (Walden University, 2012, vision, mission, and goals section para. 2)) Through the new program's patient identification and referral process, CONs may be able to improve their management of distressed patients, especially in the areas of self-care and health outcomes which may result in improved patient health as well as operational efficiency.

Problem Statement

The local nursing practice problem involved the CONs' lack of training on how to use the DT. The DT is a screening tool for oncology patients (Vitek, Rosenzweig, & Stolling, 2007)) and, per the clinic policy, should be used during each patient visit.

During an interview I conducted with the nurse manager, she reported that CONs working in the outpatient oncology unit were provided minimal training on the DT by the nurse manager and charge nurse in 2016. Since that time, nurses have not received any additional training and new nurses have not received formal training. According to the manager of the oncology outpatient clinic, the clinic has had a high turnover in CONs from 2016 till present. The clinic manager stated that the clinic had retained only two of the nurses who participated in the 2016 original training program.

The clinic policy states that if a patient's distress score is higher than or equal to 7, or if the Patient Health Questionnaire-2 (PHQ-2) score is higher than or equal to 3, a referral is generated to the social worker for follow-up and intervention. Approximately 100 oncology patients are seen in the clinic daily with only three to four referrals to social services made weekly. This number of referrals is low for the total number of patients seen weekly. Lack of knowledge on how to screen for psychosocial distress may be a factor in the low referral rate. Vitek et al. (2007) indicated that psychosocial distress is underreported in oncology patients because health care providers do not recognize or inquire about psychosocial distress. In a research by Vitek et al. (2017) oncologists reported that 36% of patients who suffered distress were not reported. Furthermore, oncology nurses have consistently underestimated patients who were in distress (Vitek et al., 2007). Hospitals providing care to oncology patients are expected to identify patients experiencing psychosocial distress with the goal of providing the patient with resources

that can help to improve health outcomes. Yet, realizing this goal has proven challenging for many health care providers, including those at the local site.

The goal of the project was to provide staff with the knowledge necessary to screen each patient using the DT and to identify patient referrals to supportive services. As Lazenby et al. (2014) discussed, the DT educational program for CONs is a means of providing these nurses with knowledge and training on how to use the DT to identify patients in distress. The CONs can then make a patient referral to the appropriate support service after identifying patients in distress. Referrals include social services, financial counseling, psychology, pain management, and supportive oncology (a program which manages oncology symptoms and provides support for the emotional and spiritual aspects of cancer). It is hoped that the DT educational module will provide necessary knowledge of the DT to CONs that may help in identification and referral of distressed oncology patients to supportive services.

Purpose

The purpose of this scholarly DNP project was to develop a clinical oncology nurse educational program on the use of the DT. The educational program should fill the practice gap by providing formal education to CONs on the use of the DT. Through their participation in the educational program, CONs will obtain the knowledge necessary to properly administer the DT and identify every patient who is in distress and who may require additional services from social workers. In addition, the educational program will

provide a resource for training on the DT for current and future nurses. The goal of the educational module is to assist clinic staff in their understanding of the policy on screening each oncology patient for distress. To use the DT properly, oncology nurses must be able to recognize and understand the risk factors of distress (National Comprehensive Cancer Network [NCCN], 2017). Risk factors for distress include having uncontrolled symptoms, cognitive impairment, limited access to health care, communication barriers, financial problems, spiritual concerns, or family conflict; being young; lacking a social network; living alone; and having young children (NCCN, 2017). The educational program developed for this DNP project should improve the CONs' identification and referral of oncology patients who are in distress during their cancer journey (Sivendran , Roda, De la Torre & Newport, 2015). Referrals to supportive services may help to improve distress management among oncology patients seen at the outpatient clinic.

Project Question

The question I sought to answer for this project was, will an educational program for CONs working in an outpatient oncology clinic improve CONs' knowledge and ability to identify patients in distress? When patients are correctly identified as being in distress related to a cancer diagnosis and treatment, then referrals can be made to assist the patient with distress management.

Nature of the Doctoral Project

This DNP scholarly project entailed the development of a new DT education training program intended to educate CONs in identifying patients who are in distress and may require support services. I obtained input from CONs to develop the educational program. To successfully plan for this DT CON educational program, I identified and worked with key stakeholders and obtained the necessary support of practice site organizational leadership. The involvement of key stakeholders such as the CONs, the oncology nurse manager, oncology physicians, and social workers was significant for the success of this DNP scholarly project. As Hodges and Videto (2011) observed, key stakeholders can share knowledge about the distress of oncology patients, which is paramount for the proper content development of this DNP scholarly project. Hodges and Videto also found that, when oncology nurses participate in developing an educational program, they take ownership of the program. I interacted with CONs and performed interviews about their knowledge of the DT. During such interviews I was made to understand that the CONs had limited knowledge on how to use the DT. I educated the CONs that my goal was to develop a DT training module that could be used to train the CONs. I gained the CONs' acceptance and sense of ownership of the DNP project to improve the success of the project and reduce distress among the oncology patients. In working with decision makers and stakeholders such as CONs, oncology nurse managers, oncology physicians, and social workers, it is essential to have open lines of

communication in decision-making (Hodges & Videto, 2011). Because of the importance of the project I was given permission by unit leadership to call and visit the unit as many times as possible to ask questions and gather information regarding the project.

Following my development of the educational program for CONs on the DT, I asked five local experts with at least five years of experience in oncology nursing to review the educational program and provide feedback and recommendations. The experts completed a five-question Likert scale survey with an added an open-ended question asking for further recommendations. I collected and analyzed the data from these expert surveys using descriptive statistics to report survey results. The five local experts were placed in a quiet room to complete the survey. Each expert was given ample time to review the CON DT educational program and provide feedback and recommendations. I revised the CON DT educational program based on the results of the survey data analysis and the experts' recommendations. I subsequently presented the results of the survey analysis as well as the revised CON DT educational program to the administration of an outpatient oncology clinic. After making all the amendments based on surveyors feedback I presented the new amended DT educational program to unit leadership. Unit leadership will develop a strategic plan to present the CONs with DT education training. I anticipate that strategic planning and implementation of the DT educational program for oncology staff nurses will occur after I have graduated.

Assumptions, Limitations, and Delimitations

Assumptions

There is evidence showing that when the CON staff are reeducated on the administration of the distress thermometer, more patients are referred to social services. In a study by Sivendran, Roda, De la Torre and Newport (2015), for instance, a large community cancer institute saw an increase in the number of patients who were referred for supportive services after the CON staff was reeducated on the DT. I assumed that a newly developed CON DT education program based on evidence-based practices would increase the knowledge of the CON staff on the DT at a large academic hospital in Florida. Based on Sivendran et al., (2015) study findings, I further assumed that an increase in DT knowledge by the CON staff would lead to an increase in the number of distressed oncology patients referred for supportive services thus improving patient quality of life.

Limitations

This DNP project was limited by the knowledge and commitment of the experts chosen to evaluate the DT education content for understanding and clinical application for the oncology nursing staff. This study is also limited by the fact that only five participant experts were asked to review the DT educational module and provide feedback which was used to amend the DT module. Since the sample size was small, this make it difficult to generalize study results.

Scope and Delimitations

I invited five experts to review a newly developed CON DT educational program. The expert panel included one oncology nurse manager, one oncology nurse, one oncology nurse researcher, one oncology nurse practitioner, and one oncology social worker. All the experts have at least five years of oncology experience. The nurse manager has been an oncology nurse for well over seven years and has been running the oncology outpatient clinic for over 5 years. The nurse manager is committed to evidence-based practice and is determined to make sure that this DT educational module comes to fruition. The oncology nurse researcher has five years of experience in dealing with oncology patients and is knowledgeable about the challenges that are frequently faced by oncology patients. The oncology nurse practitioner has been in practice for five years and also has much knowledge about the patient population. The oncology social worker has more than 15 years of experience of dealing and solving the problems of oncology

patients. The knowledge of all these clinicians coupled with the fact that these practitioners deal with the patient population on a day to day makes all of them suitable to provide feedback for the DT educational module.

Significance

Implementation of the educational program developed for this DNP project may improve the CON staff's ability to identify distressed oncology patients using the DT and to provide referrals to supportive services for oncology patients. The DNP scholarly project may result in better nursing practice and knowledge of patient distress, thus improving oncology patients' health care outcomes and quality of life.

Evidence-Based Significance of the Project

The aim of this DNP scholarly project was to develop a CON DT educational program, which was based on evidence-based practice guidelines for identifying distress in oncology patients. Translating evidence-based research into practice has the potential to improve CON staff knowledge on the DT (Fencl, & Matthews, 2017). With increased knowledge on the use of the DT, staff nurses may be able to identify more patients who are in distress. Referrals to social services can be made to assist with the patients' management of the symptoms of distress. These patient referrals have the potential to improve health care outcomes for distressed oncology patients (Finn, Green, Malhotra, 2017)).

Implication for Social Change

I expect positive social change to occur due to the anticipated improvement in CON staff education and awareness of the DT and subsequent betterment of oncology patients' quality of life and health outcomes. DT education may increase CONs' knowledge and lead to an increase in oncology patient referrals for necessary supportive services to assist with stress management. Johnson (2010) expressed that CONs are uniquely positioned to identify distress in oncology patients, and once the distressed patients has been referred to supportive services it can lead to improved health care outcomes includingimproved treatment adherence, and fewer calls and visits foranxiety and depression.

Summary

This DNP scholarly project's purpose was to develop and evaluate a CON DT educational program for CON staff in an outpatient oncology clinic. Following the development of the CON DT educational program, five local experts were invited to review the program and to provide evaluation and recommendations by completing a five-question Likert scale survey. The five experts included one oncology nurse manager, one oncology nurse, one oncology nurse researcher, one oncology nurse manager and one oncology social worker. Experts evaluated the content of the newly developed CON DT educational program. I used descriptive statistics to analyze the survey data and to report expert survey results and recommendations. In Section 2 of this DNP project capstone, I will discuss the concepts, models, and theories chosen for the DNP project. I will also provide information and context on the local setting, , consider the project's relevance to nursing practice, and discuss my role in the project.

Section 2: Background and Context

In developing this scholarly DNP project, I searched the literature for evidence-based practice models and conceptual frameworks that could be applied practically to provide guidance in solving the nursing practice problem identified in Section 1. Implementing these types of practice models ensures that researchers of all types have consistent information and interventions in solving clinical problems (Theoretical Foundations of Nursing, 2011). In researching a theory to use in facilitating the education of nurses on DT, I decided to use the diffusion of innovation framework (Rogers,1983, 1995). This theroy provides a step-by-step practical approach on how CONs will be engaged in the learning process of the education material that will be presented in theDT educational program. In designing this project, I also searched the literature for a theory that could be applied to assist the CON to help the patient to identify distress in the oncology journey. I selected the theory of interpersonal relations because the focus of this theory is on nursing as an interpersonal process which brings the nurse and patient together in an interactive process with a common goal of solving a problem such as distress (Peplau, 1992).

Concepts, Model, and Theories

For this DNP scholarly project, I applied the diffusion of innovation framework by Rogers (1983, 1995) along with the theory of interpersonal relations by Hildegard Peplau to guide the development of this new CON DT educational program. The theories

will also enhance the CON-to-patient relationship. The theories also guided me to ensure that all the important components of the DT teaching module were in place. The theories used made a significant contribution to improving the development and design of the DT educational program.

The conceptual model of diffusion of innovation has proven to be a practical framework that can be used to promote evidence-based research to nursing practice. The diffusion of innovation model by Rogers (as cited by Jeanette et al., 2012) included a definition of diffusion as "the way innovation is communicated throughout a system overtime" (para. 12). In applying concepts in the diffusion of innovation theory, the CONs will go through the following five steps to embrace the DT:

1. Knowledge: The distress thermometer was discussed with CONs and the CONs' manager casually.
2. Persuasion: Oncology nurse forms a positive or negative attitude toward the DT and how it is applied based on feedback given by this author.
3. Confirmation: The panel of five experts evaluate the newly developed educational program and give feedback which is used to amend the final educational program.
4. Decision: The DNP student provides the education program to hospital leadership to be implemented after the education program has been confirmed by a panel of experts.

5. Implementation: The newly developed DT is implemented on the unit to train CON on how to use DT.

This DNP project holds significance for the field of nursing practice because it brings to light the theory of interpersonal relations by Hildegard Peplau (Peplau, 1992). Peplau (1992) views nursing as an interpersonal process since it involves collaboration between two or more person with a common objective (Peplau, 1997). The common goal in oncology Nurisng allows for a therapeutic process between the oncology patient and oncology nurse. Peplau defined the therapeutic nurse-client relationship as a relationship that is focused on the needs, feelings, problems, and ideas of the oncology patient (Peplau, 1992). Peplau described four segments of the therapeutic nurse-patient relationship:

1. The orientation phase is guided by the oncology nurses and has to do with engaging the client in treatment and giving explanation and answering questions.
2. The identification phase starts when the oncology nurse works with a client interdependently with the oncology nurse to express feelings. The oncology nurse at this stage can gather information about the patient's distress, which will allow the oncology nurse to make a referral to the needed service. This DNP project entails designing an educational program to increase nurse’s knowledge on the DT which is used to screen patients in distress.

3. The exploitations phase is when the oncology patient makes use of the services that have been offered to him/her.
4. The last phase is the resolutions phase when the client no longer needs the services of a professional. This phase is when the therapeutic relationship ends (Peplau, 1997).

The theories highlighted in this subsection provided evidence-based frameworks for the design and implementation of this project's educational program on the DT to oncology nurses.

Relevance to Nursing Practice

In conducting a literature review on the use of the DT, I reviewed 24 articles written within the past 10 years. Searches were conducted using CINAHL Plus with Full Text, ProQuest & Allied Health Source, EBSCO, MEDLINE with Full Text, and Ovid Nursing Journals Full Text. The following keywords were used to conduct searches: psychosocial distress tools, psychosocial distress tool implementation, oncology patients and psychosocial distress tool, and cancer patient and psychosocial distress, DT. The primary inclusion criteria were that all articles be in English and had DT in the description. The following search words were used: DT implementation, DT guidelines, DT education, DT specificity, DT sensitivity, and DT characteristics). Articles that were reviewed were descriptive, and all studies reviewed were conducted in the United States.

Sensitivity, Specificity, and Cut-off Score of the DT

The DT has been validated as a measure of distress in children and adults with cancer. Tavernier (2014) expressed that DT has been tested and adopted in English and Spanish in a pediatric population. A Danish version of the DT showed validity in a study that involved women newly diagnosed with breast cancer (Tavernier, 2014). Ryan, Gallagher, Wright, and Cassidy (2012) as cited by Tavernier (2014) posited that validity of the DT had also been tested in a population of patients with advanced cancer. The DT has proven that it can measure distress in cancer patients. Hence, oncology nurses must be educated on how to use it so that distressed oncology patients are identified in a timely fashion.

Estes and Karten (2014) mentioned that the DT is a tool suggested by NCCN for psychosocial distress assessment because the DT has proven to be useful in detecting distress in oncology patients. The DT is user-friendly, cost-effective and has a vertical thermometer picture on which the patient can rate his/her level of distress on a scale that ranges from 0-10 with zero showing no distress and 10 showing an extreme level of distress (Estes & Karten, 2014). The DT also has a problem list which highlights different areas of concern. A score of four or more on the DT is the point of cutoff which indicated moderate to server distress, a point at which the oncology nurse must make the appropriate referral (Estes &Karten, 2014). The DT is a user-friendly cost-effective tool which has been tested for validity and found to be effective at detecting distress.

Lazenby et al., (2014) conducted a study to evaluate the effectiveness of the DT to be used in screening oncology patients in advanced stages of distress. Subjects of the study had at least stage 3 cancers and were an average age of 59.9 years. One hundred and twenty-three subjects participated in the study. Lazenby et al., (2014) expressed that the DT results were compared to scores of the Patient Health Questionnaires (PHQ). The researchers found the most favorable cutoff on the DT to be 4 with a sensitivity of 98% and specificity of 73% when compared with the Hospital Anxiety and Depression Scale (HADS), which had a cut of 9 with a sensitivity of 84% and specificity of 72%. It was concluded that the DT had a higher score for specificity and sensitivity.

Carlson, Walker, Groff, and Bultz (2012) evaluated screening for distress using the DT as the sixth vital sign in patients with lung cancer. The study established the DT as an appropriate tool that can be used for screening of distress in the cancer patient. Study participants were placed randomly in the following groups: a minimal screening group with DT plus usual care, a full screening with personalized triage, full screening group with DT, pain and fatigue thermometer, a psychosocial screen for cancer part C (Carson et al., 2012). Subjects were evaluated three months after. Subjects were asked to rate distress on the DT and results showed a sensitivity of 77.1 and specificity of 66.1% on the DT (Carson et al., 2012). The researchers concluded that the DT is meant to be used as a first line tool for screening that can be used by oncology providers to identify areas of problems which warrant intervention.

Characteristics of the DT

Roth et al. (1998) created the DT to evaluate psychosocial distress in cancer patients (Dilworth, Thomas, Sawkins, & Oyebode, 2011). NCCN (2003) developed the problem list that accompanies the DT. The list has 34 items which apply to the cancer patient (Dilworth et al., 2011). The DT was designed to be used in clinical settings as a therapeutic way of "improving communication and staff awareness of distress rather than as a simple quantitative measure" (Dilworth et al., 2011, p. 757). The visual analog of the DT is followed by a problem list which contains spiritual/religious, physical, practical, family, and emotional domains (Dilworth et al., 2011).

Description of the DT

The DT was developed in 1998 by the National Comprehensive Cancer Network (NCCN) to detect distress, anxiety, or depression in oncology patients (NCCN, 2017). The DT is a tool used to measure distress in oncology patients (Wenk, 2017). The DT can be self-administered allowing the patient to self-identify his or her level of distress on a scale from zero to 10 (Garlapow, 2017). A score of zero indicates no distress and 10 equals extreme distress (NCCN, 2016). A score of 4 or more alerts the oncology nurse that the patient's distress is of clinical significance. If the patient rates his/her distress at a 4 or more, the oncology nurse reviews with the patient the possible sources of distress from the following five categories which include practical, family, emotional, spiritual, or religious, and physical" (Wenk, 2017, para, 1). The DT ask the oncology patient to

answer “yes” or “no” to domains within each of the five subsections if he or she is having distress within that subsection (Garlapow, 2017). Garlapow (2017) expressed that the domains are vital because the type of intervention or support needed for each domain of distress reported is different. The domains help the patient narrow down the source of distress (Garlapow, 2017). For example, if an oncology patient endorses family as a source of distress, the intervention will be different from an oncology patient who endorses physical as a source of distress. Oncology patients who acknowledge a higher level of distress require more prompt and urgent intervention as oppose to patients who report lower levels of distress. The DT can be self-administered allowing the patient to self-identify his or her level of distress on a scale from zero to 10 (Garlapow, 2017). After the patient completes the DT, the nurse can then review the DT results with the patient.

The following is a description of the adopted DT as it is currently being used at the outpatient oncology clinic. All questions will be highlighted on the educational program on the DT to help the CONs understand the DT. The first question on the DT ask the patient to “please select the number that best describes how much distress you have been having in past week, including today” on the DT. The nurse would be educated to review the patient’s response to this question with the patient or ask the patient to rate his or level of distress on the DT. The tool measures distress on a scale of 0 to 10, with 0 being no distress and 10 being extreme distress (NCCN, 2016). The oncology nurse will

be educated that a score of four or more should alert the oncology nurse that the patient's distress is of clinical significance (NCCN, 2016).

If the patient rates their distress at a four or more, the oncology nurse will be educated to review the possible sources of distress with the patient by asking the second question on the DT which ask the patient if "any of the following have been problems for you in the past week including today (spiritual/religious, physical, practical, family, and emotional)." The oncology nurse will be educated on the importance of asking the second question because it will help the oncology nurse to zero in on the domain that is causing distress. The oncology nurse will be educated to document the domain or source of distress as it will help the social worker to have a better understanding of the source of the patient's distress. Having a good understanding of the source of distress is essential because the intervention or support needed for each domain of distress reported is different. The second question on the DT helps the patient to narrow down the source of distress (Garlapow, 2017). For example, if an oncology patient endorses family as a source of his or her distress, the intervention will be different from an oncology patient who endorses physical as a source of distress. The oncology nurses will be educated to understand that the Oncology patient who acknowledges a higher level of distress requires more prompt and urgent intervention as opposed to patients who report lower levels of distress. Oncology patients reporting lower levels of distress may receive relevant education to track the problem over time. Oncology patients who report higher

levels of distress may receive an urgent call or referral to the professional providing the service necessary to treat the cause of distress.

The third question on the DT is the PHQ2 screen for depression which asks the patient to state, “how often you have been bothered by either of the following problems: little interest or pleasure in doing things, or feeling down, depressed, or hopeless.” The patient is asked to rate the two items on a scale of 0 to 3, 0 being not at all, 1 being several days, 2 being more than half the days, and 3 being nearly every day of the week. The oncology nurse will be educated to review this question with the patient and ask the patient the third question which is the PHQ2 depression screen question. The oncology nurse will be educated that a score of 3 or higher on the PHQ2 screen will generate a referral to the social worker.

Implementation of DT

The standards on psychosocial distress identification and intervention were written in 2013 by the Commission on Cancer (MCC, 2013). Buxton et al. (2014) articulated steps for a successful implementation of a distress program. Lazenby et al. (2014) emphasized the need for all cancer care providing institutions to put systems in place for not only screening of distressed cancer patients but also providing treatment for such patients. In an article titled *Easier said than done: Keys to Successful Implementation of the Distress Assessment program*, the authors concluded that the key factors to the success of implementation of distress assessment were the “adaptation of a

programmatic approach," and a strong commitment from leadership (Li et al., 2016). The authors also noted that the successful implementation of distress assessment depended on the education provided to clinicians, technological innovation, effective and efficient communication, and a detailed evaluation of frameworks based on change and improvement of quality (Li et al, 2016). This article provides evidence that an educational program can help nurses to use the psychosocial distress tool effectively and efficiently.

There is evidence to demonstrate that when nursing staff was educated on the administration of the distress thermometer, more patients were referred to social services. In a study by Sivendran et al. (2015) a large community cancer institute saw a rise in the number of patients who were referred for supportive services after the clinical staff was reeducated on the distress thermometer. The number of referrals went from 829 patients to 1434 patients after the staff was reeducated on the distress thermometer (Sivendran et al., 2015). The fact that many more patients can be referred to social services after re-education on the DT is evidence of social change in the lives of the patients who are being referred.

In a study by Amstel et al. (2016), the researchers wanted to assess the results of nurse-led DT involvement on improving quality of life for patients with breast cancer compared with normal/usual care with nurse-led DT intervention. In the intervention group, the oncology nurse performed a thorough assessment using the DT in addition to

performing usual care (Amstel et al., 2016). Interventions were offered to patients based on the results of the DT. The control group only received usual care. The following steps were offered to every single patient in the intervention group:

1) An email was sent to the patient informing the patient about the appointment with a trained oncology nurse which will take place in addition to the usual care visit.
2) The patient was asked to complete the DT form in the clinic a few minutes before his/her appointment time.
3) An oncology nurse who was trained on the use of DT discussed the DT with the patient before he/she met with a physician. The nurse probed and asked further questions about the problems the patient checked on the problem list. The nurse asked the patient to prioritize his or her problems if the patient checked too many problems. The oncology nurse after discussing the DT with the patient asked the patient if he or she wanted to be referred to a professional.
4) The time that was reserved for the meeting between the patient and oncology nurse was 5-30minutes.
5) If the patient reported a score of less than five on the DT the oncology nurse will ask the patient if he or she could sufficiently take charge of his or her problems. If the patient had a score higher than 5, the oncology nurse carried

out an in-depth conversation, and the outcome of the conversation was discussed in a Psychosocial Multidisciplinary Team (MDT) (Amstel et al., 2016).

The oncology nurses who participated in the study were trained by a clinical psychologist, and a manual was created during the training session (Amstel et al., 2016). This study is still ongoing, and the results are not yet published, but it is anticipated that the results of the study will have an impact on the implementation of the DT.

Frost, Zevon, Gruber, and Scrivani (2011) conducted a study on the use of the DT in an outpatient oncology setting. Patients who checked into the oncology outpatient clinic were given the DT by the receptionist alongside the standard initial paperwork for the clinic. The patient took less than 2 minutes to complete the DT. After the patient completed the initial clinic paperwork, the receptionist handed the paperwork to the registered nurse (RN) who performed a nursing assessment on the patient (Frost et al., 2011). The RN attached a sticker on the top of the DT and placed it in a bin for the social worker to review. During the time of this pilot program which was three months, a total of 763 patients were screened. Of the 763 patients who were screened, 19.6 % had a score of four or higher out of 10 on the 10-point DT (Frost et al., 2011). The clinic saw positive results by developing and implementing a screening program on the DT. The outpatient oncology clinic had an opportunity to screen all patients who had head and

neck cancer for distress, identify the distress in such patients and worked proactively to resolve patient's problems.

Hammonds (2012) designed and implemented a quality improvement project at a breast cancer clinic in the Midwestern United States. Nurses at the clinic noted that only eight referrals for supportive services to manage distress had been made from 1,291 patients that had been seen over a six-month period. The eight referrals that were made due to the patients exhibiting severe distress in the clinic. To increase the number of patients that were referred for distress intervention and support, the DT was implemented at the clinic as a screening tool for distress from June 1 through July 6th, 2010 after nursing staff had obtained education on the DT and how to implement its scores. The DT was completed by every patient, after which the nurse reviewed it. The nurse made a referral for intervention and support when he/she noted that the patient had a distress score of four and above. The clinic noted an increase in referrals that were made for supportive services, and the referrals were made when the patient was not in severe distress.

A community-based cancer center implemented a new tool for assessing distress in oncology patients because the tool that the clinic had been using was ineffective at identifying distress in oncology patients (Huberty, 2014). The community-based cancer center selected the DT for the screening of distress in oncology patients. The unit council selected pivotal times during which the DT would be administered to the patient which

were during the patient's chemotherapy teaching session, at the patient's last chemotherapy session, and any time the patient's chemotherapy regimen was changed (Huberty, 2014). Patients who scored a three or less on the DT were given the business card of the social worker. Patients with a score of four or higher were contacted by a social worker within 48 hours. The CON was vital in explaining the tool to the patient and conveying its purpose of how the responses will be addressed to the patient. After the implementation described above the clinic saw an increase in the number of patients referred for distress intervention, such interventions saw a direct increase in the patient's quality of life during chemotherapy.

Importance of Using the DT

Annunziata et al. (2013) conducted a study on facilitating the integration of emotional states in patients' personal disease experience. The percentage of patients who refused to be screened and those who elected not to have scores returned to them was (15.4% and 3.1 % respectively). The percentage of patients who did not want scores returned to them was low showing evidence that there is positive reception of screening activities (Annunziata et al., 2013). National Comprehensive Cancer Network (2006) as cited by Vitek et al. (2007) expressed that a third of patients who are diagnosed with cancer experience distress and that more than five percent of such patients report symptoms of distress to their health care providers. This literature provides a synopsis as

to why distress screening is important. Patients, who are screened for psychosocial distress, are identified early and resources are implemented to improve health outcomes. The DT provides a less expensive and economical way to screen for psychosocial distress of the oncology patient. Loquai et al. (2013) conducted a study with the main goal of determining acceptance of the DT and problem as a screening tool for psychosocial distress in an ambulatory setting. 734 patients were recruited for the study. 520 patients completed the DT and problem list. 47% of the patients who completed the DT and problem list score above a five on the DT meaning that these patients met the criteria for being in distress (Loquai et al., 2013). Cancer patients who were employed and were younger expressed higher levels of distress than people who were retired and older.

Guidelines for Psychosocial Distress Intervention

The Commission on Cancer as cited by the Michigan Cancer Consortium (MCC) (2013) stipulated standards for psychosocial distress interventions which warrant that oncology patients (with active treatment) be screened for distress at every doctor's visit. The NCCN (2017) mentioned that early identification of a patient in distress leads to better distress management, improved self-care, and improved healthcare outcomes. The Commission on Cancer also indicated that healthcare organizations providing care to oncology patients identify a tool, which will be used to screen distress in cancer patients (MCC, 2013). The psychosocial distress evaluation will be used to validate "physical, psychological, social, spiritual and financial support needs" of patients suffering from

cancer. (MCC, 2013, p. 4). Once a patient is identified to be in distress, the oncology nurse will refer the patient to the appropriate support service for follow up intervention.

The American College of Surgeons (ACoS) commission on cancer, the Institute of Medicine (IOM), and the American Society of Clinical Oncology expressed that it should be a quality standard to detect, assess, and treat psychosocial distress in everyday oncology care (Pirl et al., (2014). There is data to suggest that when oncology patients are screened, identified and treated for psychosocial distress, cancer treatment is effective, and healthcare outcomes are significantly better.

The Commission on Cancer (CoC) and the American College of Surgeon (ACoS) expected all cancer-treating organizations beginning in 2015 to screen oncology patients for distress using the new NCCN accreditation requirement (ONS, 2014). The accreditation requirements include designing a care plan with referrals for distress intervention. Distress screening and intervention was expected to become a quality standard for oncology care and a part of the everyday routine care of the cancer patient (Pirl et al., 2014). The DT as suggested by NCCN to assess and manage distress will help the oncology nurse to identify distress in the oncology patient and make the right referral for proper management of distress to improve patient healthcare outcome and quality of life. It can further be noted that this quality health care intervention meets the need of some of the IOM aims which are to provide care that is *patient-centered, timely, efficient, and effective.*

Nursing Education on DT

The DT has been used in oncology clinics as part of the patient's intake assessment for all patients with an oncology clinic appointment, but identification of patients with psychosocial distress at some of these oncology clinics is weak and or non-existent (Vitek et al., 2007). Psychosocial distress has been weak to non-existent because oncology nurses fail to screen the patient for distress (Vitek et al., 2007). Muehlbauer (2014) in an attempt to implement the DT as a screening tool for distress, used multiple avenues of education including a discussion around why distress is seen as the sixth vital sign. Muehlbauer (2014) organized targeted training on the DT to build skills and confidence. Inter-professional teams from frontline staff to leadership were created to ensure that staff continues to engage and use the DT to screen oncology patients for distress. A barrier to implementing the DT as a screening tool was established by one of the interdisciplinary teams. The barrier that was established had to do with the inability to understand the definition of palliative care. "The term palliative care was misunderstood by providers and patients and was associated commonly with end-of-life care" (Muehlbauer, 2014, p. 10). Vocabulary had to be changed from palliative care to symptom management to resolve this problem. Another interdisciplinary team expressed great success in implementing the DT for distress screening but expressed that some healthcare providers may be inadequately trained to apply the DT in screening patients and how to use the scores. This interdisciplinary team expressed that "it can be

challenging for the nurse to interpret patients' rating of their distress in a clinically meaningful way without knowledge of what those scores mean (Muehlbauer, 2014, p. 10). Adequate training of nurses on the use of the DT will ensure nurses' ability to address patients' needs, make correct referral and offer intervention to ensure that patients outcome needs are met.

Pirl et al. (2014) expressed that a "comprehensive distress screening programs" for effective identification of distress in cancer patients should be set up by all organizations providing care to cancer patients (para. 4) Pierl et al. (2014, para 7) further mentioned that a "comprehensive distress screening program" not only requires the selection of the right distress screening tool, but also requires qualified staff that is trained in the processes for distress screening and intervention.

Knobf, Major-Campose, Chagpar, Seigeman, and Mccorkle (2014) designed a quality project on distress screening using the DT. Implementation of DT screening took place in two phases. After implementation of the quality initiative on DT screening the authors learned that education and engagement of all staff was crucial in establishing individual responsibilities pertaining to the DT. The authors also learned that nurses and patient care assistants (PCAs) needed to have a clear understanding of the rationale for screening patients and needed to be educated to improve interaction with the patient about the DT.

Guidelines for Proper Administration of DT

For the oncology nurse to use the DT properly, the oncology nurse must understand the risk factors of distress (NCCN, 2017). Risk factors for distress include: having uncontrolled symptoms, cognitive impairment, limited access to health care, be young, communication barriers, financial problems, spiritual concerns, family conflict, lack of social network, living alone, and having young children (NCCN, 2017). The new CON educational program proposed for this DNP project will improve the identification and management of oncology patients who are in distress during their cancer journey. Patients with cancer are vulnerable when their symptoms need further testing; they are being assessed for cancer; undergoing genetic testing; waiting for treatment; starting a new treatment; having a major treatment; experiencing treatment-related complications; being admitted or discharged from the hospital, receiving follow up, learning of a treatment failure; being diagnosed with advanced cancer; and nearing end of life (NCCN, 2017). When an oncology patient is going through any of the above conditions severe patient distress can occur. It is crucial that CONs identify a patient in distress to make referrals to supportive services to improve distress management among patients.

Local Background and Context

The clinic consists of 19 patient rooms. The CONs who work in the clinic see an average of 100 to 120 patients daily. On any given day, there is an average of five clinic staff, who provide services to patients.

The clinic policy states that if a patient's distress score is higher than or equal to seven, or if the Patient Health Questionnaire-2 (PHQ-2) score is higher than or equal to three, a referral is generated to the social worker for follow up and intervention. The DT that is used in the outpatient oncology clinic has three questions, and per the manager, staff may only ask one question or not administer the screening tool to patients. Therefore, not all patients are appropriately screened at each visit.

Clinic social workers report receiving an average of three to four distressed patient referrals per week out of an average of approximately 500 patients who are seen in the clinic weekly. The social worker further expressed that distress is underreported in the outpatient oncology clinic because of CONs lack of knowledge on how to use the DT and on distress. Vitek et al. (2007) indicated that psychosocial distress is underreported in oncology patients because health care providers have a lack of knowledge about distress and how to use the DT. Vitek et al. (2007) further expressed that clinicians do not recognize or inquire about psychosocial distress. Oncologists reported that 36 % of patients who suffered distress were not reported (Vitek et al., 2007). Oncology nurses have consistently underestimated patients who were in distress (Vitek et al., 2007). Hospital staff providing care to oncology patients are expected to identify patients who are experiencing psychosocial distress with the goal of providing the patient with resources that can help to improve health outcomes.

The goal of the project was to provide staff with the knowledge necessary to screen each patient using the DT and to identify needed patient referrals to supportive services. The DT educational program for CONs will give these nurses the knowledge and training on how to use the DT to identify many patients in distress (Lazenby et al., 2014). Once the CON has identified distress in a patient, the CON can make a patient referral to the appropriate support service. These referrals include social worker, financial counseling, psychologist, pain management, and supportive oncology. Supportive oncology is a program which manages oncology symptoms and provides support for emotional and spiritual aspects of cancer.

Role of the DNP Student

This project is in line with the Doctor of Nursing Practice Essential which warrants the doctoral-prepared nurse to participate in “inter-professional collaboration for improving patient and population health outcomes.” (AACN, 2006). To successfully plan the educational program on the DT, working with key stakeholders and obtaining the support of organizational leadership was essential. By working with the identified stakeholders and providing evidenced education and training in the coordination of services, it was possible to develop a comprehensive staff educational program that meets the needs of the identified clinic staff. CONs input was obtained in thedesign of the DT educational program. The program’s success is likely to happen because of the work with CONs, as participants in the content design of the program. When CONs participate in

developing the educational program, the CONs will take ownership of the program (Hodges & Videto, 2011). Including CONs in the content development of the educational program empower the CONs and improve acceptance of the educational program. In working with organization's stakeholders, it is essential to have open lines of communication in decision-making (Hodges & Videto, 2011). When the educational program was completed, the panel of experts evaluated and provided input on the educational program.

I designed an educational program to educate nurses on the DT. I am a home health nurse and have worked with many oncology patients who needed services such as pain management, counseling, financial services, and chaplain services. My preceptor in the practicum class was a nurse navigator at a large medical center in north Florida. Her job was to work with oncology patients in psychosocial distress and refer them to supportive services. In an interview with the nurse navigator, it was noted that there was a lack of training on the DT. Hence the reason the number of patients referred to her for psychosocial distress intervention was minimal. Due to these gaps in training on the DT at two large medical centers in Florida, I decided to design the educational program for oncology nurses on the use of the DT. As a nurse educator, I perceived that a staff educational program on the use of the DT was needed. In this identified practice environment CONs' knowledge of the DT is expected to increase, hence increasing the

number of patients who will be referred for psychosocial distress intervention, thereby improving health outcomes for patients.

I hope that this staff educational program will be used to train CONs on the use of the DT. I anticipate that the number of oncology patients identified to be in distress and referred to supportive services will increase. There were no foreseeable biases for this DNP scholarly project.

Role of the Project Team

The staff DT educational program was developed and then presented to a group of five local experts (an oncology nurse researcher, nurse manager, oncology staff nurse, social worker, and pain management nurse) via anonymous questionnaires. Five local experts were asked to complete a questionnaire and provide feedback by completing the five question Likert scale evaluation.

Summary

A comprehensive literature review provided evidenced-based guidelines for the development of the program content. The literature review solidified the idea that educating CON on the DT increases CONs knowledge of the DT and how to apply the results of the DT. The *diffusion of innovation* framework by Rogers, along with the *Theory of Interpersonal Relations* by Hildegard Peplau were used to integrate and inform the design of the educational module with the clinical problem of CONs lack of knowledge on the DT. Roger's Diffusion of Innovation theory highlights concepts such

as knowledge, persuasion, confirmation, decision, and implementation, which are all critical to create an adequate learning environment for nurses. Peplau's Theory guided and informed the interaction of nurse and patient which assist the CON to horn down on the specific distress that the patient is having that warrants a referral to supportive services. Both the Diffusion of Innovation Theory and the Theory of Interpersonal Relations informed the development of the CON educational module on the DT.

Section 3: Collection and Analysis of Evidence

Introduction

To evaluate the problem identified in this DNP scholarly project, I focused on collaboration among community stakeholders and CONs. Based on the problem identified in the clinical oncology unit, I collaborated with the CONs, CON nurses' manager, and oncology social workers to evaluate the needs assessment and develop the educational program. When mapping out an assessment of needs, it was important to identify available resources early (Hodges & Videto, 2011). An essential component of the planning process required a review of sources of evidence and theoretical understanding of the assessment of needs. In this section, I will provide a description of the development of the DT education program for CONs.

Practice-Focused Question

The question I sought to answer for this project was, will an educational program for CONs working in an outpatient oncology clinic improve CONs' knowledge and ability to identify patients in distress? When patients are correctly identified as being in distress related to a cancer diagnosis and treatment, referrals can be made to assist the patient in distress management.

Project Design

The purpose of this DNP project was to develop and validate an educational program on the DT. The project began with an evaluation of evidence-based literature to

establish a foundation of DT programs for outpatient clinics. The literature review established evidence-based support to address the clinical question. In reviewing the DT for its current use at the outpatient oncology clinic, I conducted interviews with CONs, the CON manager, oncology social worker, and psychologist. After reviewing evidence-based literature and current unit use of the DT, I used the diffusion of innovation conceptual framework (Roger,1983, 1995) and the theory of interpersonal relations (Peplau, 1992, 1997) to guide the development of the DT educational program. Following the initial development of the DT, I asked five local experts to review the developed educational program on the DT and provide feedback on the DT program. The DT educational program included a PowerPoint presentation (see Appendix B) on the DT outlining all aspects of the DT, with explanations of how to utilize the DT to assess the level of the oncology patient's distress. If the DT score of a patient is higher than or equal to 7, or if the Patient Health Questionaires-2 score is higher than or equal to 3, staff was taught that a referral was required to the social worker for follow-up and intervention.

According to Sivendran et al., (2015), one of the main reasons why oncology patients are not referred for supportive services due to distress is because CONs lack knowledge on how to administer the DT. The lack of staff nurses' education and knowledge on the DT was identified as a practice problem at the local oncology clinic. The purpose of this DNP scholarly project was

- to develop and evaluate a program for educating oncology nurses on the use of the DT at an oncology outpatient clinic,
- to provide the CONs with an understanding of the DT to identify patients who are in distress, and
- to educate the CONs on assessing and scoring distress to generate referrals to support services such as social worker, psychology, and pain management, financial, or spiritual.

For this evidence-based research project, I used a Likert scale type questionnaire (see Appendix A) to evaluate the program content and usefulness for the CON. I also included an additional question to elicit any additional program recommendations. A panel of five local experts were asked to complete a questionnaire and provide feedback by completing a five-question Likert scale evaluation. The panel of experts for this DNP scholarly project included an oncology nurse, a researcher, a nurse manager, an oncology staff nurse, and social worker. These panelists received an e-mail invitation to join the project study.

Sources of Evidence

To obtain scholarly articles for a detailed DT education module, I conducted a Boolean search of databases such Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, Google Scholar, PubMed/Medline. Search terms in the inclusion criteria were DT programs, DT education, DT implementation, and DT nursing

education. Articles were excluded if they were published more than 10 years before to ensure that the most up-to-date evidence was available to inform the project. I evaluated and appraised articles to decide which were applicable to the project design and educational program content. Articles were included if they were less than 10 years old, in English-language publications, in peer-reviewed journals, and specific to health and clinical nursing. The literature review I conducted provided evidence-based practice guidelines and research results applicable to develop meaningful content for an DT educational program for CONs and health care organizations. Using a DT education program was favorable amongst CONs and hospital administrative staff as it provided CONs with an opportunity to increase their knowledge about the DT and increase the number of oncology patients who were referred for supportive services based on DT scores.

Data Collection

I collected data for this DNP scholarly project from five local experts' surveys evaluating the newly-developed staff DT education module. Each of the experts had at least five years' experience in oncology nursing, treatment, education, and research. The five local experts were placed in a quiet room and asked to review the developed educational program and complete a five-question Likert-type survey (see Appendix A) on the content of the new staff DT education program. Each expert was given two hours to review the educational program and provide feedback on the educational program. I

used data from the feedback to make changes to the educational program. Data collected from the questionnaire remained anonymous. Descriptive statistics were used to report the results of the survey. I amended the newly-developed staff DT educational program based on the recommendations and feedback obtained from expert questionnaires. Once changes were made to the educational program, the revised staff DT educational program was presented to oncology outpatient unit organizational leadership to develop a plan to present the educational program to the CON staff working in the identified clinic. Implementation of this educational program will occur after I will have graduated from the DNP program.

Protections

I presented the Consent Form for Anonymous Questionnaires to the five local experts. The five local experts had a minimum of five years of experience in oncology nursing and were invited to participate in the project via e-mail. The panel of experts for this DNP scholarly project included the oncology nurse researcher, nurse manager, oncology staff nurse, social worker, and pain management nurse. The five experts were asked to sign a consent form, and all answers remained confidential. Walden Institutional Review Board (IRB) approval was obtained prior to implementing the education project. The organization was asked to sign the site agreement prior to presenting the educational program to a panel of experts. Data was collected and stored according to IRB requirements and all questionnaire results remained anonymous.

Analysis and Synthesis

Descriptive analysis was used to analyze survey results. To establish relevance and usefulness of the educational program pre-implementation, I asked five local experts to review the content of the educational program and provide feedback regarding the usefulness of the educational program. Feedback from the local experts addressed the following areas: (a) content (see Appendix B), (b) whether content is straight forward and easy to understand, (c) whether content meets objectives stated by me at the beginning of the developed educational program, (d) how likely the expert is to recommend the program to other units and organizations having a similar problem, and (e) whether the posttest at the end of the education program is a true test of knowledge of the content presented in the education program. Revisions to the educational program was made based on feedback obtained from the survey analysis.

Project Plan for Evaluation

The evaluation of this evidenced-based project consisted of assessment and feedback of the DT education program by five local experts using Likert scale (see Appendix A) type questionnaire to evaluate the program content and usefulness for the CON. I asked an additional question to address any additional program recommendations. Data was presented and analyzed using descriptive statistics with table representation.

Summary

In this section I have outlined the development of the newly developed CON DT educational program. The newly-developed DT program was guided by evidence-based practices that have demonstrated best practice in developing and implementing DT education. I included stakeholders to develop the DT educational program, which was validated by five local experts who provided feedback that was used to amend the developed DT educational program. A successful evidence-based educational program on the DT stands a chance to benefit CONs and oncology patients by increasing CONs' knowledge on the DT and increasing the number of oncology patients who get referred for supportive services resulting from distress. The next section will highlight project evaluation and findings.

Section 4: Findings and Recommendations

Introduction

In Section 4 of this DNP scholarly project, I detail the results of appraisals conducted by the panel of experts as well as consider the implication of the results. The purpose of the staff education project was to develop and validate a clinical oncology nurse educational program on the use of the DT. For the project, I asked a panel of five experts to evaluate the usefulness of the DT educational program using a Likert Scale type survey. Survey results will be presented in this section and the results analyzed for program improvement.

Findings and Implications

I presented the staff education program to a panel of five content experts, including an oncology nurse researcher, nurse manager, oncology staff nurse, social worker, and pain management nurse. The CON experts were all female with at least five years of experience and ranged in age from 21 to 60 years old. The panel of experts assembled in the conference room of the oncology outpatient patient clinic and signed the Consent for Anonymous Questionnaire form prior to participating in the program. Each expert reviewed the program and evaluated the content and usefulness of the program using a 5-point Likert-scale questionnaire. The Likert scale evaluated 5 questions, using a scale measuring 1 (*strongly agree*) to 5 (*strongly disagree*). Table 1 shows the survey results from the panel of experts.

Table 1

Program Evaluation

Questions	Answers (N = 5) n (%)				
	SA	A	Neither A nor D	D	SD
1. Does the content of the educational program provide knowledge of the DT that is necessary for CONs to use in identifying oncology patients in distress?	4 (80%)	1 (20%)			
2. Do you perceive the content presented in the educational program to be straightforward and easy to understand for the CON	2 (40%)	3 (60%)			
3. Do you perceive the posttest questions as a measure of understanding of content that is presented in the education program?	3 (60%)	2 (40%)			
4. Do you perceive that the educational program meets objectives highlighted by the author at eh beginning of the educational program?	2 (80%)	1(20%)			
5. Do you perceive that the DT educational program could be recommended to other units and organizations for DT training for CON	3 (60%)	2(40%)			

Note. SA = strongly agree, A = agree, Neither A nor D = neither agree nor disagree, D = disagree, SD = strongly disagree.

Summary of Results

I designed this this DNP project to assess whether an educational module on the DT increases the oncology nurses' knowledge of the DT and referral to needed specialty support services. The expert panel review indicated that the module provided a positive educational benefit to the CONs with module content that was relevant to patient screening for distress. Experts agreed that the educational module could be used for staff education in different clinic settings and other organizations.

Despite the limited number of experts reviewing the module content, project findings are supportive of this DNP project capstone intent to provide a means of conveying current clinical information on the DT and the importance of patient screening in the oncology clinic setting. The literature review supported the importance of the use of a screening tool for oncology patients to define the level of distress and need for supportive services. The practice gap in this oncology clinic was that nursing staff had not received education on the DT and lacked knowledge regarding the tool's usefulness to identity patient distress. The panel of experts reviewing the module agreed that the tool and content would meet the learning objectives for the CON staff.

I asked the panel of experts to provide written feedback on the need for modifying module content to improve the module prior to delivering the education to the CON staff. Expert recommendations included the following suggestions:

- “I think that the DT educational program will be helpful for the unit and other areas. My only recommendation is to separate a few slides to be less cluttered.”
- “Insert pictures/screen shots of DT questions as they appear in electronic assessment. Add a scenario of a return patient.”

I amended the DT educational program to incorporate the expert recommendations. I made program modifications to include separating slides for participant readability; screen shots were placed in the training module to help staff identify the DT question when they see it in the electronic health record; and questions were added for each DT question. The education module was modified to include all recommended changes. Appendix B depicts the final project will be administered to staff. Project stakeholders have been supportive of project implementation to the CON staff.

Implications for Positive Social Change

The use of the validated education module is expected to enhance CONs’ understanding of the DT which should enable them to identify patients in distress and make the appropriate referrals. Social change can result through the CONs’ ability to provide improved screening of patients for distress and referral to supportive services. CONs at the practice site will now have access to current EBP education on the DT. This education can also be applied to staff in other areas of the health care organization who care for oncology patients.

Recommendations

Use of the DT by CONs is significant for CON scoring of oncology patients. The educational program provides the CONs with knowledge and understanding related to the use of the DT. This knowledge can translate into the CON being able to identify oncology patients in distress. CON identification of patients in distress may allow for referrals to patient services, therefore, improving patient outcomes related to distress (Sivendran et al., 2005. Stakeholder recommendations included using the DT educational module to train all current CONs and all new CONs and to provide a yearly CON in service. The module will be updated yearly to include the current EBP guidelines.

Strengths and Limitations of the Project

Strengths

The strength of this educational module on the DT is availability of easily accessible educational material provided to current CONs, availability of training material for newly hired CONs, and ongoing educational updates. This educational module was designed to increase the knowledge of the CON of the DT and to empower CONs with resources to increase their understanding of the use of the DT. A detailed understanding of the DT by the CON has potential to increase the number of distressed oncology patients who are referred to supportive services thereby improving health care outcomes for the distressed oncology patient.

Limitations

A limitation of this project was that it was reviewed by a small number of participants, making it difficult to generalize study results since the sample size was very small. A second limitation was the program evaluation. The evaluation was not a validated tool but indicated positive responses for program content. Program modification and second evaluation should include a pre and posttest to measure participant knowledge after completing the learning module.

Summary

Program evaluation results demonstrated the DT educational programs usefulness and showed the DT educational program could be effective at increasing CONs knowledge of the DT. This DT educational module will serve as a guide to help nurse managers in educating CONs on the use of the DT. The validated DT education module will lead to CONs understanding of the DT which will enable them to identify patients in distress and make the appropriate referrals. The DT educational module was created in collaboration with clinic stakeholders and presented to a panel of experts. I updated the DT educational module based on feedback obtained from the five local experts. Expert review provided positive feedback stating that the DT educational module content can increase the CONs' knowledge on the use of the DT. Study strengths and limitations were discussed in Section 4. Section 5 will include a self-analysis and the plan for project dissemination.

Section 5: Dissemination Plan

Product dissemination is a significant role of the DNP scholar. Without product dissemination, much of the new knowledge obtained by the DNP scholar will not be exposed to a wider audience and the emphasis that is placed on evidenced based practice shall be sluggish. I presented the final product of the of this DNP scholarly project to hospital administration to design a plan for implementing training with CON after I will have graduated.

Project Dissemination

It is important that scholarly evidence-based work be published in academic journals as a way of disseminating scholarly products (Shehata, 2015). I will disseminate this scholarly product by presenting hospital leadership with a plan to implement the educational module to all CON staff. I would also like to publish the DNP educational project education module in the *Clinical Journal of Oncology Nursing*.

Another way that I would like to disseminate this scholarly project is to make podium and poster presentations at national oncology and education conferences. In 2019 I plan to submit an abstract of DNP project to the World Nursing Conference committee. The AACN (2006) stated that poster presentations and journal articles target a wider audience such as hospitals, community-based oncology practices, and doctor's offices.

Analysis of Self

I am the eldest of nine children. I am also the first person in my family to immigrate to the United States. Neither of my parents obtained higher than an elementary school education. Because my parents did not receive much education, they worked very hard to ensure that all nine of their children obtained the highest level of education in their chosen career path. My parents also sent us to some of the most prestigious church boarding schools in my county. In addition, my parents educated all their children to work hard by keeping us engaged in working on the farm, doing business, and attending classes while we were on holiday. My parents' limited education, the desire of my siblings and I to be better, and the knowledge that I now reside in a country where I can obtain the highest level of education in any career path have been the driving forces that have motivated me and kept me energized to face the challenge of obtaining a DNP. From the perspective of personal growth, studying to obtain a DNP has been very time-consuming, but it has opened my knowledge base in ways that are remarkable. I had always believed that obtaining a doctoral degree was challenging but never envisioned the degree of work, commitment, dedication, and sacrifice associated with the design and development of the scholarly project. Completing this DNP project has reinforced the belief that I have in me that I can do anything only if I remain steadfast, committed, focused, dedicated, and resolute to the course.

As a scholar, I have grown tremendously in knowledge attained from reading textbooks and responding to discussion board questions in the learning management system. Completing the reviews of literature required in all the doctoral degree courses and the DNP scholarly project has humbled me and opened up my knowledge base exponentially. Throughout my nursing career, I have worked at many different institutions that have assured me of attaining a broad base nursing experience. However, the 5,000 hours of practicum experience have provided me with in-depth knowledge of how to run a nursing unit and how to look for clinical practice problems and subsequently design an answer to the question using evidence from the literature.

The development of the DT education module relied very much on my educational and work experience in oncology for 2 years. My oncology nursing experience helped me to identify the practice problem, project objectives, the need for the education module, and program content. Obtaining a master's degree in nursing education and the professional skill of teaching in the RN to BSN program prepared me for success in nursing academia and research implementation of evidence-based projects. As a home health nurse, I gained interpersonal, interactive, and interdisciplinary skills and knowledge in case management which opened my eyes to the challenges faced by oncology patients who are not receiving supportive services.

Analysis of Self as a Practitioner

I have practiced professional nursing with passion, commitment, and dedication for 15 years and have enjoyed every part of the journey. My passion and dedication for nursing instilled a burning desire in me which led me to accomplish my academic and career goals from being a certified nursing assistant to being a DNP candidate. My educational qualifications and the knowledge that I have acquired in the practicum setting and through Blackboard interactions with my professors and peers across the world, in addition to the design and development of this scholarly DNP project, have enhanced my leadership skills and interactions with CON and other health care providers such as social workers. The path of obtaining this DNP has refocused my perspective on life in general, increased my self-worth, and earned me the respect of my peers, siblings, and colleagues.

This DNP scholarly project allowed me the opportunity to assess, plan, implement and evaluate a clinical problem and potentially look for its evidence-based solution. In my practicum settings, I learned to look for clinical problems by troubleshooting and analyzing data from a computer system. I learned to review the literature to devise solutions to clinical problems.

My short-term goal is to obtain a full-time teaching position in an RN to BSN program. Becoming a college of nursing faculty member will give me the opportunity to be a lifelong learner and use the skills that I have obtained in this DNP program to impart

knowledge and shape the future of young nurse practitioners. My long-term goal is to open the training program to train certified nursing assistants.

Analysis of Self as Project Manager

As project manager, I initially identified a problem in home health with my oncology patients' lack of supportive services which made the oncology patient's disease trajectory even more challenging. In my first practicum class, my mentor, who was a nurse navigator for oncology patients, noted the lack of training of CONs on the use of DT which led to a limited number of patients being referred to her for supportive services. In an interview with the manager of an oncology outpatient oncology clinic, I learned that CONs had very limited training on the use of the DT, which led to a limited number of distressed oncology patients being referred for supportive services from the social worker. These gaps in practice led me to the development of my DNP scholarly project. In the development and validation of the DT educational module, I was exposed to a wide array of databases through the literature review process. I have been working on my DNP scholarly project for more than a year now; however, the knowledge I have obtained from reviewing the literature and completing several revisions of my manuscript based on feedback from my chair and committee member translated to an enhancement in my critical thinking and writing skills. My most significant accomplishments as project manager have been developing patience, commitment, resilience, and dedication. It takes all of these qualities, I have learned, to accomplish a project of this magnitude.

Summary

I created and validated the DT educational module for CONs to provide evidence-based information to be used by clinical oncology Nurisng managers and nurse educators to train CONs on the DT to increase their knowledge of the DT and to effectively screen distressed oncology patients. Current evidence-based literature (Finn & Malhotra, 2017) informed the development of the DT educational module for CONs. My chair was instrumental in guiding and directing the development of this evidence-based scholarly project. I used the diffusion of innovation theory (Roger, 1993, 1995) and theory of interpersonal relations (Peplau, 1992, 1997) to guide the development of this scholarly project (Grove, Bruns, & Gray, 2013).

The creation of the DT educational module would not have been possible without my collaboration with the major stakeholders who are CONs, a CON manager, a clinical oncology social worker, and a psychologist. A team of five local experts was necessary to the standardization and validation of the education module. The team of five local experts anonymously answered a Likert scale questionnaire. I used their feedback to update the DT educational module to the meet the needs of the CONs (see Appendix C). I presented the final scholarly product to hospital leadership to design a plan for implementation. I hope that once CONs are trained on the DT using the DT educational module their knowledge on the DT will increase and that this increase in knowledge on the DT will lead to an increase in the number of referrals of distressed oncology patients sent to the

social worker thereby improving patient health care outcomes for oncology distressed patients. Because DNP prepared graduates are expected to disseminate scholarly work, I hope to have this product published in ProQuest.

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Appendix A: Likert Survey

Dear member of the education program review committee,

Thank you for taking the time to participate in this education program evaluation. You comment, and feedback are very valuable. Your feedback will enable me to adjust the education program for clinical oncology nurses. Please take a few minutes of your time to review the education program for clinical oncology nurses by answering the five questions below.

Please feel free to provide further feedback at the end of the survey to inform the author of anything that needs to be added or subtracted from the education program.

Thank you very much for being a part of this DNP scholarly project.

Likert Scale Questions for Education Program for Clinical Oncology Nurses

1) Does the content of the educational program provide knowledge of the distress thermometer that is necessary for the clinical oncology nurse to use in identifying oncology patients in distress?
   a) Strongly Agree
   b) Agree
   c) Neither Agree nor Disagree
   d) Disagree
   e) Strongly Disagree

2) Do you perceive the content presented in the education program to be straightforward and easy to understand for the clinical oncology nurse (CON)?
   a) Strongly Agree
   b) Agree
   c) Neither Agree nor Disagree
   d) Disagree
   e) Strongly Disagree

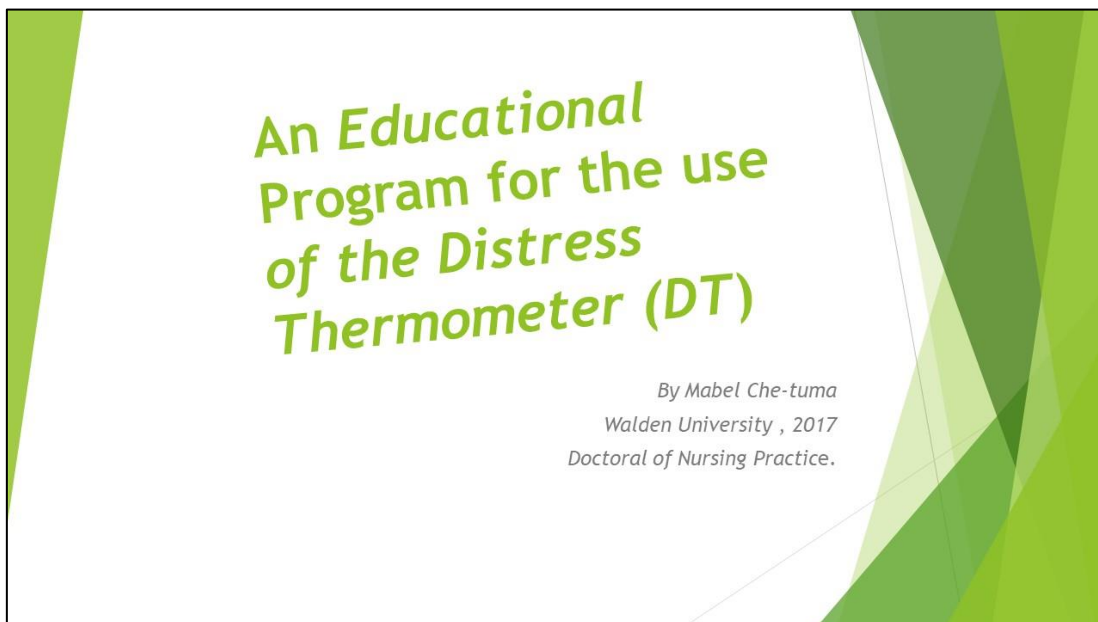
3) Do you perceive the post test questions as a measure of understanding of content that is presented in the education program?
    a) Strongly Agree
    b) Agree
    c) Neither Agree nor Disagree
    d) Disagree
    e) Strongly Disagree

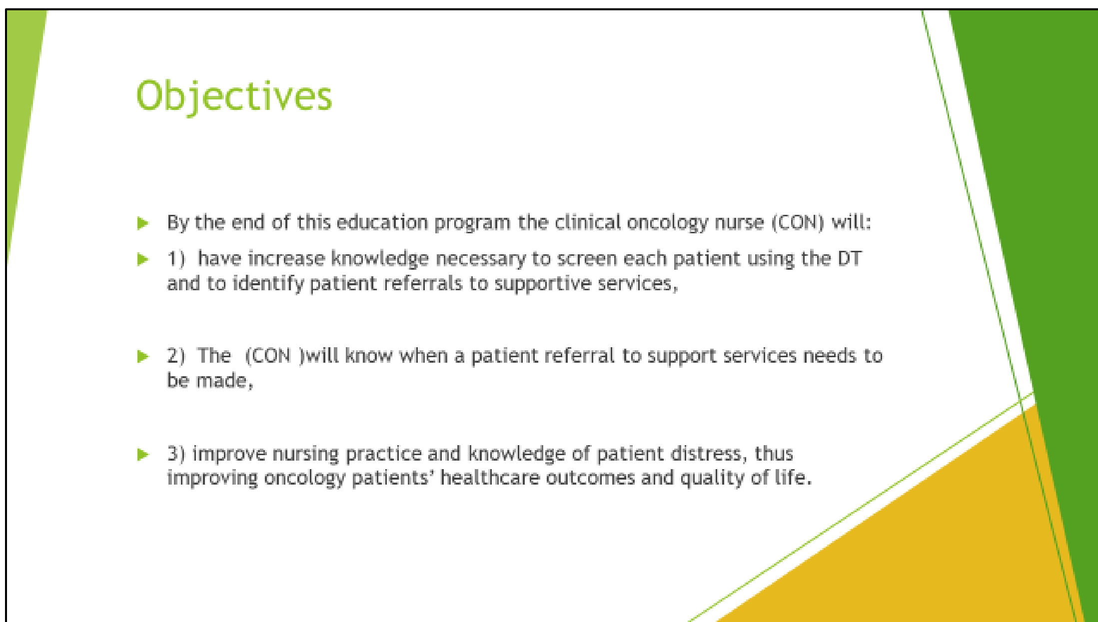
4) Do you perceive that the education program meets objectives highlighted by the author at the beginning of the education program?
    a) Strongly Agree
    b) Agree
    c) Neither Agree nor Disagree
    d) Disagree
    e) Strongly Disagree

5) Do you perceive that the DT educational program could be recommended to other units and organizations for DT education training for CONs?
    a) Strongly Agree
    b) Agree
    c) Neither Agree nor Disagree
    d) Disagree
    e) Strongly Disagree

6) Please feel free to write further recommendations or feedback in the lines below.

Appendix B: CON DT Educational Program Presentation





Definition of DT, distress and why it is important to use the DT in screening.

- The Distress Thermometer (DT) is an evidenced based practice tool that was developed in 1998 by the National Comprehensive Cancer Network (NCCN) to detect distress, anxiety, or depression in oncology patients (NCCN, 2017). The adopted DT on the unit has 3 questions and it is imperative that the CON ask the patient all 3 questions for the screening to be accurate.
- Distress is an unpleasant emotional state that may affect how a person feels, thinks, and acts (UF Health Cancer Center, 2017). A patient might describe distress using the following words anxiety, sorrow, pain, agony, torment, torture, suffering sorrow, grief, heartache, despair, sadness, worry, guilt. When a patients uses' any of the above words during the distress screen the nurse needs to probe and ask further questions about the patients distress.
- Ford (2012) define distress as "a feeling of unease stemming from concerns or worries" (para. 10). Distress can be experienced not only by the oncology patient, but also by patient care givers. Distress can manifest it's self in many ways to include: panic attacks, irritability, poor sleeping, feelings of apprehension or worry, being in denial about the cancer diagnosis and poor concentration (Ford, 2012).
- It is important for CON to use the DT to screen because the DT helps the CON to identify the patient's level of distress. If the patients score on the DT is higher than seven, an automatic referral is made to the social worker for supportive services. When a patient receives supportive services because of distress, it helps to improve health care outcomes for the patient.

Causes and Risks of distress and triggers

01

Distress can affect any oncology patient and what causes distress for one oncology patient may not be what causes distress for another oncology patient. For example some distressed patients may feel worry, some might be overwhelmed about the diagnosis of cancer and others might struggle financially and spiritually (NCCN, 2017). Some people are more likely to be distressed than others.

02

Risk factors of distress could be be anything that increases the chance of an event. Some risk factors of distress might be health related, personal risk factors, financial risk factors, family conflict, lack of family support, living alone, having young children and dealing with cancer. Highler levels of distress are linked with sexual, physical, and substance use disorders (NCCN, 2017).

03

Triggers: Learning of a diagnosis of cancer, being assessed for cancer, transitioning in care (e.g discharged from the hospital or finishing all treatment, learning that one's health has worsened.

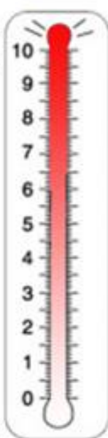
Benefits of using the DT for screening oncology patients

1) Distress screening detects oncology patients in distress. NCCN (2017) expressed that "with out standardized screening, less than half of distressed people are identified and get help they need" (p. 16). Doctors and nurses don't ask oncology patients about distress and patients don't tell their doctors about their distress (NCCN, 2017, p. 14).

2) The DT provides a way to perform a detailed evaluation about an oncology patients distress.

3) The DT allows for better distress managements. Early identification of distress leads to timely distress management (NCCN, 2017). A research study on routine distress screening and management, indicated that distressed patients referred to supportive services were less distressed 3 months after (NCCN, 2017). Early and better management of distress in oncology patients leads to improved selft care and helath care outcomes.

The adopted DT



The first question that is asked on the DT screen is:

1) Please select the number that best describes how much distress you have been having in the past week, including today.

When asking this questions it is important for the CON to know the risk factors of distress (NCCN, 2017). Risk factors for distress include: having uncontrolled symptoms, cognitive impairment, limited access to health care, be young, communication barriers, financial problems, spiritual concerns, family conflict, lack of social network, living alone, and having young children (NCCN, 2017).

If the patient is going through any of the above, it could be an indication that the patient is having significant distress. The CON must guide the patient to rate his or her distress correctly so that he or she can receive supportive services if needed.

Distress Screening

Declines participation in the Distress Screening today	No / Yes-no reason given / Yes-just completed this within the last week
Distress Thermometer Score	0 1 2 3 4 5 6 7 8 9 10 0 taken more than a year ago 1 is no distress and 10 is extreme distress. These values best describes how much distress the patient has been having in the past week including today.

Questions and answers

1) What is the DT?

The DT is an evidenced based practice tool that was developed in 1998 by the National Comprehensive Cancer Network (NCCN)

2) Why is it important to administer the DT to every single patient?

It is important to administer the DT on every single patient to detect distress, anxiety, or depression in oncology patients (NCCN, 2017).

The second question on the DT

Have any of the following been problems to you in the past week, including today?

Spiritual/religious

Physical

Practical

Family

Emotional

- The second question on the DT helps the patient to narrow down the source of distress (Garlapow, 2017). For example, if an oncology patient endorses family as a source of his or her distress, his or her intervention will be different from an oncology patient who endorses physical as a source of distress.
- The CON needs to understand that the Oncology patient who acknowledges' a higher level of distress requires more prompt and urgent intervention as oppose to a patient who report lower levels of distress.
- While oncology patients report lower levels of distress might get relevant education to tracking of the problem overtime, oncology patients who report higher levels of distress might get an urgent call or referral to the professional providing the services that the patient is suffering from.

Problem Areas | None | Emotional | Family | Physical | Practical | Spiritual/Religious

« Emotional taken more than a year ago

These are the problem areas that the patient has had for the past week.

This Photo by Unknown Author is licensed under CC BY-NC-ND

Question and Answer

1) Why is it important to narrow down the source of the oncology patient's distress?

It is important to narrow down the source of the patients distress to enable the social worker to align resources to target the particular problem the patient is having.

2) what are some of the stressors that can trigger distress in an oncology patient?

Learning of a diagnosis of cancer, being assessed for cancer, transitioning in care (e.g discharged from the hospital or finishing all treatment, learning that one's health has worsened.

The third question on the DT is the depression screen

- The third question on the DT is as follows:
- Over the last 2 weeks, how often have you been bothered by either of the following problems? Please select the number that best describes how you have felt this way.
- This question specifically targets depression
- A score of three or higher on the PHQ2 screen will generate a referral to the social worker.

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

PHQ-2

Little interest or pleasure in doing things
0 1 2 3
0 taken more than a year ago
Over the last 2 weeks, how often has the patient been bothered by this problem?

Feeling down, depressed or hopeless
0 1 2 3
1 taken more than a year ago
Over the last 2 weeks, how often has the patient been bothered by this problem?

PHQ-2 Total
1 (calculated) taken more than a year ago
This is the total score of the PHQ- 2 values documented above.

Questions and answers

1) What is the Patient Health Questionair-2 (PHQ)

The PHQ-2 is the depression screen : it screens patients for any signs and symptoms of depression.

2) Name at least 3 experts who provide supportive services to a distressed oncology patients

Social worker, psychologist, nurse, chaplain

Role of the oncology team

The oncology team can monitor an oncology patient's distress and manage distress symptoms such as: fear, worry, uncertainly about the future, concerns about cancer, sadness about loss of health, poor sleep, poor appetite, poor concentration, frequent thoughts of illness and treatment, concerns about social roles (eg, mother, father, caregiver) (NCCN, 2017).

- Experts in distress management.

Examples of professional who have completed training in distress management are:

1) Chaplains: The problem list has spiritual and religious concerns. Chaplains provide care for problems such as grief, guilt, loss of faith, and spiritual concerns (NCCN, 2017)
2) Social workers: Social workers can provide help with practical and psychosocial concerns. Oncology social workers have been trained about cancer, and educated to proved a range of services to cancer community (NCCN, 2017).

Experts in distress management cont.

1) Psychologist: Psychologist can provide range of services to the oncology patient such as health issues (pain, weight, sleep, sex, taking medication), cognitive problems such as (dementia, chemo brain), mood and anxiety problems (e.g. depression, panic, worry), substance use (eg, drugs, alcohol, smoking), relationship issues (e.g., caregiving, strains, social conflict) (NCCN, 2017)
2) Nurses: nurses are trained to screen the oncology patient for distress, provide assistance with practical matters, provide counselling, and refer the oncology patient for supportive services (NCCN, 2017).

Scenario 1

Mrs. Smith is a 30 year old new oncology patient who reports pain at 8/10 and was recently diagnosed colon cancer. Mrs. Smith saw her oncologist last week and is due to start chemotherapy today. She has 4 young children. At the beginning of the triage the CON ask randomly about distress and Mrs. Smith said "I am not in any distress"

How will the CON administer the DT to Mrs. Smith and how will the CON address her comments of stating "I am not in any distress"

- The CON will tell the Mrs. Smith what the DT is.
- The CON will explain to Mrs. Smith that based on their little discussion she has exhibited risk factors of potential distress such as being a new oncology patient, new diagnosis of colon cancer, having four young children having pain of 8/10
- The CON will ask the patient permission to administer the tool and tell Mrs. Smith the advantages of administering the tool. The CON will explain that a score of 7 and up on the will send the referral to the social worker for further intervention and a score of 3 on the depression screen will also send a referral to the social worker.
- The CON will administer the DT by asking the patient all 3 questions that are on the DT.

Scenario 2

Jon Smith is a 59 year old African American male who was diagnosed with colon cancer five months ago. He presents to the clinic today for continuation of chemotherapy. During Mr. Smith's appointment, he lets the clinical oncology nurse (CON) know that his wife is terminally ill. He further explains to the nurse that he has a very poor family net work with very little or no support. He further informs the nurse that he is concerned about having chemotherapy because of the side effects he has been having. What are some of the things that Mr. Smith told the CON that will alert the CON that Mr. Smith might need a referral to the social worker?

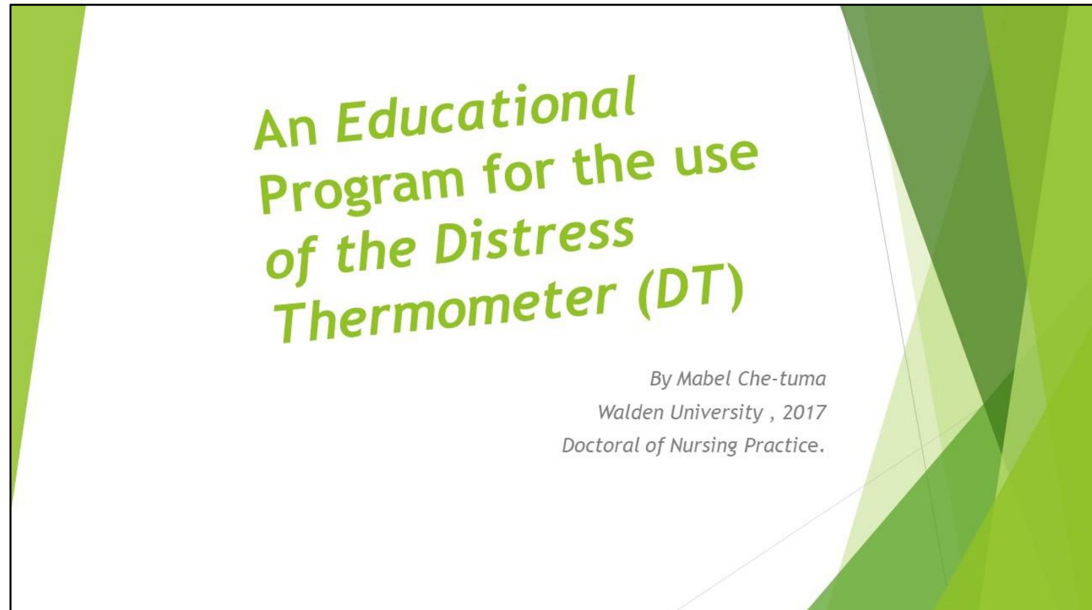
- Answer
- Diagnosed with colon cancer five months ago
- Wife is terminally ill
- Poor family net work.
- Side effects from Chemotherapy, doctor might change his chemo medication.

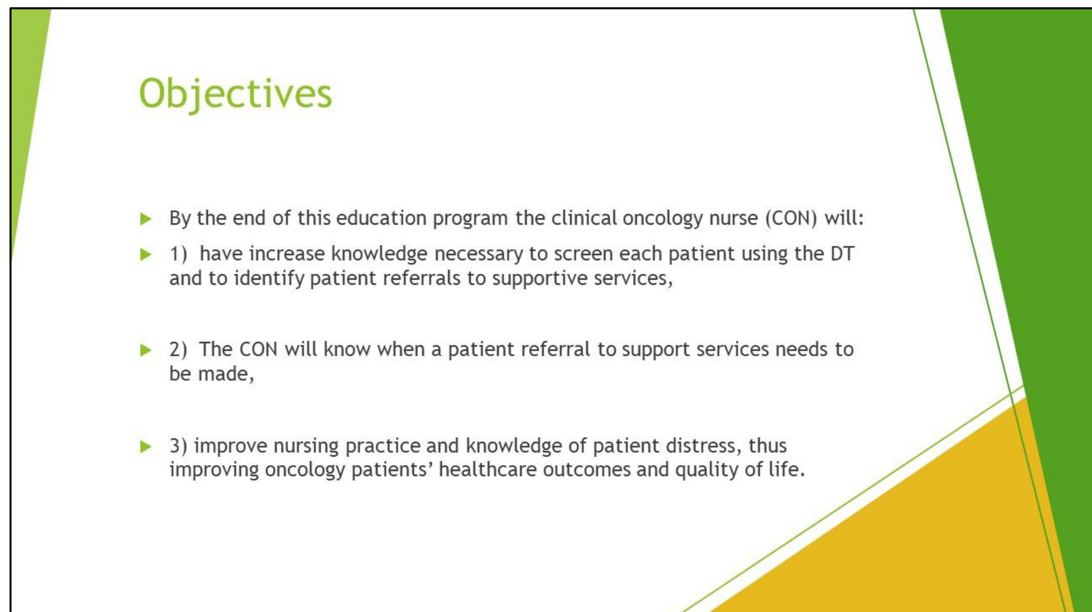
References.

Ford, M. (2012). A tool to measure levels of psychological distress. https://www.nursingtimes.net/clinical-archive/cancer/a-tool-to-measure-levels-of-psychological-distress/5045561.article

National Comprehensive Cancer Network (2017). Distress supportive care book series (2017) Retrieved from https://www.nccn.org/patients/guidelines/content/PDF/distress.pdf

Appendix C: Original CON DT presentation





Definition of DT, distress and why it is important to use the DT in screening.

- The DT is an evidenced based practice tool that was developed in 1998 by the National Comprehensive Cancer Network (NCCN) to detect distress, anxiety, or depression in oncology patients (NCCN, 2017). The adopted DT on the unit has 3 questions and it is imperative that the CON ask the patient all 3 questions for the screening to be accurate.
- Distress is an unpleasant emotional state that may affect how a person feels, thinks, and acts (UF Health Cancer Center, 2017). A patient might describe distress using the following words anxiety, sorrow, pain, agony, torment, torture, suffering sorrow, grief, heartache, despair, sadness, worry, guilt. When a patients uses' any of the above words during the distress screen the nurse needs to probe and ask further questions about the patients distress.
- Ford (2012) define distress as "a feeling of unease stemming from concerns or worries" (para. 10). Distress can be experienced not only by the oncology patient, but also by patient care givers. Distress can manifest it's self in many ways to include: panic attacks, irritability, poor sleeping, feelings of apprehension or worry, being in denial about the cancer diagnosis and poor concentration (Ford, 2012).
- It is important for CON to use the DT to screen because the DT helps the CON to identify the patient's level of distress. If the patients score on the DT is higher than seven, an automatic referral is made to the social worker for supportive services. When a patient receives supportive services because of distress, it helps to improve health care outcomes for the patient.

Causes and Risks of distress and triggers

Distress can affect any oncology patient and what causes distress for one oncology patient may not be what causes distress for another oncology patient. For example some distressed patients may feel worry, some might be overwhelmed about the diagnosis of cancer and others might struggle financially and spiritually (NCCN, 2017). Some people are more likely to be distressed than others.

Risk factors of distress could be be anything that increases the chance of an event. Some risk factors of distress might be health related, personal risk factors, financial risk factors, family conflict, lack of family support, living alone, having young children and dealing with cancer. Highler levels of distress are linked with sexual, physical, and substance use disorders (NCCN, 2017).

Triggers: Learning of a diagnosis of cancer, being assessed for cancer, transitioning in care (e.g discharged from the hospital or finishing all treatment, learning that one's health has worsened.

Benefits of using the DT for screening oncology patients

1) Distress screening detects oncology patients in distress. NCCN (2017) expressed that "with out standardized screening, less than half of distressed people are identified and get help they need" (p. 16). Doctors and nurses don't ask oncology patients about distress and patients don't tell their doctors about their distress (NCCN, 2017, p. 14).

2) The DT provides a way to perform a detailed evaluation about an oncology patients distress.

3) The DT allows for better distress managements. Early identification of distress leads to timely distress management (NCCN, 2017). A research study on routine distress screening and management, indicated that distressed patients referred to supportive services were less distressed 3 months after (NCCN, 2017). Early and better management of distress in oncology patients leads to improved selft care and helath care outcomes.

The adopted DT

Extreme Distress

No Distress

- The first question that is asked on the DT screen is:

1) Please select the number that best describes how much distress you have been having in the past week, including today.

When asking this questions it is important for the CON to know the risk factors of distress (NCCN, 2017). Risk factors for distress include: having uncontrolled symptoms, cognitive impairment, limited access to health care, be young, communication barriers, financial problems, spiritual concerns, family conflict, lack of social network, living alone, and having young children (NCCN, 2017).

If the patient is going through any of the above, it could be an indication that the patient is having significant distress. The CON must guide the patient to rate his or her distress correctly so that he or she can recieve supportive services if needed.

The second question on the DT

Have any of the following been problems to you in the past week, including today?

Spiritual/religious

Physical

Practical

Family

Emotional

- The second question on the DT helps the patient to narrow down the source of distress (Garlapow, 2017). For example, if an oncology patient endorses family as a source of his or her distress, his or her intervention will be different from an oncology patient who endorses physical as a source of distress.
- The CON needs to understand that the Oncology patient who acknowledges' a higher level of distress requires more prompt and urgent intervention as oppose to a patient who report lower levels of distress.
- While oncology patients report lower levels of distress might get relevant education to tracking of the problem overtime, oncology patients who report higher levels of distress might get an urgent call or referral to the professional providing the services that the patient is suffering from.

The third question on the DT is the depression screen

- The third question on the DT is as follows:
- Over the last 2 weeks, how often have you been bothered by either of the following problems? Please select the number that best describes how you have felt this way.
- This question specifically targets depression
- A score of three or higher on the PHQ2 screen will generate a referral to the social worker.

The Patient Health Questionnaire-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

Role of the oncology team

The oncology team can monitor an oncology patient's distress and manage distress symptoms such as: fear, worry, uncertainly about the future, concerns about cancer, sadness about loss of health, poor sleep, poor appetite, poor concentration, frequent thoughts of illness and treatment, concerns about social roles (eg, mother, father, caregiver) (NCCN, 2017).

- Experts in distress management.

Examples of professional who have completed training in distress management are:

1) Chaplains: The problem list has spiritual and religious concerns. Chaplains provide care for problems such as grief, guilt, loss of faith, and spiritual concerns (NCCN, 2017)
2) Social workers: Social workers can provide help with practical and psychosocial concerns. Oncology social workers have been trained about cancer, and educated to proved a range of services to cancer community (NCCN, 2017).
3) psychologist: Psychologist can provide range of services to the oncology patient such as health issues (pain, weight, sleep, sex, taking medication), cognitive problems such as (dementia, chemo brain), mood and anxiety problems (e.g. depression, panic, worry), substance use (eg, drugs, alcohol, smoking), relationship issues (e.g., caregiving, strains, social conflict) (NCCN, 2017)
4) nurses: nurses are trained to screen the oncology patient for distress, provide assistance with practical matters, provide counselling, and refer the oncology patient for supportive services (NCCN, 2017).

Scenario

Mrs. Smith is a 30 year old new oncology patient who reports pain at 8/10 and was recently diagnosed colon cancer. Mrs. Smith saw her oncologist last week and is due to start chemotherapy today. She has 4 young children. At the beginning of the triage the CON ask randomly about distress and Mrs. Smith said "I am not in any distress"

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- The CON will administer the DT by asking the patient all 3 questions that are on the DT.

Quiz

1) What is the DT
2) Why is it important to administer the DT to every single patient
3) How many questions are on the adopted DT that is used on the unit.
4) Is it important to administer all the question on the DT to every single patient? Yes or No
5) under what circumstances should a nurse not administer the tool to a patient.
6) Name at least 3 experts who provide supportive services to a distressed oncology patients.
7) what are some of the stressors that can trigger distress in an oncology patient?

Answers

1) The DT is an evidenced based practice tool that was developed in 1998 by the National Comprehensive Cancer Network (NCCN) .

2) to detect distress, anxiety, or depression in oncology patients (NCCN, 2017).

3) The adopted DT on the unit has 3 questions and it is imperative that the CON ask the patient all 3 questions for the screening to be accurate.

4) Yes

5) if the patient refuses.
6) Social worker, psychologist, nurse, chaplain
7) Learning of a diagnosis of cancer, being assessed for cancer, transitioning in care (e.g discharged from the hospital or finishing all treatment, learning that one's health has worsened

References.

Ford, M. (2012). A tool to measure levels of psychological distress. https://www.nursingtimes.net/clinical-archive/cancer/a-tool-to-measure-levels-of-psychological-distress/5045561.article
National Comprehensive Cancer Network (2017). Distress supportive care book series (2017) Retrieved from https://www.nccn.org/patients/guidelines/content/PDF/distress.pdf