A structured self-reporting new patient assessment tool: Guide to oncology nursing practice

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Abstract

Ambulatory nursing care of the patient with cancer presents unique challenges for the assessment, prevention and management of patient problems. In the ambulatory setting, the time available to the nurse with each patient is limited, and nurses must have a strong knowledge base and keen assessment skills. Use of a structured, self-reporting assessment tool designed to tap the high incidence problem areas for the oncology patient can facilitate effective and efficient data collection.

This type of tool was developed and piloted on 321 patients in the ambulatory area of a cancer referral centre. These patients were visiting the institution for the first time, and included patients who were newly diagnosed, patients who were seeking a second opinion, and patients requiring adjuvant therapy. Review of the pilot data revealed interesting trends regarding the prevalence of various problems or needs. The top problems pertained to the performance of activities of daily living (ADL) and included: Bending/lifting, sleeping, climbing stairs, walking or moving around, etc. Each of the ADLs were cited by at least 16-25% of the patients. Symptom management problems such as breathing, constipation, nausea etc. were each cited by less than 15% of the patients.

This paper describes the trends observed, the implications of the data for defining the role, scope and process of ambulatory oncology nursing practice, and outlines some of the practice changes that have been stimulated by nurses' greater awareness of the prevalence of these problems. Plans for continued use and tool refinement will also be discussed.

Structured assessment tools assist nurses in obtaining a sufficient amount of subjective and objective information to proceed with care. Ambulatory care requires a high level of practice in order to assess and identify problems in patients who have only limited contact with health care professionals and are often characterized by high acuity levels. Fifteen to 30 minutes may be the maximum time a nurse has with a patient and the nurse needs to be able to assess those problems for which an oncology patient is at risk. Standards of nursing practice outline the nurse's role with regard to assessment (College of Nurses of Ontario, 1990; American Nurses' Association and Oncology Nursing Society, 1987). Systematic and ongoing data collection regarding patient health status needs to be obtained, recorded and communicated. This first step of the nursing process must be reliable and valid for quality patient care.

Pertinent patient information must be obtained efficiently and accurately so that patients' needs can be quickly and appropriately addressed. This challenge of expert assessment and intervention was analyzed by nursing administration at the Ontario Cancer Institute/Princess Margaret Hospital (OCI/PMH) and a tool for maximum data collection was developed.

Ambulatory area demographics

The ambulatory department at OCI/PMH manages approximately 73,000 patient visits/year, 6,200 of which are new patients. Each ambulatory nurse is responsible for approximately 15 patients in a three-hour clinic period. Not every patient can be seen by the registered nurse (RN) so patient

problems are prioritized and patients are seen by an RN in addition to the physician, depending upon their needs. Within each three-hour clinic period every nurse sees one to three new patients (Table One).

A new patient often requires more time than a patient being evaluated for follow-up since the health care team is unfamiliar with the new patient and obtaining a thorough history is a lengthy process. At the time the new patient assessment form was developed, the implementation of primary nursing was slowly occurring in the ambulatory department. Nurses were experiencing numerous changes simultaneously. Nurses were attempting to manage new primary patient caseloads as well as expand their knowledge base. Knowledge of basic oncology nursing care was growing at different rates for each of the 24 nurses. Some were more familiar than others with a specific disease site, or about what oncologic problems a patient was at risk for, but in general, assessment followed by the identification of patient problems was not consistent throughout the nursing staff. Therefore, it became clear that something was needed in order for the entire staff to achieve the practice standard of assessment.

New patient assessment form

The new patient assessment form (NPAF) was designed with these time constraints and knowledge deficits in mind. Its development originated out of the goal to assist nurses in understanding their patients' problems. It was

UN OUTIL D'AUTO-ÉVALUATION STRUCTURÉ À L'USAGE DES NOUVEAUX PATIENTS: GUIDE POUR LA PRATIQUE DES SOINS INFIRMIERS ONCOLOGIQUES

ABRÉGÉ

Les soins infirmiers ambulatoires des patients atteints d'un cancer présentent des défis originaux au niveau de l'évaluation, de la prévention et de la gestion des problèmes auxquels ils font face. Dans un milieu ambulatorio, l'infirmière dispose de peu de temps pour chaque patient et elle doit posséder des connaissances approfondies et des compétences d'évaluation certaines. L'emploi d'un instrument d'auto-évaluation structuré conçu pour exploiter les domaines fréquemment problématiques chez le patient cancéreux peut faciliter la collecte efficace et efficiente des données.

Un instrument de ce genre a été mis au point et mis à l'essai dans le service ambulatorio d'un centre d'aiguillage pour les cancéreux. Ces patients se rendaient au centre pour la première fois et incluaient des patients qui venaient juste de faire l'objet d'un diagnostic, d'autres qui voulaient prendre l'avis d'un second médecin et d'autres encore qui devaient recevoir une thérapie adjuvante. L'analyse des données produites par l'étude pilote a révélé des tendances intéressantes au niveau de la fréquence des divers problèmes ou besoins. Les problèmes les plus fréquents se rapportaient à la performance des activités de la vie quotidienne y compris: se pencher/soulever, bien dormir, monter des marches, marcher, se déplacer, etc. Chacune de ces activités a été mentionnée par au moins 16-25% des patients. Les problèmes de gestion des symptômes comme la respiration, la constipation, la nausée, ont chacun été mentionnés par moins de 15% des patients.

Le présent article décrit les tendances observées, les implications tirées des données au niveau de la définition du rôle, de la portée et du processus de la pratique des soins infirmiers en oncologie ambulatorio. L'article souligne aussi quelques-uns des changements qui se sont produits une fois que les infirmières ont mieux pris conscience de la fréquence de ces problèmes. On y discute aussi des plans concernant l'emploi continu de l'instrument et son perfectionnement.

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not intended to be a form that was merely filled out and filed in the chart. It was intended to guide nurses in their thinking and decision-making processes. The form was a structured tool. Miaskowski and Nielsen (1985) report incomplete data collection and insufficient information obtained from assessment forms with broad subject headings. The form was also intended to provoke nurse-physician collaboration about identified problems. Prior to the assessment form and the implementation of primary nursing, physicians and nurses had been functioning in parallel practices. Collaboration was encouraged by the assessment process, since the nurse reviewed the collected data, identified patient problems and had information with which to participate.

The designed form resulted in assessment of 10 of the 11 high incidence problems (exclusion of prevention and detection) (Table Three), common rehabilitative problems cited in the literature (ANA and ONS, 1987; Ganz, Rofessart, Polinsky et al., 1986), and common side effects of cancer and cancer treatment (Table Two). The high incidence problem areas are covered in 24 questions, eight of which pertain to pain, and the questions were written at a tenth grade reading level, as determined by the SMOG readability formula (Redman, 1988). Information was covered in a consistent question style. Examples of the questions within the assessment form are shown in Table Four.

Designing the form so that the high incidence problem areas provided a structured guide to assessment facilitated the nurses' learning of the high incidence problem areas and it educated everyone involved about the scope of an oncology nurse's practice. Once patient problems were identified, they then had to be managed. For some nurses, this growth in their scope of practice was new and somewhat overwhelming. Nurses needed to learn what to do for each problem, which in the past might have been managed by the physician or had gone unaddressed.

Form completion

The assessment form is handed to patients by a registered nursing assistant (RNA) upon arrival in the ambulatory waiting area. The RNA explains the form, how to answer it, and assists in its completion. The RNA might delve further into questioning if she believes it is warranted. The assessment form requires approximately 20 minutes to complete and by using "waiting time" it maximizes the use of the patient's time.

Upon completion of the assessment form, the RNA gives it to the primary nurse with any additional observations or insights. The primary nurse reviews it, noting any problem areas requiring more indepth and specific assessment. The assessment form combined with the RNA input comprises the preliminary assessment for the nurse and health care team, streamlining and directing the team's efforts to specific problem areas.

Assessment form identified patient problems and implications

The assessment form was piloted with 321 oncology patients new to the ambulatory department of the Princess Margaret Hospital during the period of October 7 through November 30, 1991. One of the most interesting results came out of question seven, "Do you have problems with any of the following? Check if yes" (Table Four). The first seven problems cited by at least 15% of the patients all pertain to activities of daily living (ADL) and rehabilitative needs (Table Five). Inquiring further into each of these cited problems led to the unique causes and corresponding unique interventions. It is not until the eighth most common problem cited that physical symptoms emerge.

The implications of these results affect nursing interventions as well as research (Table Six). In a health care setting where the "medical" care aspects are emphasized, it is interesting to point out that what actually brings a patient to a health care setting may not be a medical problem and might be managed in a more cost-effective setting, i.e. a nurse-run clinic. Second, nursing needs to look at the present status of interventions to check if actions are meeting the needs of patients. If 25% of patients report problems with ADL then some type of routine education, routine home care assessment, preventive intervention or rehabilitative care might be in order.

Third, since patients could check off more than one problem, we need to ascertain at what point do the patients' cumulative problems with ADL force them into some type of inpatient setting. Could some

of these problems be managed by home care, thereby reducing the overall burden of problems to the patient and keeping the patient at home?

Challenges in utilizing the form

Difficulties the ambulatory nurses encountered with the assessment form pertained more to their roles and their scope of practice than the form itself (Table Seven). As previously mentioned, the nurses historically supplemented and assisted the physicians and other health care team members' practices. The use of this assessment form brought to light what an oncology nurse should understand, should assess, and either manage independently or collaboratively manage. For some health care members, this was a new awareness of what an ambulatory oncology nurse's role entails, and required education in order to meet the new standard of practice. The education was twofold. First, nursing literature discussing the various problems and their management within the scope of an oncology nurse's practice was distributed. Second, standards of practice and position papers established by the Canadian Association of Nurses in Oncology (CANO) and the Oncology Nursing Society (ONS) were distributed (College of Nurses, 1990; CANO, 1988; and ONS, 1987). The practice standards and position papers provided the national and international view of the oncology nurse's practice. The nursing literature supported the overwhelming benefit of nursing involvement with oncology patients.

A major resistance initially arose from the medical staff. There was concern that nurses were incapable of managing the problems which were being identified. Physicians were also unfamiliar with the level of practice expected of ambulatory oncology nurses. Supplying the position papers and practice standards of the professional nursing organizations assisted the medical staff in comprehending the new evolving ambulatory oncology roles. Reassurance that nurses would be working with their physician partner, sharing data collected, eased many concerns. Strong nursing administrative support combined with a willingness of all involved to reach mutually satisfying resolutions was critical to the eventual acceptance of the form and role.

Education also assisted in the reassurance that symptom and problem management was not violating the "rules" of a tertiary care referral setting.

Table One: Patient volume

- 73,000 patient visits/year
- 6,200 new patients/year
- 1 new patient: 11.5 follow-up patients
- 1 nurse: 15 patients/three hours

Table Two: NPAF design

Design:

- 24 close-ended questions
- 10 high incidence problem areas
- literature cited rehabilitative problems
- tenth grade reading level

Facilitates:

- systematic, organized patient review
- education of staff about 11 high incidence problem areas
- multidisciplinary communication
- documentation of assessment

Table Three: Eleven high incidence problem areas

Prevention/detection*	Information
Coping	Comfort
Nutrition	Protective mechanisms
Mobility	Elimination
Sexuality	Ventilation
Circulation	

Standards of Oncology Nursing Practice, 1987

* not assessed

Table Four: Examples of the questions within the assessment form

History

5) Do you have any other health problems?

☐ No ☐ Yes

If yes, check all that apply:

☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ Stroke ☐ Seizures ☐ Headaches

☐ Other _____

6) Do you feel that you have enough energy for your daily activities?

☐ No ☐ Yes

7) Do you have problems with any of the following? Check if 'yes'

☐ Bending or lifting ☐ Bladder control

☐ Fatigue ☐ Walking/moving around

☐ Vomiting ☐ Climbing stairs

☐ Nausea ☐ Driving

☐ Breathing ☐ Sleeping

☐ Sweating/perspiring ☐ Fevers

☐ Frequent napping ☐ Relaxing

☐ Concentrating ☐ Doing household chores

☐ Remembering things ☐ Shopping

☐ Thinking clearly ☐ Child care

☐ Diarrhea ☐ Drowsiness

☐ Hearing ☐ Constipation

☐ Other _____

8) Are you taking any medicines?

☐ No ☐ Yes

If yes, please list them: _____

9) Do you have any allergies to foods, medicines, etc.?

☐ No ☐ Yes ☐ I do not know

If yes, please list them: _____

Reaction: _____

Discomfort

10) Some people experience pain or discomfort for different reasons. Do you have any pain or discomfort?

☐ No ☐ Yes

If yes, please describe: _____

If you do not have pain or discomfort, move to Question #18

11) Do you take any pain medicine?

☐ No ☐ Yes

12) Does the pain medicine control your pain?

☐ No ☐ Yes

13) Using the scale below, please circle the number that best describes your pain one hour after you take your pain medicine. There is no right or wrong answer. You are the only person who can describe the pain or discomfort you may have.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain you can imagine

14) Do you have any side effects from your pain medicine?

☐ No ☐ Yes

If yes, please list them: _____

15) Do the side effects ever keep you from taking your pain medicine?

☐ No ☐ Yes

16) Does anything else relieve the pain?

☐ Heat ☐ Massage ☐ Other

17) Do you have any pain at this moment? Please circle your pain level on this scale.

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain you can imagine

Nutrition

18) Are you on a special diet?

☐ No ☐ Yes

Describe: _____

19) Do you have any of the following problems?

☐ Gaining too much weight ☐ Food is unappealing

☐ Inability to gain weight ☐ Food tastes bad

☐ Recent weight loss ☐ Difficulty swallowing

Personal concerns

20) Having an illness can affect family and friends. Is there anyone you are concerned about as a result of your illness?

☐ No ☐ Yes

Why or in what way? _____

21) Illness can often affect a person's emotions in many ways. Since your illness have you felt any of the following? Check if yes.

☐ Anxious or more anxious than usual

☐ Upset or more easily upset than usual

☐ Depressed or more depressed than usual

☐ Overwhelmed by emotions and feelings about your illness

☐ Angry

☐ None of the above

22) Many people being treated for illness have concerns about changes in their sexuality. Do you have any concerns that you would like to speak to your nurse or doctor about?

☐ No ☐ Yes

Table Five: Commonly cited problems

Problems cited	N=321	%
1. Bending/lifting	82	25%
2. Sleeping	81	25%
3. Climbing stairs	75	23%
4. Walking/moving around	59	18%
5. Remembering things	58	18%
6. Frequent napping (new)	55	17%
7. Doing household chores	52	16%
8. Breathing	49	15%
9. Hearing	49	15%
10. Constipation	43	13%
11. Shopping	43	13%
12. Sweating/perspiring	40	12%
13. Bladder control	38	11%
14. Drowsiness	32	9%

Table Six: Implications of most commonly cited problems

1. Care sought for "non-medical" nursing problems
2. Are present nursing interventions meeting patient needs?
3. Role of rehabilitative interventions in care of the oncology patient
4. Problem management in the home vs the inpatient setting.

**Table Seven:
NPAF: Obstacles to use**

- Varying levels of oncology nursing knowledge and practice
- Overlap into other disciplines
- Virgin territory
- Primary vs tertiary care setting

Table Eight: Patient evaluation of the assessment form

N=232

	Yes	No
Understood questions asked	91 (39%)	3 (<1%)
Question made patients uncomfortable	19 (8%)	206 (89%)
Discomfort answering in waiting area	16 (6%)	162 (70%)
Lack of privacy	18 (7%)	160 (69%)
Helped put thoughts in order	114 (49%)	84 (36%)
Form reminded patient of concerns which had slipped their mind	67 (28%)	143 (62%)

Table Nine: New patient assessment form Advantages

- Articulation of nursing practice
- Increased patient problems identified
- Documentation improvement
- Improvement in quality of care
- Communication facilitated
- Educational needs of staff highlighted
- Registered nursing assistant independence promoted
- Staff educated regarding the needs of oncology patients

Patients deserved relief from symptoms and problems due to the disease process and/or the medical treatments. A cancer referral centre is the most equipped to manage those problems.

Nursing administration believed that assessment begun in the waiting room would make the most of patient waiting time, which could average as long as one hour. The medical staff was concerned that patients would feel the assessment form completion in the waiting area was impersonal despite RNA-facilitated administration.

Form evaluation

Evaluation of the form consisted of surveying the nursing staff and having the patients complete an evaluation questionnaire. In a primary nursing system which was incurring role changes, the RNA group was happy to verbalize a "job responsibility" that was concrete and a "sure thing" for them. An increase in problems being identified by the primary nurses led to an increase in nursing interventions and overall increase in the nursing component of patient care. This increased activity forced the health care team to listen and to seek the nurses' involvement. In addition, communication was being facilitated verbally and in writing. In studying the patient problems identified on the form and documented in the charts, there was an increase in correctly worded nursing diagnoses relating to high incidence problem areas other than "Information" and "Coping" which previously had been the major patient problems identified. The problem cited the least pertained to sexuality. Discussion with the staff pointed out that some of the reason was due to personal discomfort, but for the most part, staff requested further education so that they could not only assess for problems of sexuality, but also intervene appropriately.

Two hundred and thirty-two patients were asked about the new patient assessment form (Table Eight). Results were overwhelmingly in support of continuing the form since 89% of the patients surveyed were not made uncomfortable with the questions asked. Seventy per cent did not experience discomfort or feel a lack of privacy (69%) completing the assessment form in the waiting area. Additional benefits noted by 49% of the surveyed patients were that the assessment form helped put their thoughts in order and for 28% the form reminded patients of concerns they had forgotten. As often expressed by patients, waiting can be very tedious, especially when not feeling well or being evaluated for a possible life-threatening illness such as cancer. The assessment form actually made constructive use of time people spent waiting and began the care process from the moment patients entered. Additionally, patients noticed and expressed satisfaction at the increased nursing involvement which was evolving from assessment form use and the primary nursing process. It was concluded that the form did not cause discomfort, did not anger anyone, and assisted people in their first visit to the ambulatory department, which can be a very anxiety-provoking experience.

Summary

The advantages of this new patient assessment form pertain to the nursing staff as well as patients. Thorough assessment combined with communication and collaboration can only provide a better quality of care for patients. By directing the oncology nurses' assessment to specific potential problem areas, work time is maximized and appropriate patient care planning is facilitated.

The ease of administration is a big advantage. Other studies with structured self-reporting assessment interviews have proven this approach acceptable to oncology patients. Our combined complementary approach mixes the sensitivity and efficiency of the

self-reporting questionnaire with a shorter, more concise clinical interview that explores identified problem areas in more detail, obtaining crucial information for treatment planning. On a larger scale, the information obtained from the data has led to staff educational sessions, patient support groups, and home care liaisons (Table Nine).

The new patient assessment form has led to the development of site specific assessment guides and is leading to the development of a flow sheet to capture documentation, as well as creation of patient education materials. In addition, social history and the eleventh high incidence problem area of prevention and detection will be added. This assessment form has served a number of purposes, but professionally, it was a vital stepping stone in assisting the ambulatory nurses to develop and articulate their individual oncology nursing practice. ♥

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