Integration of a Psychosocial Distress Screening in an Acute Care Setting

The Commission on Cancer of the American College of Surgeons (CoC) is the accrediting program for hospitals and cancer treatment centers. Established in 1922 by the American College of Surgeons, the organization’s purpose is to improve quality in cancer care. The CoC publishes standards that address cancer care, from prevention to survivorship to end of life care. In 2011 a standard was published that requires the development of a process that would integrate and monitor on-site psychosocial distress screening and provide referral for the provision of psychosocial care. The process would be phased in for 2015.

The Baptist Breast Center (BBC) was forward thinking and way ahead of the standard. The Patient Navigation program was used to quickly develop a process for the BBC. However, the standard includes all patients with cancer at all stages of the disease. Would the same process be able to be duplicated in the inpatient hospital setting? How would the hospital incorporate the psychosocial distressing screening for all oncology patients into the standard of care?

Situation Background

All patients require screening of needs on an on-going basis and all patients require relevant information, emotional support, good communication and symptom management. The Joint Commission (TJC) and the Center for Medicare & Medicaid Services (CMS) require hospitals to collect information about the patient’s health history as well as physical, functional and psychosocial status. This information should then be used to make care, treatment and service decisions.

Each patient at time of admission to a Baptist Health System hospital has an admission history performed by an interdisciplinary team. The Registered Nurse is responsible for completing this assessment. (See figure 1)

These assessments may be more appropriately described as screenings instead of a true assessment. For example a Registered Nurse would be able to perform a nutritional screening but would require a Registered Dietician to actually perform the assessment. Included in this process are screenings that include nutritional, spiritual/ethical, functional assessment, along with other types of intake screens.

Additionally there is a psychosocial documentation module within the Horizon Electronic Documentation (HED) (See figure 2). During this process, if a need is identified then some type of action will occur. These actions may include but are not limited to active listening, reassuring, communication to physician, etc. Some of these assessments may also trigger a referral or consult. While Case Management is the usual referral/consult there may other referrals such as to Pastoral or Dietary consults.
figure 1

[Diagram of Admission Assessment]

- Admission History
- Admission Data
- Privacy
- Advance Directives
- Anesthesia/Transfusion History
  - Anesthesia
  - Blood Transfusion
- Immunizations
- Emergency Contacts
- Surgical Procedures
- Interdisciplinary Screens
  - Infection Control
  - Abuse
  - Functional
  - Nutrition Hx/Screen
  - Diabetic
  - Wound/Okostomy
  - Spiritual/Ethical
  - Discharge
- Substance Use
  - Tobacco
  - Alcohol Hx
  - Drugs
- Elimination History
  - Gastrointestinal
  - Genitourinary
- History Reviewed
- OB/GYN

figure 2

[Spreadsheet of Patient Data]

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Opportunity Identification:

CoC Cancer Program 2012 Standard 3.2: Psychosocial Distress Screening

- The Cancer Committee develops and implements a process to integrate and monitor on-site psychosocial distress screening and referral for the provision of psychosocial care.

Challenges in the integration of a psychosocial distress screening tool (PSDST) in an acute care setting versus a dedicated center would need to be identified and addressed. A valid and reliable tool should be chosen. Determining how the tool would be implemented also includes how the success of the tool will be assessed for measurable outcomes and the ability for future reporting. Because of the great differences in staff capacity in an acute care setting this standard evolved into a study of processes.

Problem Definition

BHS has the opportunity to develop and provide a psychosocial distress screening that will identify the needs of the Cancer patient admitted to an inpatient bed that may be experiencing distress and provide these patients the appropriate resources and/or referral to meet these needs when admitted to an inpatient bed.

Barriers

The main concern in implementing this standard was in the treatment settings of an acute care hospital with the shift changing of the nursing staff. Adding another step in already busy day of a nurse was not considered favourable. The perception that another screening would even be necessary and found to have patient benefit would be a major obstacle. In light of time constraints and fewer resources it was critical to have a thoughtful, well developed plan that would recognize the barriers and allow the creation of approaches to address. The goal was to incorporate these processes into the standard of care for Oncology inpatients.

Additional, with BHS transitioning to another documentation system the ability to build an electronic tracking report was not available. The process would be manual.

Implementation

The first action was to assemble a team. The core team consisted of the Quality Coordinator, Case Manager and Oncology Nurse Manager. These individuals would guide the initial process and be the champions. Process mapping occurred with the following processes identified.

- Recognizing
- Documenting
- Monitoring
- Provision of Resources

Other disciplines were included such as Pastoral Care, Oncology Nursing, Nursing Quality and Nurse Navigation were included at different intervals. There was a strong commitment and collaboration with
all of the stakeholders. The American Cancer Society (ACS) was also a rich resource provider and partner to the team. Resources were identified.

Recognizing

The standard requires that the screening would occur at a “pivotal medical visit.” The team had to define for the acute care setting what that “visit” would be. For the acute care setting this visit would occur upon admission for all inpatient patients with a Cancer diagnosis.

The different screening tools were researched. The key components were to find a valid, reliable tool that would allow for modifications as it relates to BHS. A decision was made that the tool would be completed by the patient or caregiver so the tool would need to be easy to use. The National Comprehensive Cancer Network (NCCN) was found to meet all these components (See figure 3). Permission was requested and granted. BHS was able to make modifications (See figure 4).

(figure 3)
The distress screening tool process was flow charted by each step (See figure 5). The team agreed that it was important prior to implementation that a through cycle of plan, do, study, act (PDSA) would helpful. The tool and the process underwent testing for two weeks on the oncology floor at Northeast Baptist. The nurses and the patients reported that the tool was simple and easy to use. The sample was made up of 12 patients. The average distress score was 2.3. 58% (7) of the patients noted stress related to physical concerns.

**Documenting**

Due to the changes with the EMR the tool would stay as a part of the medical record to avoid having the nurse recreate the score and interventions on another document. The Oncology Nursing Council also determined that performing the screening upon admission would be the best way to make the process manageable. This time will be defined as a “pivotal medical visit.”
Inpatient Admission of any Patient with a Cancer Diagnosis to a BHS facility (***Any Nursing Unit)

Nurse Provides BHS Distress Screening Tool to Patient/ Caregiver During Admitting Process

Nurse & Patient/ Caregiver Review the Completed Tool

Scores of 4 or Greater is an Automatic Referral to Case Management (All Causes of Distress)

BHS Distress Tool is Placed in the Physician Progress Note Section of the Chart for Review & Signature

Case Manager Responds to Referral by Meeting with the Patient to Assess for Needed Resources & Services and to Offer Support

Resources are Provided by Case Management

Case Manager Documents Referrals and Services Provided in the Appropriate Electronic Program. Documents are Entered into the Medical Record.

Case Manager will Enter an Intervention for "BHS Cancer Distress Checklist"

Annual Reports to the Cancer Committee will be done by Quality and Case Management monitoring
Based upon screening results all scoring greater than or equal to 4 will have an automatic referral to Case Management/Social Services. This decision was soundly based on the research and literature available.

(figure 6)

Green Zone
Score of 0-3
This zone is considered a mild level where the patient is managing the concern well and has low symptom distress

Yellow Zone
Score of 4-6
This zone is a warning signal that things are getting out of control for this patient. There needs to be a clear intervention to get this patient back to the green zone.

Red Zone
Score of 7-10
This zone demands an urgent response by the clinical team. These patients would be identified as having the more severe issues and a more thorough, immediate assessment would take place.

For all groups the following should take place:
1. Scores acknowledged
2. What the score means to the patient discussed
3. Conversation charted
4. Follow through on action plan identified

Guide to Implementing Screening for Distress, the 6th Vital Sign: Background, Recommendations, and Implementation

Conclusion

Psychosocial distress in an individual with a diagnosis of cancer will be intensified by the disease and the treatment that accompanies it. Research suggests that these factors may actually have a negative impact on the course of the disease. Addressing stressors and the effects on our cancer patients is the goal of the BHS oncology program. The realization after going through this process that all issues cannot be resolved in the acute care setting but will take a care delivery model that includes many disciplines in the acute and post acute setting. The potential benefits of this screening will become apparent as the process matures. The team will continue to assess the program implementation process and build upon its effectiveness.