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Development of a nurse-initiated proactive telephone nursing assessment guideline for new cancer patients

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ABSTRACT

Telephone practice is an essential component of ambulatory nursing practice to address patient concerns between their clinic visits. Proactive telephone practice has been part of oncology nursing at a large regional cancer centre for six years and involves taking the initiative of calling patients and families before they are in distress. A review of nursing practice regarding proactive calls in the centre revealed a lack of standardization across cancer disease sites in identifying and assessing patients who would benefit from proactive calls, and variability in how nurses documented telephone interactions.

To create a standardized approach for proactive telephone practice, we began by identifying when patients require a proactive call based on key transition points across their cancer care trajectory. Based on the practice review of proactive calls, the needs assessment with patients, and a literature review, a Proactive Telephone Nursing Assessment Guideline was developed. The guideline provided guidance for conducting a proactive telephone call and identifying patient needs, intervening as required, and documenting the exchange.

The guideline was piloted with newly diagnosed patients to determine if the call helped in meeting their needs. Informational and practical needs were most common. The pilot revealed both patients and families were satisfied with the proactive call. Nurses felt the guideline was useful, but could be burdensome, especially when it was first used. Through the pilot, it was identified that proactive telephone calls can be utilized to focus on patient and family supportive care needs.

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INTRODUCTION

As cancer care continues to move into the ambulatory setting, the role of nurses in telepractice will continue to develop and expand. Nurses play a vital role in the cancer care continuum by providing care, support, education and counselling and navigation through the healthcare system (Canadian Association of Nurses in Oncology, 2001). As outlined in the Cancer Care Ontario (CCO) (2019a) Oncology Nursing Telepractice Standards, telepractice has developed to provide holistic person-centred care focusing on assessment, communication and decision making. Nurses deliver, manage, and coordinate care for patients and families along the illness trajectory (CCO, 2019a), but in an ambulatory cancer centre, nurses have an important role in providing telepractice services to address the needs of patients and families between clinic appointments.

BACKGROUND

As patients move across the cancer care continuum, they experience a variety of concerns that require support and interventions to meet their needs. The lived cancer journey for individuals and their families varies, as they each can experience different physical, social, informational, psychological, emotional, spiritual and practical needs over the course of the disease (Fitch, 2008).

The literature contains numerous reports describing how patients experience many unmet supportive care needs including informational, practical, psychosocial and physical needs (Giuliani et al., 2016). For new cancer patients, the most common needs they experience are informational and psychological needs (Puts et al., 2012), requiring appropriate interventions and resources to meet these needs (Fitch & Steele, 2010). Unmet supportive care needs can lead to increased feelings of distress, anxiety and result in poor outcomes (Fitch & Steele, 2010). At the time of diagnosis, patients can report feelings of shock, disbelief and emotional distress, which can impact their informational needs. They are apt to be challenged with accepting their diagnosis and may not be able to focus on reading or comprehending the resource materials provided (Fitch et al., 2007). Therefore, completing a proactive call for new patients can allow for time for them to process the diagnosis and address concerns before patients reach their lowest point.

Telephone practice in ambulatory oncology has continued to expand and grow over the years, as more cancer care moves into the primary care and home setting. Over the past few years with the COVID-19 pandemic, virtual care, including telephone practice, has continued to expand, as it becomes a central part of nursing care. Telepractice involves delivering nursing services over the telephone to identify and meet the needs of patients and their families (College of Nurses

of Ontario [CNO], 2020; Greenberg, 2009). Telephone practice has been established at our regional cancer centre as an expectation of nurses for many years and has included making proactive calls. Proactive telephone practice involves the nurse initiating calls to assess and meet patient or family needs and concerns, as opposed to a reactive telepractice where the patient initiates a phone call when they desire assistance. Proactive calling has the benefit of early risk assessment, prevention of issues becoming worse, and early intervention for an emerging concern (Pirshcel, 2018).

At the regional cancer centre, patients are cared for across their cancer journey from prevention to recovery and survivorship or palliation. Issues may arise at various times throughout this journey, but there are certain points where the risk for patients is higher and oncology nurses must be able to anticipate when problems might arise for individuals at home Pirschel, 2018). Proactive telephone calls are part of the nursing practice in all the different cancer disease sites. However, the calls occur at different transition points in the care trajectory or for particular patients, as determined by the members of the disease site team and assessment of patient needs.

Due to this variability in transition points and a desire to align with a patient-focused approach, it is imperative to determine when patients would like to receive a nurse-initiated telephone call and at which key transition points across their cancer journey. As identified in the literature (Sutherland, et al., 2009), through Cancer Care Ontario (2019) and in consultation with nursing staff, key transition points in the patients' view could include prior to or after their first visit at the cancer centre, after receiving a diagnosis of cancer, prior to the start of their treatment, after their first chemotherapy treatment, after discharge following surgery, after radiation therapy is completed, when their primary treatment has ended, or during end of life. By contacting the patient or family at key transition points, nurses are able to provide support and information and address unmet needs.

A recent quality improvement initiative at the centre, which includes answering calls in real time (Live Voice Answer) to address symptom and appointment-related calls, has freed staffing resources and enabled nurses to develop their proactive calls practice. This article provides a description of a quality improvement project regarding proactive telephone practice at the Odette Cancer Centre, including the development, implementation and pilot evaluation of standardizing our approach.

Aim

The aim of the proactive telephone practice project was to have a standardized approach for nurses to engage in proactive interactions with patients through telephone practice. It was anticipated this would proactively address patient and family needs, as well as improve patient and nurse satisfaction.

As a result of a Live Voice Answer Telephone Initiative (Elmi et al., 2022) that was implemented in 2016, many urgent symptom- and appointment-related telephone calls were now being addressed in real time. This created additional capacity for nursing staff to be able to provide further support for cancer patients through proactive telephone calls.

METHODS

The proactive telephone practice project began in 2017 and used a three-phase approach. The first phase was a literature search and creation of a survey for patients, families and nursing staff. The survey identified when patients or families would have liked to receive a nurse-initiated telephone call during their cancer journey. The second phase was the design of a standardized approach to complete proactive telephone calls entitled the Proactive Telephone Assessment Guideline. Last, the third phase included implementing the Telephone Assessment Guideline as a pilot and evaluating its use from a patient/family and nursing perspective. The evaluation explored the feasibility and patient satisfaction of using the assessment guideline for nurse-initiated proactive telephone calls for newly diagnosed cancer patients.

Survey

A needs assessment survey was developed to determine when patients would like to receive a telephone call initiated by a nurse. The survey was developed by taking into consideration nursing literature, Cancer Care Ontario Standards, and the current state of proactive calls practice in each disease site nursing team at our regional cancer centre. The respondents were asked for selected demographic information (e.g., age, disease site) and to rank their top five options for receiving a telephone call by a nurse from the following list; before the first visit to the centre, within two days after their first visit, after receiving a cancer diagnosis, while waiting for the start of treatment, after the first chemotherapy treatment, after surgery, after radiation therapy is completed, after a visit to the Emergency Department, when primary treatment ends, or during end of life. The survey was delivered to 13 patients and families of the centre's Patient and Family Advisory Council (PFAC) and 50 of cancer centre's nurses. The survey asked the same question of the two groups. This survey of both clients and families allowed the future proactive calls to be driven by patients' identified needs. The survey responses were analyzed and compared between the nurses and patient and family responses to create recommendations for the proactive telephone calls practice.

Standard assessment and documentation guideline

A Proactive Telephone Nursing Assessment Guideline was developed to create a standardized approach for assessing and intervening regarding a patient's supportive care needs across the cancer care continuum during a proactive telephone interaction. The guideline was created based on current telepractice standards, literature, and the needs assessment survey results. The assessment guideline document provides guidance for assessment and intervention, as well as allowing the recording of information from the call. Documentation encompasses demographic data including the date, time and length of call, the reason for the

proactive call, the current phase of the patient's cancer journey, assessment of patient needs and concerns, appropriate intervention and follow-up care.

The guideline was developed using three key documents, which focused on the patient or families' needs including the Canadian Problem Checklist (Bultz et al., 2011), the Supportive Care Framework (Fitch, 2008) and the College of Nurses of Ontario (2020) Telepractice Guideline. The Canadian Problem Checklist was previously utilized at the centre to assess common concerns or problems related to emotional, practical, spiritual, informational, social and physical domains (Bultz et al., 2011). The Supportive Care Framework was incorporated, as it highlights how individuals endure and live with cancer as they experience various needs including informational, emotional, psychological, social, practical, physical and spiritual needs (Fitch, 2008). The guideline aligns with the College of Nurses of Ontario (2020) Telepractice standards, principles and documentation requirements.

During the call, the guideline is used to assess and explore patient or families' needs or concerns across the various supportive care domains (i.e., informational, emotional, psychological, practical, social, physical). Based on the patient or families' primary concern, each of the areas can be explored in greater depth by the nurses using these subdomains as shown in Figure 1. Based on the assessment of the patient or families' needs, an intervention can be applied to address their concerns. Interventions may include providing information, support or health advice; connecting individuals to various resources, or instruction for developing self-care strategies.

The assessment guideline was developed in collaboration with, and reviewed by various stakeholders (i.e., nursing manager, supervisors, Advanced Practice Nurses) at the cancer centre and by disease site nurses in addition to those in the lung site, where the pilot would be conduced, to obtain feedback and make appropriate adjustments prior to the pilot.

Pilot implementation

In 2017, proactive call priorities were determined by the lung site team, which also identified new clients for future consideration of proactive calls due to the overwhelming care needs of newly diagnosed lung cancer patients. Hence, the lung site team was selected as the pilot team for implementing and evaluating the new proactive call approach. Nurse-initiated proactive telephone calls were completed for five lung cancer patients and two head and neck cancer patients to pilot test the Telephone Assessment Guideline. The patients identified for the pilot were newly diagnosed patients seen in clinic and who

Figure 1

Sample of Proactive Telephone Nursing Assessment Guideline

Primary Concern:

Assessment of Needs/Concerns

Informational	Emotional	Psychological	Practical
-Understanding of illness/treatment/next steps ☐ -Treatment and side effects ☐ -Procedures/ results ☐ -Managing side effects ☐ -Care processes ☐ -Communication with health care providers ☐ - Treatment decisions ☐ -Resources ☐ -Prognosis ☐ -Second opinion ☐ Other: Narrative:	-Fears/distress ☐ - Grief/sadness ☐ - Anger/frustration ☐ - Guilt ☐ - Powerlessness ☐ - Shame/self-blame ☐ - Abandonment ☐ - Isolation ☐ - Hopelessness ☐ Other: Narrative:	- Changes in lifestyle ☐ - Loss ☐ - Loss of personal control ☐ - Depression ☐ - Anxiety ☐ - Changes in self-image/ body image ☐ - Changes in appearance ☐ - Fear of recurrence ☐ Other: Narrative:	- Work/school ☐ - Finances ☐ - Transportation ☐ - Appointments ☐ - Daily home help ☐ - Child care ☐ - Activities of daily living ☐ - Legal issues ☐ - Stress ☐ - Meal planning/food prep ☐ Other: Narrative:
Social	**Physical**	**Spiritual**	**Other**
- Burden ☐ - Worry about family/friends ☐ - Social relationships ☐ -Feeling alone ☐ -Changes in role ☐ - Difficulty telling others ☐	- Pain ☐ - Frailty ☐ - Weakness ☐ - Fatigue ☐ - Concentration/memory ☐ - Changes in appetite ☐	-Meaning/purpose in life ☐ - Faith/ religious beliefs ☐ - Existential despair ☐ - Examine values/ beliefs/ priorities ☐	

had answered the phone when a nurse called the patients proactively. Patients had been informed by the nurse during their clinic appointment that they would be receiving a proactive call in 48 hours after their first clinic visit.

The guideline was evaluated by both patients and nurses to determine if it was effective and beneficial for both stakeholder groups. A patient satisfaction survey, developed at the cancer centre and administered over the telephone, was used to evaluate the proactive telephone call experience and see if the patient thought the call fulfilled its purpose (i.e., analyze the primary needs and concerns of the patients and families at the particular transition point along their cancer journey). The feasibility of using the assessment guideline was evaluated by two nurses using the Theoretical Framework of Acceptability (Sekhon et al., 2017). The Theoretical Framework of Acceptability measures the extent to which individuals who are delivering healthcare interventions consider them appropriate based on their own cognitive and emotional responses and the relevance of the intervention based on attitude, burden, ethicality, opportunity costs, and effectiveness (Sekhon et al., 2017).

RESULTS

Survey

In total, all 13 patients/families and 25 nurses (50% response rate) responded to the survey. The top three responses were all endorsed by 62% of the patients and families indicating they would have liked to receive a proactive call after receiving a cancer diagnosis, when primary treatment ends and after visiting the emergency department (Figure 2). In reviewing the top three responses from nurses, 80% of nurses felt that patients should receive a proactive call after visiting the emergency department, 72% after receiving the first chemotherapy treatment, and 64% after radiation therapy has been completed. There was some similarity in responses between the two groups (patients/families and nurses) in that they both identified that patients should receive a proactive call after surgery, when primary treatment ends and after visiting the Emergency Department. However, more patients would have liked to receive a proactive call before visiting the centre, within two days after their first patient visit, after receiving a cancer diagnosis and waiting to start treatment. In reviewing the responses from nurses, they felt that patients should receive a proactive call after the first chemotherapy treatment, when radiation therapy is completed and during end of life. Based on these results, recommendations were created for future proactive telephone calls for patients.

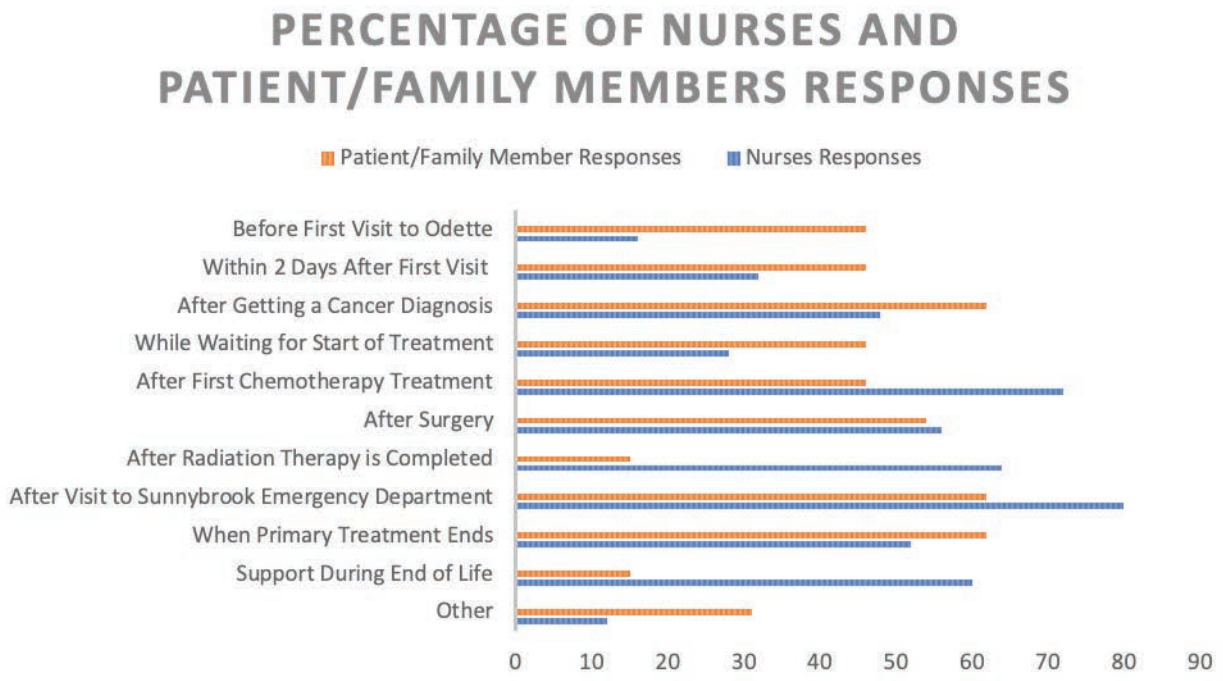
Additional comments and suggestions were written on the surveys by both nursing staff and patients and families. The comments included creating an agreed upon time or an appointment time to complete proactive telephone calls, have nurses who are familiar with the patient and subsequent care make the proactive call, and individuals with more serious illness may require more frequent proactive calls.

Documentation during call

The documentation in the standardized assessment guideline allows the most common issues patients and

Figure 2

The Percentage of Survey Responses from Patients/Families (n = 13) Compared to Nurses (n = 25)



families are experiencing to be identified at specific transition points. As seen in Figure 3, five out of seven patients in the pilot stated they had informational concerns including difficulties understanding their illness or scheduled procedures or diagnostic testing, and three patients expressed practical needs (e.g., transportation issues getting to and from appointments, financial concerns). Furthermore, one patient had physical concerns (specifically lack of appetite and dietary questions), and one patient had psychological concerns related to coping difficulties. Based on their primary concerns, the patients received specialized interventions aimed at addressing their needs and reviewed the next steps within their illness trajectory.

Feasibility

The nurses who assessed the feasibility of using the new guideline felt it was worthwhile and straightforward. However, the proactive call, completion of the guideline, and documentation may be time consuming. It should be noted that the average length of time for the proactive calls was 8.5 minutes and the average time for documentation was 9.5 minutes.

The nurses indicated the guideline fits with the values of the organization and that the patients' and families' concerns can be addressed over the telephone. There were mixed responses regarding opportunity costs with the belief that, at times, workload can be increased with the call. However, the proactive call process allows for flexibility to complete the call within the day. The nurses felt confident in utilizing the guideline for the proactive call and found that it achieves the purpose of evaluating the needs and concerns of patients and their families.

Patient satisfaction

Five out of the seven patients who had participated in the proactive calls when the new guideline was piloted, completed the satisfaction survey. Two patients did not answer the telephone during call-backs. Three patients felt that their concerns were addressed by the staff during the proactive call. Half of the patients felt that the staff provided information or support that addressed the concerns they expressed. Three patients agreed or strongly agreed that their concern was resolved by staff. All of the patients surveyed were very satisfied with receiving a nurse-initiated telephone call within two days following their first visit at the cancer centre and with the overall experience of receiving a proactive call.

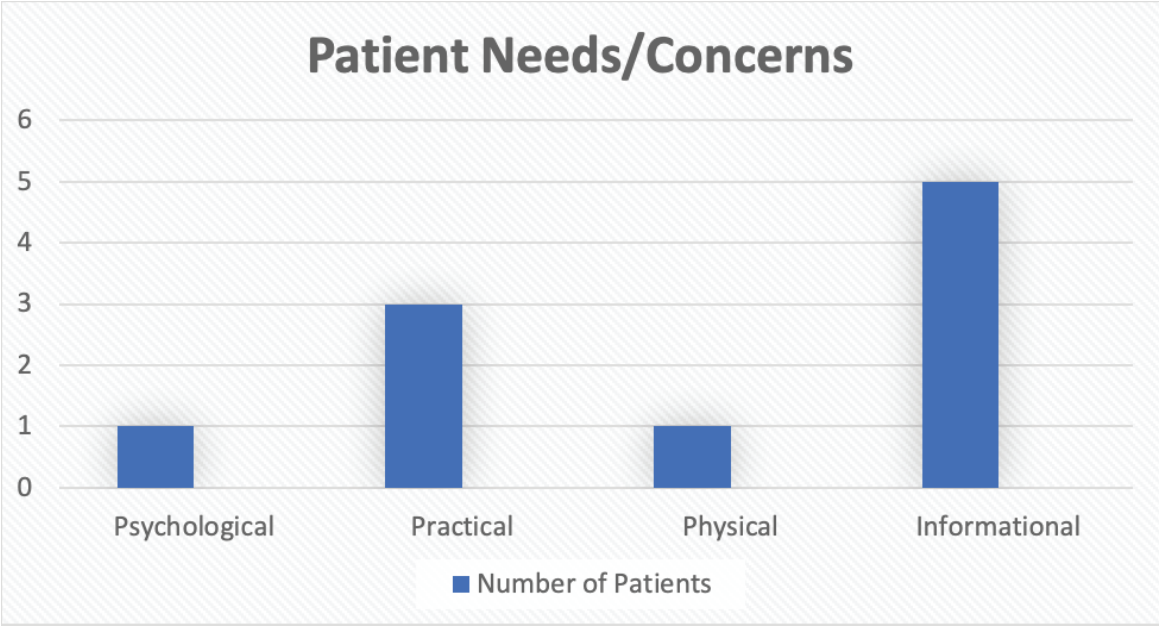
DISCUSSION

This quality improvement project facilitated the evolution of proactive telephone call practice. The initial survey to determine when patients would like to receive a nurse-initiated telephone call showed some similarities and differences between the perspectives of patient and nurses. Nursing staff felt that patients should be receiving proactive telephone calls around their time of treatment. Patients and families identified they would like to receive a nurse-initiated telephone call around their first visit to the centre and during their diagnostic stage prior to initiating treatment, often a time when cancer patients are known to experience the highest unmet supportive care needs (Puts et al., 2012).

With these data, we were able to question the current practice of proactive calls being determined by the nursing site team. The focus of proactive calls ought to be driven by patient-identified needs and focus on the top three recommendations for proactive calls, as identified by patients and families (i.e., after receiving a cancer diagnosis, when primary treatment ends, after visiting the Emergency Department). Although there is the limitation in the low response rate to the survey, the

Figure 3

Number of Newly Diagnosed Patients (n = 7) Who Identified Their Primary Concern Under the Supportive Care Framework (Fitch, 2008) Subdomains



results helped us to focus on providing patient-centred care and prioritize the proactive calls as identified by patients and families. This created a base for a paradigm shift in the centre for nursing telepractice.

We were able to design and pilot test a standardized approach as a basis for proactive calls. Both patients and nurses agreed the approach was beneficial and able to identify needs with the small sample of newly diagnosed individuals. It will have to be implemented and tested with a larger sample of patients and those who are at other transition points. Nurses who piloted the guideline felt it was appropriate and straightforward, but could be burdensome to complete. However, this perspective may change with additional practice using the guideline.

Future considerations

Our next steps include expanding this work on proactive telephone calls to multiple disease sites for new patients and for patients at other transition points along their trajectory. This will also require assessment of staffing resources and workload. Furthermore, the assessment guideline will continue to be evaluated, with additional feedback and review from nursing staff and leadership to make any necessary adjustments.

Conclusion

The results of this quality improvement project gave us a basis to have our telephone practice evolve and allowed for proactive calls to be prioritized and standardized based on patient- and family-identified needs, and focused on providing patient-centred care across their illness trajectory. In completing proactive telephone calls using the newly designed guideline, we are in a position to better address the concerns of patients and families and provide individualized interventions and support to address their needs. The use of proactive telephone calls and a standardized patient assessment is beneficial in addressing and meeting patient and family needs when providing virtual care when cancer care continues to expand beyond the hospital setting.

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