Hospitals stays are becoming shorter, and care is increasingly technical, fragmented, and impersonal; therefore, recognizing patient psychosocial needs in a timely manner is critical (Gosselin, Crane-Okada, Irwin, Tringali, & Wenzel, 2011; Keller et al., 2004; Pasacreta, Kenefick, & McCorkle, 2008). Between 30%-50% of patients with cancer experience psychosocial distress (Gosselin et al., 2011; Keller et al., 2004). Patients report having unmet psychosocial needs and a desire for support at varied phases of their cancer treatment (Absolom et al., 2011). The National Comprehensive Cancer Network has suggested that psychosocial distress be considered the sixth vital sign (Holland & Bultz, 2007). Nursing is a trusted profession, and the amount of time nurses spend with patients make them well positioned to play a key role in assessing patients and intervening to minimize psychosocial needs (Pasacreta et al., 2008).

The Institute of Medicine (2007) emphasized the importance of meeting the psychosocial needs of patients with cancer, but stressed that education regarding how to best approach those psychosocial needs. Therefore, the purpose of this survey was to determine the educational needs of inpatient oncology nurses in terms of providing psychosocial care to patients and to determine the barriers that inpatient nurses experience when providing psychosocial care. Twenty-six inpatient oncology RNs participated in an online survey that assessed barriers to psychosocial care as well as educational needs. Nurses identified that time, lack of patient privacy, nurses’ emotional energy, confusion about clinical guidelines, lack of experience with screening tools, not knowing how to approach sensitive topics, and poor communication between team members undermine psychosocial care. Inpatient nurses need additional training to provide excellent psychosocial care.
Rennie and MacKenzie (2010) surveyed oncology nurses throughout British Columbia and reported that learning needs were a function of the region in which the oncology nurse worked. Nurses across regions requested education on cultural aspects of care, treating anxiety, and nurse self-care with local in-services as the preferred educational venue (Rennie & MacKenzie, 2010).

In 2008, the Oncology Nursing Society conducted a survey of 1,180 advanced practice nurses (APNs), including clinical nurse specialists and nurse practitioners, to determine barriers to psychosocial care and the educational needs of their members (Gosselin et al., 2011). The most common barriers to provision of psychosocial care were time and the nurse perception that families did not wish to address psychosocial concerns. Nurses felt patients and families were troubled by the stigma associated with psychosocial care. APNs also identified that more training was needed in the use of standardized psychosocial assessment tools.

### Methods

#### Participants

Twenty-six of 74 inpatient oncology nurses (35%) responded to the survey. Eleven percent of nurses (n = 3) were aged 21–29.

### Table 1. Participant Responses to Individual Survey Statements (N = 26)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Never</th>
<th>Sometimes</th>
<th>Frequently</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient-related factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients and families want to address psychosocial issues.</td>
<td>1</td>
<td>12</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Patients and families have the mindset that psychosocial care is not as important as medical care.</td>
<td>3</td>
<td>17</td>
<td>5</td>
<td>–</td>
</tr>
<tr>
<td>Patients and families are influenced by the stigma of psychosocial care and avoid these issues.</td>
<td>2</td>
<td>16</td>
<td>8</td>
<td>–</td>
</tr>
<tr>
<td>Time is a barrier that interferes with a patient’s psychosocial needs.</td>
<td>–</td>
<td>13</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td><strong>Nurse-related factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial assessment is as important as the rest of a patient’s physical assessment.</td>
<td>–</td>
<td>3</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>My lack of experience with psychosocial screening tools makes me uncomfortable providing psychosocial care.</td>
<td>7</td>
<td>14</td>
<td>4</td>
<td>–</td>
</tr>
<tr>
<td>Not knowing how to bring up sensitive topics interferes with me providing psychosocial care.</td>
<td>5</td>
<td>18</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>I know when and to whom to go to if my patient needs psychosocial care.</td>
<td>–</td>
<td>7</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>I don’t have enough energy to provide emotionally draining psychosocial care to patients.</td>
<td>6</td>
<td>19</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td><strong>Provider-related factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providers have the mindset that psychosocial care is not as important as medical care.</td>
<td>4</td>
<td>15</td>
<td>7</td>
<td>–</td>
</tr>
<tr>
<td>Poor communication between team members interferes with providing psychosocial care to patients.</td>
<td>5</td>
<td>12</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td><strong>Environmental or practice-related factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There isn’t enough time in a shift to assess and address psychosocial needs and issues with patients.</td>
<td>2</td>
<td>13</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Lack of privacy in the care setting interferes with discussing psychosocial needs with patients and/or families.</td>
<td>3</td>
<td>15</td>
<td>8</td>
<td>–</td>
</tr>
<tr>
<td>The lack of clinical practice guidelines and protocols interferes with me providing psychosocial care.</td>
<td>9</td>
<td>13</td>
<td>4</td>
<td>–</td>
</tr>
</tbody>
</table>

*Note. Because of missing data, not all responses total 26.*
years, 38% (n = 10) were aged 30–39 years, 19% (n = 5) were aged 40–49 years, and 31% (n = 8) were aged 50–59 years. Sixty-two percent (n = 16) of the nurses had bachelor’s degrees and 38% (n = 10) had associate degrees. Sixteen percent (n = 4) had worked on the oncology unit fewer than two years, 16% (n = 4) had worked 3–5 years, 40% (n = 10) had worked 6–10 years, 20% (n = 5) had worked 11–15 years, and 8% (n = 2) had worked on the unit more than 20 years. Thirty-five percent of the nurses (n = 9) identified their background as being Asian or Pacific Islander, 4% (n = 1) identified themselves as African American, 11% (n = 3) identified themselves as Hispanic, and 50% (n = 13) identified themselves as Caucasian. Information is not available regarding demographic differences among nurses who returned the survey compared to those who did not return the survey.

Setting

This survey of oncology nurses was conducted at an academic medical center consisting of 619 inpatient beds and 27 inpatient oncology beds. The hospital uses a primary nurse model of care, serves a diverse patient population, and is a level one trauma center, with designation as a National Cancer Institute Comprehensive Cancer Center. The hospital also is affiliated with four other rural regional cancer centers. Oncology nurses from the academic medical center provide mentorship and training for nurses from the four affiliated rural hospitals.

The survey was reviewed by the committee responsible for protection of human participants and was exempt. Survey Monkey® was used to contact nurses after the first author conducted an in-service to discuss the study and posted flyers on the unit describing the survey. The study purpose, outlined risks and benefits, as well as the fact that only group data would be presented were described during an introductory statement using Survey Monkey. One reminder was sent to all 74 oncology nurses via email in November 2012, following the initial invitation that went out in October 2012.

Survey statements were adapted from a similar survey that focused on advanced practice Oncology Nursing Society member needs in relation to providing psychosocial care (Gosselin et al., 2011). The survey by Gosselin et al. (2011) was developed by nine members of the Psychosocial Project Team of the Oncology Nursing Society to develop a position paper on psychosocial services for patients with cancer. This team held eight conference calls and reviewed multiple email versions to perfect the survey. Twelve of the 18 statements from the original survey were included in the study because they were relevant to a university medical center and to the role of a bedside RN in an acute care facility.

Statements focused on types of barriers oncology nurses face when providing psychosocial care to patients. No definition of psychosocial care was provided; instead, nurses were allowed to interpret that as it occurred in their practice. Response options were “always,” “frequently,” “sometimes,” and “never.” Two other statements, “I know when and who to go to if my patient needs psychosocial care,” and “Not knowing how to bring up sensitive topics interferes with me providing psychosocial care,” were added to the survey. Likert-type scale responses were used for the majority of the survey. However, open-ended questions also were included to target nurses’ suggestions for improving the provision of psychosocial care (“What strategies would you suggest for improving psychosocial care?”), as well as identifying the top educational needs (“What type of education would be most helpful?”).

Findings

Findings were organized according to patient-related factors, nurse-related factors, provider-related factors, and environmental- or practice-related factors. In the category of patient-related factors, nurses felt that 88% of patients and families sometimes or frequently have the mindset that psychosocial care is not as important as medical care. Ninety-two percent of nurses felt that patients and families sometimes or frequently are influenced in a negative way by the stigma of psychosocial care.

In the category of nurse-related factors, 76% of nurses felt that their lack of emotional energy was sometimes a barrier to providing excellent psychosocial care. Seventy-two percent of nurses identified that sometimes or frequently their lack of knowledge regarding screening tools was a barrier. Eighty-one percent of nurses felt that sometimes or frequently not knowing how to bring up sensitive topics was an issue.

In the category of provider-related factors, 85% of nurses felt that providers sometimes or frequently have the belief that psychosocial care is not as important as medical care. Seventy-seven percent of nurses felt that poor communication among team members interfered with providing psychosocial care.

In the category of environmental and practice-related factors, 50% of nurses identified that time was frequently or always a barrier to the provision of excellent psychosocial care. Eighty-eight percent of nurses felt that sometimes or frequently the lack of privacy interfered with discussing patient psychosocial needs. Sixty-five percent of nurses felt that sometimes or frequently the lack of practice guidelines interfered with providing excellent psychosocial care.

Percent responses and cross tabulations by age and education were calculated. Responses to individual survey statements are provided and organized by the categories described (see Table 1).

One statement, “I am familiar with community resources that I use in providing psychosocial care” was rated as “strongly agree” by 4% (n = 1) of nurses, as “agree” by 15% (n = 4) of nurses, as “unsure” by 54% (n = 14) of nurses, as “disagree” by 31% (n = 8) of nurses. Sixty-five percent of nurses identified that sometimes or frequently their lack of knowledge regarding screening tools was a barrier. Eighty-one percent of nurses felt that sometimes or frequently not knowing how to bring up sensitive topics was an issue.

![FIGURE 1. Cross Tabulations for Education (N = 26)](image-url)
23% (n = 6) of nurses, and as “strongly disagree” by 4% (n = 1) of nurses. In response to the open-ended question asking what suggestions they had about improving psychosocial care, nurses responded with “Create a unit website on assessing psychosocial needs,” “We need a designated place for community resource handouts for staff,” and “Psychosocial care should be more of a focus during shift change report.” In response to the open-ended question asking about educational needs, nurses responded that they needed education about “how to deal with difficult patients,” “how to broach sensitive subjects,” and about “community resources.”

Discussion

Acute care bedside nurses experience a variety of barriers to providing excellent psychosocial care to patients with cancer. Similar to findings by Pasacreta et al. (2008), nurses in this study reported that patients and family members often feel stigmatized by psychosocial care. This perception may interfere with nurses offering psychosocial care. Educational sessions need to stress offering psychosocial care in a way that does not increase stigma or patient discomfort. Consistent with the results reported by Absolom et al. (2011), nurses in the current study reported needing more accessible information on community resources and referral pathways.

Although the current study focused on the educational needs of inpatient oncology nurses rather than on the needs of APNs, the results were similar to the findings of Gosselin et al. (2011). Both studies found significant barriers to the provision of psychosocial care, including poor communication between team members, lack of privacy, providers believing that psychosocial care is not as important as medical care, and stigma interfering with patients seeking support. As with the Gosselin et al. (2011) study, room for improvement existed in the current study in terms of nurse comfort when using psychosocial screening tools.

Unlike the Gosselin et al. (2011) findings, 38% of nurses in the current study frequently found that time was an issue, compared to 57% of APNs who often or always found time to be an issue. In the current study, no nurses responded that they lacked the emotional energy to provide psychosocial care on a frequent or always basis, compared to Gosselin et al.’s (2011) findings that 39% of APNs often or always felt lack of personal energy was a problem. In the current study, 76% of nurses felt that sometimes personal energy was a problem; however, only 41% of APNs in Gosselin et al.’s (2011) study noted lack of energy as being a problem sometimes.

Type of education (bachelor’s or associate degrees) and age influenced nurse responses in the current study (see Figures 1 and 2). Compared to nurses with associate degrees, bachelor-level nurses identified time, stigma, emotional energy, lack of guidelines, lack of experience with screening tools, not knowing how to bring up sensitive topics, and poor communication among team members as larger barriers to providing psychosocial care. In addition, bachelor-level nurses also perceived psychosocial care as being as important as physical care more often than nurses with associate degrees. Nurses aged 30–39 years were more likely to identify time, lack of emotional energy, and poor communication among team members as barriers than did nurses in other age ranges. However, these age- and education-related results may be because more nurses in the 30–39 year age range and bachelor-level nurses responded to the survey.

Implications for Practice

> Tailor oncology-related education programs to the specific, regional needs of nurses.
> Review standardized screening tools and clinical practice guidelines related to psychosocial care.
> Nurses should maintain active self-care strategies.

Implications for Nursing

Because regional differences have been identified, additional research is needed regarding the educational needs of nurses with respect to psychosocial care in rural hospitals, private for-profit hospitals, and mid-sized hospitals. Future studies should focus on whether age and type of education influence nurse perceptions. Training programs should be individualized to regional, educational, and age-related needs of nurses.

Because the responses of surveyed nurses were somewhat limited in terms of the type of education nurses believe would be most effective in improving psychosocial care for oncology patients, additional studies are needed. Conducting focus groups or individual qualitative interviews would be a good way to
increase the depth of responses to open-ended questions about needed education. Oncology nurses in varied settings should be queried about the effectiveness of existing educational programs. Nurses in a variety of settings should be asked to review and evaluate existing psychosocial resources, standardized screening tools, and clinical practice guidelines, which could help nurses improve the psychosocial care provided to patients.

Conclusion

Hospitals would benefit from offering interdisciplinary training that includes role playing about how to initiate discussions about sensitive topics. Offering interdisciplinary training might help minimize nurse concerns about ways in which poor communication between team members affects psychosocial care. Self-care strategies should be covered during training to minimize nurses feeling that they do not have enough energy to provide excellent psychosocial care. Each unit should have a conference room available so that nurses, patients, and family members have a private setting in which to discuss sensitive topics. Nursing schools should use instructors who convey the importance of psychosocial care and integrate it into the curriculum to a greater extent. Training sessions should cover ways to integrate psychosocial conversations into routine care so that time pressures do not become a major barrier to the provision of excellent care.

References


