



Ask Us: We Know About Psychosocial Care

Oncology nurses have always known that a diagnosis of cancer impacts the psychosocial well-being of a person. And, often, oncology nurses are the ones who detect psychosocial concerns in patients, as well as noticing changes—often subtle differences in a patient's usual manner—which require further assessment and possibly referral or treatment.

Although it is well known that cancer and its treatment affect physical functioning, a focus on the physical care and administration of treatments often has neglected the psychosocial concerns of patients and their families. Now, with an increasing emphasis on comprehensive cancer care, both providers and staff at healthcare facilities are taking a closer look at the well-being of the whole patient with cancer. The effects of the diagnosis and treatment often extend beyond the physical side effects, impacting social functioning and psychological well-being as well. For example, it did not take long for providers to realize that interferon, a treatment for later stages of melanoma, may cause significant and prolonged depression requiring careful assessment and even prophylactic treatment with antidepressants. Providing patient-centered care means more than evaluating symptoms and treating physical side effects of the disease and treatment.

In 2007, the Institute of Medicine report *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs* highlighted the psychosocial needs of people with cancer as a vital component of comprehensive cancer care. In 2011, the American College of Surgeons Commission on Cancer® (CoC®), developed a new accreditation standard regarding the psychosocial concerns of people receiving cancer care. CoC, standard 3.2, requires cancer centers seeking accreditation to assess the psychosocial concerns of patients with cancer at least once during their care. Implementation of this standard by 2015 will be conducted by the

cancer committees at each center. Cancer committees will develop and implement a process to screen for psychosocial distress, as well as a system for referral and treatment. However, cancer committee members charged with the oversight for implementing this new standard are *licensed mental health professionals*, and, although it does not specify a nurse, one could certainly argue that, in many states, a mental health clinical nurse specialist (CNS), particularly an oncology-certified CNS, would be ideally suited for this position on the cancer committee. Given that oncology nurses spend the most time with patients and their families, nursing should be at the table to discuss when to screen patients, what tools to use for screening, and how to integrate a process for referral and/or treatment.

I would like to propose three recommendations for oncology nurses working in facilities to implement CoC, standard 3.2.

Be present on cancer committees. Oncology nurses are key members of oncology teams and cancer centers and spend the most time with patients and their families. Their expertise is necessary to determine how and when patients should be screened for psychosocial concerns and determine the processes for appropriate follow-up mechanisms.

Know the assessment tools for psychosocial concerns. Oncology nurses should be involved in tool selection as the assessment for these concerns is most often the role of nursing. They need to be involved in decisions about when patients should be screened and also which tools are easiest to use with a minimum of effort for patients. Consideration should be given to the use of electronic assessments to simplify tool administration, improve

electronic documentation, and decrease the burden on patients.

Share nursing knowledge about adaptation, psychosocial concerns, and distress. Oncology nurses, with their knowledge of critical times when patients are more vulnerable to distress, understand when more intensive assessment may be necessary. Implementing easy-to-use tools allows nurses to screen and detect changes, quantify levels of distress and specific concerns, and work with the oncology team to provide necessary care and referrals.

We see it daily—a subtle change in mood, a downward glance, difficulty communicating, changing relationships, less responsiveness, more silence, worry, anger, or a spiritual crisis. However, we also see healing and recovery, personal growth, renewed hope, strengthened relationships, and even acceptance. Our daily and prolonged relationships with patients provide opportunities to detect changes from normal patterns of coping and functioning.

We understand the spectrum of psychosocial concerns in cancer care. It has always been a part of how oncology nurses provide care to their patients. Ask us how to implement psychosocial care. We have been doing it for years.

References

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