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EDUCATIONAL NEEDS ASSESSMENT OF THE NURSES
PROVIDING CARE TO THE CANCER PATIENT

M. Lois Hollingsworth

A Thesis
in
The Department
of
Education

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts
(Educational Technology)
at
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ABSTRACT
EDUCATIONAL NEEDS ASSESSMENT OF THE NURSES
PROVIDING CARE TO THE CANCER PATIENT.
M. Lois Hollingsworth

In providing care to cancer patients, many general hospitals have developed a specific consultation service. Such a service should not only meet the needs of patient care, but should also serve as a means of continuing education for those providing supportive care. To introduce this service in a 700 bed teaching hospital, a questionnaire was designed to assess the perceived learning needs of nurses, and to establish where educational intervention would be most appropriate. There were five major areas covered: 1) Physical care of cancer patients: learning needs identified by nurses, 2) Psychosocial care of cancer patients: learning needs identified by nurses, 3) Issues that nurses have most difficulty discussing with patients and families, 4) Nurse identified frequency of concerns expressed by patients and families upon discharge from hospital, and 5) Nurses' knowledge of correct resource services to contact on discharge planning. A sample of 119 nurses responded to the questionnaire from 17 general medical and surgical nursing units. A high level of concern was expressed for information regarding pain management, side effects of chemotherapy, helping the patient accept the cancer diagnosis and talking about death and dying. An analysis of the data provided the basis to design ongoing instructional packages to meet the educational needs of the nurses and ultimately the care of the cancer patient.

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TABLE OF CONTENTS

Chapter	Page
1. Rationale	1
Objectives	5
2. Literature Review	
Caring	7
Attitudes	8
Knowledge and Skills	11
Needs Assessment within a Continuing Education Context	12
3. Method	
Sample	18
Instrumentation	18
Field Testing	20
Data Collection	21
4. Results	
Part 1	
Section 1	
Demographics	22
Section 2	
Learning Needs	26
Section 3	
Patient Concerns (Hospitalization)	29
Section 4	
Nurses' Concerns	31

Chapter	Page
4.	Section 5
	Patient Concerns (Discharge) 32
	Section 6
	Discharge Planning 33
	Part 3
	Additional Learning Needs 37
	Individual Comments 38
5.	Discussion 40
	Physical Needs
	Pain Management 41
	Cancer Chemotherapy 46
	Radiation Therapy 49
	Psychosocial Needs
	Helping Patient Accept Diagnosis 51
	Talking About Death and Dying 53
	Discharge Planning 54
	Patient/Family Concerns (Hospitalization)
	Physical Discomfort 56
	Worry Regarding the Disease 56
	Talking About the Illness 59
	Upset Regarding Medical Treatment 60
	Nursing Concerns 61
	Patient/Family Concerns (Discharge) 64

Chapter	Page
5. Discharge Planning	
Identifying Resources	67
Requested Additional Learning Needs	
Chemotherapeutic Agents	68
Investigational Trials	69
Chemotherapeutic Effects on Normal Cells	70
Safe Handling Recommendations	71
Surgical Procedures	71
Radiation Therapy	72
Promoting Effective Goals	73
Assisting Colleagues in Communication	74
Support Care Services	75
Individual Comments	75
Summary	76
Recommendations	
Educational Approaches	78
Implementation	80
Conclusion	82
References	85
Appendices	
A. Covering Letter for the Survey Instrument	96
B. Survey Instrument	98
C. Tables	104

LIST OF TABLES

Table

1. Frequency of Problem Identification in Order of Importance by Years of Nursing (Management of Pain).
2. Frequency of Problem Identification in Order of Importance by Type of Nursing Unit (Management of Pain).
3. Frequency of Problem Identification in order of Importance by Years of Nursing (Chemotherapy Side Effects).
4. Frequency of Problem Identification in Order of Importance by Years of Nursing (Radiotherapy Side Effects).
5. Frequency of Problem Identification in Order of Importance by Type of Nursing Unit (Radiotherapy Side Effects).
6. Frequency of Problem Identification in Order of Importance by Years of Nursing (Help Patient Accept Cancer.)
7. Frequency of Problem Identification in Order of Importance by Years of Nursing (Talking About Death and Dying).
8. Frequency of Problem Identification in Order of Importance by Years of Nursing (Discharge Planning).

CHAPTER ONE

RATIONALE

Technological advances in the health care field necessitate that practising professional nurses continually update their knowledge and skills in order to maintain and enhance quality patient care. A variety of continuing education methods may be used to heighten their awareness of current concepts and findings that are applicable to practice.

Cancer is a long-recognized disease, but Oncology is among the most recent of medical specialties. The development of Oncology as a medical specialty reflects the ebb and flow not only of technical advance and scientific ideas, but also and equally of cultural beliefs. Progress in medical treatment of cancer and the refinements in surgery and radiation, along with increasing numbers of clinical oncologists, has profoundly influenced cancer care. This progress in medical practice has been associated with similar progress in nursing practice and a greater depth and scope of nursing roles in cancer care. The Oncology nurse must be skilled in nursing assessment, application of knowledge to individual tumor types, the various types of treatment available and their side effects, psychosocial counselling skills, and rehabilitation methods. Too often cancer nursing is not regarded as an area of specialization and Nursing School curricula devotes relatively few hours to the total care of the cancer patient. Many of the nurses who lack the appropriate training in cancer care may feel

helpless in caring for their patients and their families. These conditions exist in spite of the fact that cancer is second only to heart disease as a cause of death, and that, in Montreal, virtually all hospital units house and treat cancer patients on an ongoing basis.

It is interesting that we would never entrust the care of a patient who had undergone open-heart surgery to a nurse who was not specially trained to care for that patient, yet we expect him/her to care for the cancer patient and his/her family without any additional knowledge or skills. With today's information explosion, the management of every medical problem has become increasingly complex and demanding. Staff on busy active treatment services have many competing priorities that limit the time and attention they can give to any individual patient. In addition, the lack of staff available to address the special needs of the cancer patient is critical and severely affects the ideal care of the cancer patient. Consequently, patient care goals must be organized and adjusted in accordance with the priorities of the practice setting. The more informed and the more caring the staff is, the more frustrated they will be at their inability to respond to all needs.

From a practical perspective, the present era of inadequate staffing, multiple tasks and efficiency require that nurses behave in ways that have the most meaning for patients. Nurses when asked to identify the most important aspects of the care they give, such as listening, touching, and talking, have consistently ranked effective aspects as the most important. (Leninger, 1978).

The question which should be considered is whether patients hold similar perceptions? A woman hospitalized in the Montreal General Hospital was asked, "what makes you feel cared for?" She replied, "without a doubt, it is what the nurse says to me and how she listens to me. However, the nurse must first prove to me that she knows how to manage my medications and my treatments. Until then, I'm not too interested in what she has to say." (Interview with MGH patient, 1988). It appears that a critical first step in addressing the concepts of effective nursing care as it relates to cancer nursing, is to understand the patients' perceptions of the caring behaviour the nurse exhibits.

It is frequently stated that if health care staff were better informed as to the particular needs of cancer patients and their families, they could modify the care presently being given, and problems would be resolved (Melzack, 1976; Bevis, 1981; Larson, 1984). Melzack maintains that education is sorely needed, for many staff are unaware of the principles of pain and symptom control, or of the psychosocial dynamics of those facing loss.

The increase in the complexity of cancer therapy, the increasing numbers of people in active treatment for cancer, and the growing sense of responsibility to consider quality of living for these patients and their families, along with length of survival time, have all contributed to a need for changing the amount and the nature of continuing education in cancer nursing.

Continuing education (CE) is a process of planned change involving a collaborative effort between the staff development department and the individual

practitioner in order to enhance professional growth and ultimately work performance (Lewis, 1987).

In advocating quality patient care, the Canadian Nurses' Association (Canadian Nurses Association, June 1980) and the Joint Commission on Accreditation of Hospitals (Canadian Council on Hospital Accreditation, January 1983) have endorsed the need for continuing education. According to the CNA, all practitioners are responsible for maintaining their competency in nursing. The CNA Standards for Continuing Education in Nursing further stipulate that "the employer carries a responsibility to promote the continuing education of nursing personnel" (CNA,1980). The CNA considers it essential that all practising nurses participate in continuing education to maintain and increase the special knowledge and skills required for the specialty practice of Oncology Nursing.

General factors hinder a nurse's access to CE programs. Limited resources (e.g. funds, geographical location of conference, applicability of conference to work setting, and length of program) minimize staff attendance at community programs. Therefore, in-house centralized CE programs have become a viable alternative to resolve this dilemma.

Use of physical and human resources within the agency is conducive to the development of a cost-effective program that is applicable to staff needs. In order to enhance the nurses' role with the cancer patient, and to upgrade their skills by providing continuing education "on site", the Montreal General Hospital,

Department of Nursing and the Division of Medical Oncology, will collaborate to implement a Support Care Consult Service.

The purpose of this study is to describe the development and implementation of the educational needs assessment. The analysis of the data returned will be utilized to formulate the objectives and goals of the Support Care Consult Service already alluded to.

Objectives

A survey was made of five university teaching hospitals in Montreal and Ottawa, and informal interviews were held with nursing administration, education and general staff nurses. In replying to questions about content and clinic experience, all subjects felt their educational programs in cancer nursing were adequate in basic factual material. However, they were less satisfactory in the ways in which they dealt with students' feelings and attitudes related to cancer and lacking in current information about therapy and patient response to therapy. Meetings with head nurses in the Montreal General Hospital elicited opinions that practising nurses also appeared to need current information about therapy and help in dealing with their feelings about cancer.

A needs assessment is the first step and the key to a successful program. It deals with the identification of staff's learning and the selection of appropriate educational programs. In assessing the learning needs of the staff nurses at the Montreal General Hospital, two research questions were asked.

1. "What nursing needs of cancer patients do staff nurses see as important and not adequately met, and what are the areas in cancer care where they feel a need for further education?"
2. "Could a planned individualized teaching program change nurses' perception of cancer patients and of themselves and change or reduce the areas in which the nurses feel a need for further education?"

CHAPTER TWO

LITERATURE REVIEW

Caring

Caring is the essence, the very core of nursing, and is considered to be its distinguishing characteristic. Leninger (1978) a major proponent of caring as the central focus of nursing, states, "Caring is one of the most crucial and essential ingredients for health, human development, human relatedness, well-being and survival". Scientifically based knowledge of caring is limited, and nurses cannot be certain that behaviour and skills consistently create in patients a sense of feeling cared for.

In a study done by Larson (1984) it was reported that the patients felt "being accessible" and "monitoring" and "following through" as most important nursing caring behaviours. These findings resemble somewhat the indicators of care surveillance and demonstration of professional knowledge identified by adult medical-surgical patients in Brown's study (1978). The findings are also in agreement with Ford's study (1980) in which listening appeared an important nurse caring behaviour. The high ranking of nurse caring behaviours that fall within the realm of demonstrated competency on the part of the nurse, indicates that, for the majority of the patients in Brown's study, demonstrated competency of skills precedes the patient's need to be listened to by the nurse. Listening and talking, psychosocial skills highly valued by the nurse, appeared to become important to these patients only after their basic "getting better" needs were met.

Attitudes

Nurses who have been responsible for the care of cancer patients and/or for teaching such care, know that "cancer" frequently elicits a response of helplessness and hopelessness, even among health care providers (Ford, 1980). Clinicians and educators have tried to deal with negative perception in various ways but a search of the literature reveals that such efforts have produced little measurable success. In trying to define some dimensions of the problem, Crayton, Brown, and Morrow, (1978) found that nurses feel less confident of their skills to deal with physical needs of their patients receiving active treatment for their cancer as contrasted with the emotional needs. Conversely, Dickenson (1979) found that nurses caring for dying patients felt relatively secure in meeting the physical needs of their patients, and very uncomfortable in dealing with their psychosocial problems. Brown (1978) found working with a small group of nurses that it was possible to begin to break down nurses' stereotyped perceptions of cancer patients by a planned program aimed at increasing the nurses' feelings of competence to provide cancer care. The literature also suggests that negative attitudes of health professionals about cancer are detrimental to the patients' care while positive attitudes enhance patient care (Popoff, 1980). The literature abounds with studies conducted on the attitudes of the medical profession toward the cancer patient, but has produced little on recommendations relating to further training if they are to meet the patients' needs. Clinical impressions of possible reasons for nurses' concerns are

consistent with the reported literature. Nurses attitudes seem to reflect those of the general public; that is, they perceive cancer as a dread disease, as a terminal event, and share with laymen feelings of hopelessness in the face of this diagnosis (Abrams, 1966; Olson, 1974; Quint, 1965). Galley (1980) found in a nationwide survey that 58% of all respondents named cancer as the worst affliction that could happen to them.

Several research studies have documented the existence of these pessimistic attitudes about cancer among physicians, medical students, and nurses (Easson and Johnson, 1970; Sherman, 1976). Gilner and Hassels (1984) found that hospital staff nurses feared cancer more than nurses in other positions.

The difficult experiences which patients face are evident and distressing and lead to avoidance behavior as nurses seek to protect themselves from discomfort, and to get away from feelings of guilt and frustration (Meinhart, 1978). Benoliel (1979) notes that anxiety about cancer is not restricted to persons with the diagnosis but is also experienced by people around them. It seems quite possible that higher levels of anxiety increase the difficulty which nurses experience in cancer care. Feeling unable to relieve pain and emotional distress threatens nurses' feelings of competence, and may lead to the desire to escape stressful situations (Davitz, 1975).

Regressed behavior, grief, and crying which are real problems presented by cancer patients, threaten the young and inexperienced nurse, increases feelings of helplessness and alienation, and lead to further role deprivation (Kramer, 1974; Meinhart, 1978). With increasing experience, the older practitioners'

perception of the role of the ideal nurse may become less clearly delineated, different from the younger nurses and more congruent to the real situation (Brophy, 1981).

Dickenson (1976) investigated nurses' perceptions of the care of dying cancer patients and found that nurses felt secure in meeting most physical needs of patients. They also felt secure in dealing with patients who had hopeful, cheerful attitudes and were not completely helpless. However, these nurses felt insecure in the use of therapeutic interpersonal techniques in helping the patient deal with their diagnosis, communication skills with the patient and family, and dealing with patients who were completely alone.

The effect of positive attitudes on cancer patients has also been documented by several research studies. Kyle (1984) found that cancer patients who received supportive nursing care had fewer negative personality reactions and were able to make more realistic plans than patients who received only physical nursing care. Also, the strengths the patient needed to face disease--related crises were enhanced by an accepting relationship with supportive nurses. Buehler(1975) reported that the hopeful attitude of the staff of a radiation therapy clinic resulted in cancer patients who were hopeful about their futures and coped more successfully with the stresses of their treatment. In an investigation by Sonstegard, Hansen and Johnston, (1976) using an intensive nursing approach which gave patients an opportunity to understand cancer and its treatment and to verbalize and work through their feelings about their

diagnosis, many side effects of radiation therapy were reduced and in some cases almost eliminated.

Knowledge and Skills

The literature has suggested that negative attitudes of health professionals about cancer are detrimental to the patient and his care while positive attitudes enhance patient care. Therefore, in an effort to improve patient care, it seems desirable to change positively the perceptions of health professionals. Two approaches to changing these perceptions can be found in the literature: the use of psychiatric consultation and the use of programs to increase knowledge and skill. Psychiatric consultation concentrated on supporting staff by helping them to understand cancer patients' behavior and feelings and to accept their own reactions to working with terminally ill patients. This approach has improved staff and patients morale, communication and patient management (Craig, 1978; Klagsbrien, 1980; Byser, Sheldon and Schwartz, 1981; Leigh, 1983).

There is evidence in nursing literature that increased knowledge and skills have improved nurses' attitudes about cancer. In a two-year study by Kohl and Brass (1979), the attitudes of county health nurses were more positive toward cancer as a result of knowledge gained from cancer nursing educational programs. Attitudes of nurses toward cancer were changed in a positive direction by a program of staff development characterized by more effective teamwork, an emphasis on treating cancer actively, and working consciously toward better living for patients (Buehler, 1975). It has also been found that

the satisfaction which nurses derived from giving care to dying patients related directly to their feelings of confidence in their own abilities (Popoff, 1975).

Tillman (1985) compared nursing care requirements of patients on general medical-surgical units and those on an oncology unit and found that the hours of nursing care per patient day required by the oncology patient were significantly higher than those required by the general medical-surgical patient. This study supports the need for contact and experience with oncology patients beyond basic medical-surgical nursing courses as found in most nursing programs. As nursing knowledge continually expands, the amount of time available in a nursing curriculum for any specific area of contact is limited. A survey of American schools of nursing indicated that the average amount of time devoted to cancer nursing contact was 14 1/2 hours with some contact areas receiving considerable attention and others not (Brown, Johnson, and Groenwald, 1983). The oncology contact in nursing curricula may therefore not be adequate to meet the needs of nurses caring for oncology patients.

Needs Assessment within a Continuing Education Context

Instructional sessions within a hospital setting are based on the assumption that consumers of continuing education programs are adult learners. Therefore, adult learning principles are incorporated into the teaching programs. One of the major principles of adult learning is that adults are amenable to learning when they perceive a need to learn and are given the opportunity to participate in the planning of their own learning experiences (Knowles, 1980). Knowles notes that the participants' interests should always define the starting

point in planning for any continuing education program. All too often programs are planned on the basis of intuition, personal preference, administrative mandate, or the current "hot topic". Such a limited perspective leads to programs that meet the needs only of the educator, not the learner.

Frequently in-service projects are implemented to address performance deficits rather than educational deficits. Anticipated improvement in staff behaviour may not occur and much time and effort are wasted all around. A systematic approach to problem identification and learning needs assessment can circumvent such waste and give rise to high-quality, meaningful educational offerings (Volker, 1987). A learning need has been defined by Cooper (1984) as a "discrepancy between what individuals know and can do, and what they need to know and do in order to achieve a higher level of performance." The underlying assumption is that a gap exists between the current situation and the desired state (Knowles, 1980). Knowles describes a learning needs assessment as the process of diagnosing gaps between knowledge and ability. He maintains that learning needs are fluid and change with new job responsibilities and alterations in practice, personal interests, and professional trends.

It is important to distinguish between "felt" needs and "ascribed" needs (Cooper, 1984). She characterizes ascribed needs as those identified by someone other than the learner, such as an employer, a physician, a clinical expert, or an accrediting committee. Examples of ascribed needs in nursing are chemotherapy certification, administering medications, and cardiopulmonary resuscitation requirements. Felt needs are those needs perceived by the learner as being

important. They produce the greater motivation for learning and must be addressed during program planning (Knowles, 1980). Although ascribed needs must be considered as well, programs based solely on such needs tend to be poorly attended and ineffective (Austin, 1981).

Kaufman and English (1979) define need as a gap between current outcomes or outputs and desired (or required) outcomes or outputs. They subsequently define a needs assessment as an identifying, harvesting, justifying, and selecting of gaps to be closed. They strongly suggest that the use of appropriate needs assessment tools, techniques, and strategies can greatly improve educational success. They maintain that an appropriately designed and executed needs assessment can help achieve reliability, validity, and utility.

Once the need for a continuing education program has been determined, planning is essential. Planning provides the skeletal structure for all subsequent phases in the development of a program. Kaufman's concept of planning is called a system approach because it attempts to put means and ends into useful perspective and because it intended to design, from "scratch", a system--a set of ways and means to identify, verify, and resolve problems (1968, 1970, 1972). The approach looks at the future and the attainable goals and then looks at the present to establish the gaps or needs between the present and the future. It is termed a "system approach" because it intends to identify, define, justify, design, implement, evaluate, and revise a system from the beginning. It assumes very little about how things are currently accomplished. They describe the approach in terms of inputs, processes, outputs, and the extent of interaction

with the environment, equating means to the processes and ends to the results (1979).

Kaufman & English (1979) are adamant that the starting place for planning is a critical consideration. They suggest a taxonomy of planning which would identify a relationship and order between various types of needs assessments. In other words, where do we start planning and have we made the correct assumptions at the selected point? Kaufman & English suggest that if one does not start at the beginning, one is taking a very big risk in planning the intervention. This approach concurs with Knowles' theory (1980) already cited that the learners' interest is always the beginning.

The first step in needs assessment is to define the population. Programs often fail as a result of the attempt to offer all topics to all nurses. Program content, methodology, and logistics will differ depending on the target population. For example, offerings designed to meet the needs of all oncology nurses from a large geographic area will vary greatly from those planned for staff from a single inpatient unit. According to Volker (1987) one must define the characteristics of the potential audience in terms of educational background, experience, job description, and patient population.

Rossett (1987) describes a sampling of assessment strategies and tools available. Deciding which to use depends upon time and money available, expertise with the techniques, scope of the learning need, and number of learners involved.

Interviews are useful when structured questions are used with a relatively small target population. Interviews yield a large amount of information at low preparation cost, but the process is time-consuming and data may be difficult to interpret. Respondents have the opportunity to voice opinions and concerns but may be intimidated by the lack of anonymity. Telephone surveys reach larger sample populations and are more time and cost-efficient.

Informal observations are particularly useful for staff development needs. They can be used for short-term problems that are limited in scope or for ongoing assessment within a specific group of nurses. This approach requires the expertise of an accessible, non-threatening professional with enough experience to detect discrepancies in practice.

Working in small groups is another approach to needs assessment. Rossett (1987) describes a meeting as "a purposeful gathering of three or more people, a leader and at least two participants, which affords opportunity for interaction". According to her, common sense suggests that "two heads are better than one" therefore working in groups promises synergy, a greater out-put of ideas and energy than is possible from any one individual participant.

A written questionnaire is a versatile tool that can reach a large sample population. It is easily utilized because it is relatively easy to construct, fill out, and evaluate. Respondents also prefer the questionnaire technique due to its anonymity.

The goal in this study was to assess the needs from a large representative sample of nurses in the Montreal area. A print-based questionnaire containing biographical data, areas of perceived needs developed with the assistance of the literature and subject matter experts, open-ended questions, and an assessment of knowledge of the discharge system was developed and utilized.

CHAPTER THREE

METHOD

Sample

A random sample of 180 nurses working in direct patient care in the Montreal General Hospital was selected by choosing every second name on the nursing payroll sheets. The subjects were drawn from each of the 17 general medical and surgical nursing units. In addition, 100% of the nurses in two pilot study units were asked to participate, representing both surgery and medicine. All subjects were felt to reflect varying kinds of exposure and approaches to cancer patients. The subjects were assured by the covering letter and their head nurse that all responses would be kept anonymous and confidential. In addition, all staff were instructed that they could agree or refuse to participate (See Appendix A).

Instrumentation

Development of the survey questionnaire included:

1. Review of the literature on needs assessment (Austin, 1981; Cooper, 1984; Kaufman, 1968; 1970; 1972; Kaufman and English, 1979; Knowles, 1980; Volker, 1987).
2. Review of the literature on the principles of adult education (Austin, 1981; Cooper, 1984; Knowles, 1980).
3. Review of the literature on nurses' views and perceptions related to cancer care, cancer patients, and cancer nurses (Brophy, 1981; Brown, 1978; Crayton, Morrow, and Brown, 1978; Ford, 1980; Larson, 1984).

4. Interviews with nurses caring for cancer patients on selected units.
5. Interviews with subject matter experts in cancer care.
6. Consultations with content specialists, statistician, and researchers.
7. The clinical expertise of the investigator.

Information gathered from the above was used to develop the first draft of a questionnaire. The questionnaire was organized in the following way.

Section 1 of the needs analysis questionnaire contained questions relating to demographic data such as age, educational background experience, type of nursing unit, and position on unit. The "needs" content of the questionnaire consisted of eight questions (Section 2-6) covering four major areas related to physical and psychological care of the patient and family concerns during hospitalization and on discharge, nursing concerns, and resource services in the community. They are listed as follows:

1. Additional knowledge needed in the physical care of the patient.
2. Additional knowledge needed in the psychosocial care of the patient.
3. Nurse-identified issues that patients and/or families discuss during hospitalization.
 - a) The four areas of concern most frequently expressed
 - b) The four areas of concern that the nurse has the most difficulty dealing with.
4. Nurse-identified frequency of concerns expressed by patients and/or family upon discharge from the hospital.

5. Finally, a question was added to assess nurses' knowledge procedures (as opposed to perceived needs). Nurses's knowledge of correct resource service to contact for patient assistance upon discharge from the hospital.

Field Testing

Before distribution of the assessment tool, it was field-tested at the Montreal General Hospital by six nursing students, three nurse clinician educators, and the colleagues of the investigator of the Oncology-Chemotherapy Center. The purpose of the field test was to measure the validity and the reliability of the instrument. This was done to (1) estimate the time required to complete the questionnaire, (2) identify any unforeseen problems in sample selection and data collection, (3) familiarize the investigator with the procedure, and (4) obtain feedback from the subjects on the understanding and clarity in the wording for the questionnaire in order to enhance the reliability of the instrument, and (5) to again examine content validity by verifying the importance of included items and to identify any missing items. After they had completed it, all subjects chosen for the field-test were asked if they had any difficulties and if they did, their nature. Their reactions and impressions of the study as well as their suggestions for improving it were discussed and implemented. Alterations to the study and the questionnaire were made when warranted. Although there were no major changes, items such as "constipation" was added to the list under physical discomfort, and "myths and beliefs" was added to the issues discussed by patients and families (See Appendix B).

Data Collection

Each questionnaire was placed in a brown envelope along with the covering letter and given to the head nurse of the corresponding unit, along with a list of names of those subjects that had been randomly selected to complete it. Her responsibility was to distribute the questionnaire to the appropriate nurses and indicate when and where it should be returned. The respondents were allowed two weeks to complete it given their busy work schedule primarily because the investigator wanted the nurses to relate the answers to their clinical practice in a meaningful way. They were instructed to return the questionnaire to the head nurse's office in the original sealed envelope. The investigator was responsible for collecting the envelopes from each unit at the end of the two-week period. An additional week was granted to all delinquents and a computer message was sent to each nursing unit and posted in the coffee room, to remind all respondents at the end of the third week. This did not elicit any further completed questionnaires beyond the total of 119 already collected.

CHAPTER FOUR

RESULTS

For the 180 questionnaires sent out, one hundred and nineteen replies were received. A return rate of 66% was calculated on that basis.

The results will be presented in three parts. Part I will consist of the statistical data in frequencies and relative frequency percentages. Part II will include comparisons and cross-tabulations of the data and Part III will incorporate comments and opinions made by the respondent in relationship to the specific questions.

PART 1

SECTION 1: DEMOGRAPHICS (QUESTIONS 1 - 6)

1. Unit (write in unit or "f" for float)

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Medical Units	33	27.7
Surgical Units	85	71.4
Float	1	.8

2. Nursing Education (check off as many as apply)

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
A) Diploma	98	82.3
B) Degree	23	19.3
C) Masters	3	2.5

3. Number of years in Nursing

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Medical Units		
0 - 4	17	14.3
5 - 9	6	5.0
10 - 14	0	0
15 - 19	3	2.5
20 plus	7	5.9
Not answered	1	.8

Surgical Units

0 - 4	48	40.3
5 - 9	16	13.4
10 - 14	8	6.7
15 - 19	4	3.4
20 plus	9	7.6

Mean 6.615

Median 4.000

4. Number of years caring for cancer patients (at this hospital and elsewhere)

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Medical Units		
0 - 4	21	17.6
5 - 9	5	4.2
10 - 14	4	3.4
15 - 19	1	.8
20 plus	2	1.7
Not answered	1	.8

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Surgical Units		
0 - 4	52	43.7
5 - 9	14	11.8
10 - 14	6	5.0
15 - 19	2	1.7
20 plus	11	9.2

Mean 4.313

Median 3.000

5. <u>Age</u>	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
20 - 25	52	43.6
26 - 30	23	19.3
31 - 35	9	7.5
36 - 40	8	6.7
41 plus	15	12.6
Not answered	12	10.0

Mean 31.6

Median 26.0

6. Position (check off appropriate answer)

	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
A) Full-time	101	84.9
Part-time	18	15.1
B) Permanent Unit	111	93.3
Float	1	2.5
Not answered	5	4.2

Note: All planned comparisons between age, number of years in cancer nursing, and types of education with response tendencies to the question below produced no statistical or substantive differences

SECTION 2: LEARNING NEEDS

(QUESTION 7 - 9)

This section of the questionnaire is designed to identify the learning needs of the nurses in order of importance, in relationship to the physical and psychosocial care of the cancer patient.

7. Please indicate the areas in which you feel most in need of additional knowledge by placing a "1" beside the most needed area, a "2" beside the next most needed area, and so on through "8" as the least important.

Listed below are the frequency of first choices by area.

PHYSICAL

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1	Management of Pain	54	45.4
2	Dealing with side effects of chemotherapy	38	31.9
3	Dealing with side effects of radiotherapy	14	11.8
4	Stomatitis	12	10.1
5	Anorexia	5	4.2
6	Nausea and vomiting	4	3.4
7	Shortness of breath	3	2.5
8	Constipation	1	.8

8. Please indicate the areas in which you feel most in need of additional knowledge by placing a "1" beside the most needed area, a "2" beside the next most needed are, and so on through "8" as the least important.

PSYCHOSOCIAL

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1	Helping the patient come to terms with the fact that he/she has cancer	48	40.3
2	Talking about death and dying	30	25.2
3	Dealing with your own feelings about cancer	15	12.6
4	Helping the patient deal with an uncertain future	14	11.8
5	Discharge planning including referrals	12	9.2
6	Giving information on hospital procedures	10	8.4
7	Involving family and/or significant others in the planning and care of the patient	7	5.9
8	Communicating with family and/or significant others	4	3.4

9. If there are other areas of knowledge needed than these listed in question 7 or 8, please list them here:

There were seven additional areas of knowledge identified as existing needs directly related to the physical and psychosocial care of the cancer patient and four areas relating to discharge planning. These will be referred to in Part 3.

SECTION 3: PATIENT CONCERNS (HOSPITALIZATION)

(QUESTIONS 10 AND 11)

This section of the questionnaire is designed to identify the issues discussed with nurses by patients.

10. What kinds of issues do patients and their families talk to you about during hospitalization? Please check all that apply.

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1	Physical discomfort	114	95.8
2.	Worry re the disease	113	95.0
3	Taking about the illness	107	89.9
4	Upset re medical treatment	102	85.7
5	Body image	94	79.0
6	Emotional changes	88	73.9
7	Mobility	78	65.5
8	Work	74	62.2
9	Changes in family role	73	61.3
10	Dissatisfaction with medical treatment	72	60.5
11	Social life	70	58.8
12	Myths and beliefs	59	49.6
13	Finances	50	42.0
14	Sexuality	25	21.0

11. Of the issues listed in question #10, please write the letters to indicate the **four** areas of concern most frequently expressed by patients and their families and/or significant others in the space provided.

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1	Physical discomfort	99	83.1
2	Worry re the disease	90	75.6
3	Talking about the illness	49	41.1
4	Upset re medical treatment	47	39.4
5	Body Image	38	31.9
6	Role change	31	26.0
7	Dissatisfaction with Medical Treatment	29	24.3
8	Emotional changes	25	21.0
9	Work	19	15.9
10	Sexuality	15	12.6
11	Social change	14	11.7
12	Mobility	13	10.9
13	Finances	9	7.5
14	Myths and belief	8	6.7

SECTION 4: NURSES' CONCERNS

(QUESTION 12)

This section of the questionnaire is designed to identify the areas indicated in question #10 that the nurse has the most difficulty discussing with the patient and their family and/or significant other.

12. Of the issues listed in question #10, please write the letters to indicate the four areas with which you have the most difficulty.

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1.	Emotional Changes	67	56.3
2.5	Worry re the disease	45	37.8
2.5	Upset re medical treatment	45	37.8
4	Talking about the illness	44	36.9
5	Dissatisfaction with Medical Treatment	42	35.2
6	Physical discomfort	36	30.2
7	Sexuality	35	29.4
8	Changes in family role	29	24.3
9	Myths and beliefs	28	23.5
10	Body image	25	21.0
11	Change in social life	18	15.1
12	Finances	14	11.7
13	Work	9	7.5
14	Mobility	5	4.2

SECTION 5: PATIENT CONCERNS (DISCHARGE)

(QUESTION 13)

This section of the questionnaire was designed to identify the most frequently expressed areas of concern by the cancer patient and family and/or significant others upon discharge from the hospital.

13. What areas of concern are most frequently expressed by patients with cancer and their families and/or significant others upon discharge from hospital? Please check off the four most frequently occurring areas of concern.

<u>Rank</u>		<u>Frequency</u>	<u>Relative Frequency Percentage</u>
1	Symptoms of recurring illness	89	74.8
2	How to care for self	76	63.9
3	Availability of nursing and household help	75	63.0
4	Availability of medical assistance	60	50.4
5	Type and amount of work patient can do	49	41.1
6	Talking to family and friends about illness	45	37.8
7	Availability of financial assistance	38	31.9
8.5	How to choose foods to maintain weight	20	16.8
8.5	Transportation	20	16.8
10	Amount of exercise	11	9.2

SECTION 6: DISCHARGE PLANNING

(QUESTION 14)

This question was designed to verify the nurses' knowledge in correctly identifying the appropriate resource service they would contact to implement discharge planning for the patient.

14. Patients being discharged from hospital sometimes need assistance in the areas listed below. For each area write the name of the research service you would contact to organize assistance.

The correct service is indicated by an asterix (*).

<u>Area</u>	<u>Resource Service</u>	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Financial Concerns			
	*Social Service	95	79.8
	CLSC	8	6.7
	Family Member	2	1.6
	Business Office	1	.8
	Cancer Society	1	.8
	Not Answered	12	10.0
Transportation			
	*Social Service	73	61.3
	Ambulance	16	13.4
	Medicar	9	7.5
	Unit Co-ordinator	6	5.0
	Home Liaison Nurse	3	2.5
	CLSC	3	2.5
	Not Answered	9	7.5

<u>Area</u>	<u>Resource Service</u>	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
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Meals on Wheels

*Social Service	61	51.2
Home Liaison Nurse	21	17.6
CLSC	13	10.9
Volunteers	2	1.6
Not Answered	22	18.4

Homemaker

*Social Service	58	48.7
*Home Liaison Nurse	27	22.6
CLSC	13	10.9
Not Answered	21	17.6

Visiting Nurse

*Home Liaison Nurse	56	47.0
VON	33	27.7
CLSC	18	15.1
Social Service	9	7.5
Not Answered	3	2.5

<u>Area</u>	<u>Resource Service</u>	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
Family Counselling			
	*Social Service	48	40.3
	VON	20	16.8
	Home Liaison Nurse	11	9.2
	*Psychiatry	11	9.2
	CLSC	6	5.0
	Minister	1	.8
	Not Answered	22	18.4
Home Assessment			
	*Home Liaison Nurse	52	43.6
	*Social Service	33	27.7
	CLSC	16	13.4
	VON	4	3.3
	Not Answered	14	11.7
Physiotherapy			
	Physiotherapy Dept.	68	57.1
	*Home Liaison Nurse	11	9.7
	Social Service	9	7.5
	CLSC	6	5.0
	Private Physiotherapist	1	.8
	Not Answered	24	20.1

<u>Area</u>	<u>Resource Service</u>	<u>Frequency</u>	<u>Relative Frequency Percentage</u>
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Occupational Therapy

Occupational Therapy Dept.	49	41.1
*Home Liaison Nurse	17	14.2
Social Service	9	7.5
CLSC	9	7.5
Physiotherapy Dept.	8	6.7
Psychiatry	3	2.5
Not Answered	24	20.1

PART 3

Requested additional learning needs identified in Question 9 were related to physical and psychosocial care of the cancer patient and their family and also to problems related with communication. They are listed as follows:

- Information on chemotherapy, specifically preparation, adequate care and administration, and safe handling of chemotherapeutic agents according to the Oncology Nursing Standards. (8 respondents)
- Investigational trials and how specific drugs are selected for specific tumor types. (7 respondents)
- The effects of chemotherapy on normal tissues and cells and any danger involved for those administering the drugs. (5 respondents)
- New surgical approaches to cancer and their implications for nursing. (3 respondents)
- Information on the types of equipment used in Radiotherapy so better teaching can be given to the patients by their nurse before their radiotherapy treatments. (6 respondents)
- Making goals with the patient and their family for psychosocial adjustment to his/her disease and treatment plan. (4 respondents)
- How to deal with professional staff and colleagues who have problems talking to cancer patients and tend to avoid them. (4 respondents)

Additional learning needs identified by nurses related to discharge planning are summarized as follows:

- Information about volunteer services in the community for home visits, volunteer drivers.
- Facilities available to patients outside the hospital such as household help, visiting nurses, medicar services, ambulance services for those patients over 65.
- Psychosocial support systems available in the community.
- Palliative Care Concept such as specially trained visiting nurses, volunteers and household help.

Individual comments emerged from a number of different questions. They are as follows:

- "How do I bring the conversation to what the patient is afraid of?"
- "How do I deal with a patient who is really scared about dying - talking about religious beliefs or other deaths from cancer in the family?"

- Where and how should the doctor tell the patient his/her diagnosis and how can I help?"

- "Something really hard for me is to deal with the patient and family when they are very anxious and uptight and there is so much anguish in their faces - I don't know what to say or do."

- "When I am trying to establish a good relationship with a patient who has cancer - one thing makes me very uncomfortable. When they look right into my eyes, I find it very hard to receive his/her message."

- "I like to stress ultimate freedom - like, why the hell should a patient have to have treatment just because the doctor say so. I sure wouldn't have it - I'd just take my chances."

CHAPTER 5

DISCUSSION

The purpose of this study is to describe the development and implementation of the educational needs assessment to serve as a means to provide continuing education to the nurses caring for the cancer patients in a large general hospital. A questionnaire was designed to assess the perceived learning needs, and to establish where educational intervention would be most appropriate.

The nurses surveyed in this study indicated they needed to learn more about cancer care. These areas included dealing with the effects of the disease, managing the current effects of therapy, and meeting the social and psychosocial needs of the patients and their families. Physical care and emotional support were seen as equally important and remarkably similar needs were expressed by the entire group of staff nurses.

The discussion will be organized according to the following format. First, I will present the responses to questions 7 and 8 that deal with a) the physical, and b) psychosocial care of the cancer patient. This will be followed by the responses to question 11 that identifies the four areas of concern that are most frequently expressed by patients and their families. Question 12 follows with four of the issues with which the nurses have identified as having the most difficulty. Question 13 presents the most frequently expressed worries that the patient and the family have on discharge from the hospital, and question 14 identifies the

nurse's knowledge in implementing the correct resource service for the patient on discharge.

Following the above, I will expand upon the responses to question 9 that describe requested additional learning needs not referred to in the questionnaire, and individual comments that emerged from different questions. The final content will be the recommendations and conclusions.

PHYSICAL NEEDS

Question # 7 dealt with concerns about physical needs. Areas of priority are covered in order below.

Pain management

When the eight physical or nurse centered care factors were ranked in order of importance, the most needed area of additional knowledge indicated by the nurses was pain management (See Table 1, Appendix C for importance by years of nursing breakdown). This was a positive and encouraging result, because our society has focused little attention on pain until quite recently. This is in spite of the fact that pain probably affects and/or disables more individuals than any disease and that the monetary costs of pain are considered a major economical problem (McCaffery, 1979). Nevertheless, health professionals, scientists, and the lay public have shown increasing interest in algology, the science of pain. Journals of the various health professionals have begun to publish many more articles on pain. It is estimated that between 1972 and 1977 over 2400 articles and books related to pain were published (Buckwalter, Rains

and Daniels, 1977). This is a dramatic increase in published information on pain, resulting in many nursing textbooks containing entire chapters on pain, and books devoted to the subject are now available. This is in strong contrast to the nursing textbooks published in the 1950s and the 1960s where only a few sentences in an isolated chapter addressed pain relief. Another encouraging indicator of nurses' concern and desire to treat pain as a major health problem was demonstrated in a nationwide survey designed to probe priorities for clinical nursing research. Pain management was identified as being among those topics with the greatest potential value to the profession (Lindeman, 1975).

In spite of this recent interest in the study of pain, it seems perhaps only the tip of the total pain problem iceberg is being reached. Donovan (1985) states that Oncology nurses report pain to be one of the most frustrating aspects in caring for cancer patients, and describe pain management as a complex process. In view of these statements, one wonders about the lack of accountability by nurses for pain management, as a surprising result of this study was that less than one half of the respondents ranked it as their number one learning need. Fifty-four nurses viewed it as a number one learning need, with 29 being nurses with less than five years' nursing experience, and 8 with more than twenty years'. When calculated according to the top three learning needs, 78 respondents saw it as being a priority area. Their scores were widely distributed and indicated that they see themselves as being fundamentally cognizant of the principles of pain control. This is an interesting observation as it clearly demonstrates that pain management is not seen as a highly problematic

area to some experienced nurses and particularly to many less experienced nurses. Perhaps the lower ranking of the more experienced nurses indicates that they do indeed understand the principles of pain management and are knowledgeable about pain relief methods and does not necessarily signify a lack of sensitivity to the problem.

The data also illustrated that there was no difference in the ranking between the medical and surgical nurses, so that pain management was not seen as an urgent need by either specialty (See Table 2, Appendix C for importance by unit breakdown).

It was expected that the medical nurses would indicate a greater need for more knowledge in pain management as compared to the surgical nurses. The surgical nurses had always expressed a more practical attitude, characterized by expectations for patient improvement and hopes for cure. They also acknowledged that they rarely see patients return as treatment failures, and that there were always things they could do for their post-operative patients in relation to pain management. In comparison, the nurses working on the medical unit tend to care for those patients that are more acutely ill, and have usually been admitted to the hospital after having failed on previous forms of therapy, and in many of these patients pain is a major problem. The equal ranking of both groups demonstrated that the surgical nurses, although confident in their care of the post-operative patient, see the need for added knowledge in the care of the cancer patient when they are faced with management of pain.

Clinical impressions of possible reasons for nurses' concerns are consistent with the reported literature. Nurses' attitudes seem to reflect those of the general public; that is, they perceive cancer as a dreaded disease, as a painful terminal event, and share with layman feelings of hopelessness in the face of this diagnosis (Abrams, 1966, Olson, 1974, Quint, 1985). Unfortunately, their attitudes may not be far from the truth! It is estimated that approximately 1 million cancer patients in the United States suffer from chronic pain, and it is suggested in some studies that 25% of cancer patients throughout the world die either at home or in the hospital without relief of pain (Twycross and Lack, 1984). In a survey done at the Memorial-Sloan Kettering Cancer Center, it was found that 30% of the patients required the use of narcotic analgesics to relieve their pain, and as they came closer to death the incidence increased to 60%. An overall view of studies in the United States and Canada on the existence and severity of pain associated with cancer suggests that moderate to severe pain is experienced by one - third of cancer patients in active therapy, and by 60-90 % of patients with advanced disease (Foley and Sundaresan, 1985).

The literature suggests the lack of a consistent approach by nurses to assess pain in cancer patients (Anderson, 1982). Heidrich and Perry (1982) found that some nurses may not know how to assess pain, and therefore simply rely on their own judgement regarding how much pain they believe patients are experiencing. Evaluating pain in another person must always begin with the recognition that pain is a subjective phenomenon, and that many factors influence the perception of, the response to, and reporting of pain (Jacox, 1979).

Unfortunately, these informal judgements frequently hamper the development of effective pain management protocols.

Lack of pain relief has also been attributed to a lack of knowledge concerning pain management. Charap (1978) conducted a survey of nurses actively caring for cancer patients and concluded that pain relief was not being given to cancer patients because of the caregivers' misconceptions about analgesics and their lack of knowledge concerning recent advances in pain management. There are many prejudices that characterize nurses when dealing with a cancer patient in pain (Hackett, 1980). Lack of knowledge, misconceptions, communication, and/or attitude are but a few. Unfortunately, the most common and dangerous of all is the tendency to undermedicate patients because of an unreasonable and totally unfounded concern for iatrogenic addiction. Although this attitude of health professionals has been somewhat modified in the past few years with the advent of the hospice concept, and wider acceptance of a more humane approach to relieving patients from unnecessary pain, it still exists.

The implications of these data are directly applicable to clinical practice. The nursing process provides the foundation and framework for nurses to improve the quality of life for the cancer patient in pain. It is difficult to interpret the results of this study in terms of pain management. Why do only half of the study population see it as being the number one learning need, and who and where are the nurses who have indicated little or no interest at all in increasing their knowledge of pain management? It is clear that factors such as

youth, relative inexperience, lack of special training, and education have not influenced their responses. Variables such as the above showed no significant difference in the results. It is likely however, that many nurses harbor misconceptions either due to inexperience, lack of knowledge, attitude toward pain, cultural expectations regarding how one should deal with pain, and a host of other factors. More extensive research into their attitude toward, knowledge of, and clinical management of patients in pain must be explored urgently in order to implement change. It stands to reason that if up to 50% of the respondents do not see pain management as a problem, and yet both the majority of the respondents in this study and the literature cited above indicated that it is indeed a major problem, then at least some of this population are uninformed, and remedial action is called for. More attempts should be made to communicate to nurses about pain and the proper use of analgesia, in order to influence nurses' behavior, attitudes and knowledge.

Cancer Chemotherapy

"Dealing with the side effects of cancer chemotherapy" was rated as the second highest learning need, rated number one by thirty-eight of the respondents. Of those who ranked it number 1, twenty-four were those with less than 5 years' nursing experience as opposed to 3 with more than 20 years' experience (See Table 3, Appendix C for importance by years of nursing breakdown). This result was not unexpected, as many of the nurses have conceivably had limited opportunity to care for many cancer patients on chemotherapy, and do not understand the significance of the side effects. Some

nurses are possibly not aware of the chronic side effects associated with some treatments, and were responding to the questionnaire in relationship to the acute problems they have observed. Despite this rather small number of nurses ranking it as a number one priority, ninety-seven of the total number of nurses ranked it within the top three learning needs, indicating its' importance in the nursing care plan.

Cancer chemotherapy has emerged as an important area of clinical specialization for nurses over the last two decades. This development is related to the successful use of chemicals for the treatment of patients with disseminated cancers not amenable to surgery or radiotherapy. In addition, the success of combination chemotherapy regimens in patients with early stage disease, has permitted new approaches to be developed for the management of many common tumors as an adjunct to the above treatments. However, the impact of this treatment is not well appreciated by many people in the medical profession (Rose,1982). Despite the fact that the incidence of cancer is increasing, analysis of age-specific trends in cancer mortality in the United States and Canada since 1960 indicates that the death rate has decreased 30% for individuals under 45 years of age (Axtell, Azire,and Myers,1981) due to chemotherapeutic programs. It should also be recognized that chemotherapy can effectively palliate metastatic disease in a growing number of cancers, prolonging survival and improving the quality of life for many patients formerly considered untreatable.

A major responsibility of the nurse is to provide teaching and support to the patient participating in chemotherapy protocols either on an in-patient or an

out-patient basis. These patients frequently perceive a variety of physical, psychological, and psychosocial changes that influence their lives and daily habits. Thus, patients must assume major responsibility for their care and must have sustained motivation to continue the regimen, especially when the treatment produces side effects (Holland and Warren, 1979). Patients must understand their treatment plan and the potential toxicities so that they can actively participate in their own therapy to reduce or prevent complications related to treatment. The ability of patients to become involved in the management of their disease is, to a great degree, dependent on the quality of the nursing care. The nurse must be astute in her ability to develop a therapeutic relationship which is dependent on the generation of mutual trust. Demonstration of this trust must be accompanied by a demonstration of professional competence and knowledge about the specific tumor, available therapies, side-effects associated with treatments, and ultimately the prognosis for survival. However, it is not enough to be an expert in clinical practice. In many situations, the nurse will recognize that the risks may outweigh the benefits of an aggressive chemotherapy regimen for the patient with advanced cancer. The nurse must keep in mind that the decision to participate in a treatment protocol is the prerogative of the patient, and that in no way should one attempt to discourage that patient in his/her choice of therapy by exhibiting a negative attitude regardless of one's own personal bias. We must keep in mind that the instinct for survival is so inherently strong in all beings, that we have an ethical and moral responsibility to assist the patient in keeping that instinct viable.

Radiation Therapy

The third learning need that was identified as a priority was "Dealing with radiotherapy side effects" with fourteen nurses ranking it as number one (See Table 4, Appendix C for importance by years of nursing breakdown). When analyzed according to specialties, twelve were from surgery and two were from medicine. (See Table 5, Appendix C for importance by unit breakdown). Eighty of the total group ranked it within the top three learning needs, with forty-one being those nurses with less than five years experience. When analyzed according to specific units, 62 nurses were from surgical units, and 18 were from medicine. This result likely indicates that there is the same proportion of patients in surgery receiving radiotherapy as in medicine, thus requiring concentrated nursing assessments and teaching in both specialty areas. Once again, it is conceivable that few nurses have had the opportunity to nurse many patients receiving radiotherapy, as the treatments are usually implemented after the patient is discharged.

One-half of all cancer patients receive radiation therapy some time in the course of their overall treatment (Battles, 1985), so the nurse caring for the cancer patient should be aware of how radiation affects them. With this basic knowledge, the nurse can formulate a comprehensive care plan to return patients to their optimal level of functioning. The nurse can also support the patient and family during this important phase of treatment. Myths have developed over the years about radiation therapy, mostly based on the fact that the department was generally located deep within the hospital's sub-basement and the treatment was

delivered by huge machines in a barren room with the client alone, while the technician watched through a little window. The whole process seemed rather removed and dehumanizing, and in the early era of radiation therapy, it was seen as a rather crude treatment (Battles,1985). Fortunately, science does improve, and today, radiation therapy is an acknowledged specialty within medicine, with the aim of the radiation oncologist falling into three categories: cure, palliation, or as an adjunct to other treatment modalities. It is not seen as an acknowledged specialty within nursing however, but is sometimes viewed as a "stop gap" method of arresting the course of the disease.

The major effects of radiation therapy on normal tissue can be divided into three categories: acute, intermediate, and late, and it is within the first category that the nurse caring for the cancer patient in the hospital sees him or herself as making the most significant impact. However, one must remember that the intermediate effects which occur shortly after completion of treatment, and the late effects that can occur anywhere from months to years following treatment, can result in the most anguish for the patient. Under these circumstances, the nursing care of these patients must be based on solid knowledge of ionizing radiation and its effects on the cells within the body. The patient and family must be included in treatment planning and instructed in preventive measures to lessen the known unavoidable effects of radiation therapy. The nursing care must incorporate the aim of the radiation oncologist, the data collected concerning the type of therapy, area treated, and expected complications. Nursing interventions should be based on this information and preventive

measures instituted prior to starting treatment when the opportunity permits. A comprehensive and knowledgeable plan of care carefully developed and openly communicated will maintain consistency in the care of these patients.

The present curriculum in the nursing schools at the CEGEP and University level do not include the principles of radiation therapy nor the care of the patient receiving this treatment. It is clear that since this is one of the major treatment modalities for cancer, the nurse must have access to some form of educational process related to this specialty within her working environment.

PSYCHOSOCIAL NEEDS

Question # 8 dealt with concerns about psychosocial needs. Areas of priority are discussed in order below.

Helping The Patient Accept Diagnosis

The results lent support to literature cited previously by Dickenson (1976) that some nurses feel insecure in the use of therapeutic interpersonal techniques in helping the patient deal with his/her diagnosis. Forty eight nurses ranked "helping the patient come to terms with his/her diagnosis" as the area seen most in need of additional knowledge and half of this total were nurses with less than five years' of nursing experience (See Table 6, Appendix C for importance by years of nursing breakdown). Ninety-four nurses ranked it within the top three learning needs and when tabulated by groups according to years of experience, greater than half of each category ranked it accordingly.

A diagnosis of cancer is a tremendous assault to both the patient and his/her family and there is no doubt that psychosocial factors play a great part

in an individual's ability to accept and cope with the disease and its implications. Self blame and projection are thought to be the two major psychological obstacles to an acceptance of the diagnosis (Watson, 1982). Watson also maintains that a belief that cancer is inherited or contagious is deeply ingrained in some families and communities. Krant (1976) maintains that cancer carries with it a social stigma, a stigma that depicts cancer as unclean, painful and dehumanizing. As a disease process, it has never acquired the respectability accorded high status diseases such as coronary artery disease which is often associated with aggressiveness and "the good life". For many, a diagnosis of cancer is equated with chronic endless debility, loss of muscular power and a withering away of life. These thoughts may be compounded by fear of job loss, abandonment, and financial crisis. Confronting a diagnosis of cancer is always difficult, and each patient will have his own method of coping, some more healing than others. A patient's silence in the face of such disruption should not be equated with acceptance or denial of the situation. Adjustment to cancer is complex and confusing, therefore, the silence may only mean the patient is sensing the nurses's discomfort and waiting for sanction to discuss feelings and fears. There is little doubt that hope remains the most crucial element in the patient's response to a diagnosis of cancer. Although the diagnosis may be clear cut, the nature of cancer remains unpredictable. This fact should be used as the basis for hope and not despair. The nurse who is cognizant of the psychosocial meaning of cancer for the patient and his family is in a better position to assist them in the process of adaption. Therapeutic assistance will be enhanced only if

open communication exists among all members of the health care team. An empathic approach capable of sustaining realistic hope at the time of diagnosis is crucial to the success of the treatment endeavor. The nurse must be aware that the first step in this approach is the establishment of trust that evolves from the patient's positive experiences with the nurse. For the patient and family, the treatment phase of the cancer experience is costly in both physical and psychological terms. When the outcome is successful, adaption is facilitated by the feeling that "it was all worth it" in the end. On the other hand if the cancer continues to progress in spite of all efforts to halt its growth, the process of adaption becomes increasingly difficult for everyone involved.

Talking About Death And Dying

This area was seen as most important by thirty nurses. (See Table 7, Appendix C for importance by years of nursing breakdown). Seventy-three nurses ranked it within the top three learning needs with greater than half being nurses with less than five years' experience. When compared proportionately to those nurses with 20 or more years' experience, 5 ranked it as a top priority, and more than half of that group ranked it within the top three learning needs, indicating that this particular topic is not an easy area to deal with regardless of the years of nursing experience.

These data are not surprising as many medical personnel tend to avoid engaging in conversation with the patient about death as they rarely feel comfortable in doing so (Cassileth,1989), and likely do not see it as a problem if they have not been faced with that difficulty. Conversely, some nurses have

been so strongly schooled in the idea that cancer patients should talk, express feelings, and cope with their deteriorating condition, that they will personally set goals, expecting that the patient will disclose his/her innermost feelings regardless of the communication style of the patient. However, what this particular group of nurses must also understand is that there is no need to initiate this sort of interaction if the recipient of that revelation is not ready for it.

There is no doubt that the nurses' experience is much more difficult and frustrating when death is imminent (Kubler - Ross, 1969). In our society, emphasis is placed on physical fitness, and there is no room for dying. For the most part, nurses do not know what to say or how to handle the situation when a patient asks questions regarding the process of dying. The nurse, when faced with this situation, must acknowledge the fact that there are no standard answers to many of the questions he/she will be asked. Communication difficulties will occur in a patient/nurse relationship if one or both participants have unrealistic or false expectations of each other, and the nurse must avoid that stress at all costs. The fact remains that if they are sure of their feelings and philosophy, the exact words aren't important--manner, voice, facial expression, and genuine empathy are all that matter.

Discharge Planning

This study revealed that 11 nurses saw discharge planning as being a priority area in need of more knowledge (See Table 8, Appendix C for importance by years of nursing breakdown). There was no difference in terms

of years of experience. In that the majority of scores were clustered around the lowest relative ranking the population as a whole viewed discharge planning as being less of a problem. Nevertheless, responses to question 14 make it evident that their knowledge in correctly identifying the appropriate resource service to implement discharge planning is lacking and that urgent clarification of the resources is necessary.

There is limited empirical evidence in the literature describing who uses home care and what benefits it can provide. An early study of hospital-based home care by Thompson (1951) found that cancer patients required more frequent visits than patients with other diagnoses. Brill, Schollosser and Widner (1978) reported that malignancies were the most frequent diagnoses encountered in home health agencies. They found that the patient's level of physical functioning, rather than diagnostic classification, influenced the use of agency resources. With this information available, there is no doubt in relation to this study that creative and knowledgeable nurses can function both to identify eligible patients for home care and offer them suitable assistance in the community. It is essential that professionals and consumers understand the range of potential services offered, the types of agencies available, the qualifications of the staff and the benefits that can be expected.

The other content areas under physical and psychosocial care of the cancer patient were ranked by the study population as a whole as relatively unimportant as no significant results were seen.

PATIENT/FAMILY CONCERNS IN HOSPITAL

The four areas of concern cited in question # 11 by the nurses most frequently expressed by patients and their families while in hospital in order of priority are discussed below.

Physical Discomfort

Ninety-nine nurses ranked "physical discomfort" as being the area of concern most frequently expressed by patients in the hospital. Krant (1979) cited stereotypic association of cancer with pain, death and dying as being very disruptive to the patient and family, so the overall nursing goal should be to counter the emotional disorganization experienced. Comfort is defined broadly as the minimizing of psychobiological distress (Schneider, 1978) and represents what is considered to be the major need in all cancer patients, but particularly so for those patients with advanced cancer. It is recognized and acknowledged that other needs exist, but physical discomfort represents the major need and also the concept that unites all the nursing interventions aimed at this population of patients (Marino, 1981). The nurse must be cognizant that the concept of comfort includes numerous activities such as: hygiene, activity, rest, sleep, safety, nutrition, elimination, oxygenation, sensory needs, and pain (Schneider, 1978). Also, central to comfort is open and honest communication.

Worry Regarding The Disease

Ninety nurses indicated "worry regarding the disease" as the second most frequent area of concern expressed by patients and family while in hospital. While no one would deny the life-threatening nature of cancer, it is an over

simplification to categorize patients with cancer as dying patients. It is true that some cancer patients can be more sure than most people of when they will die, but not all patients can be that sure. Even for those patients who will die from their cancer, they will continue to function within a social network until their death. It is important for the patient to understand that more and more, cancer is being characterized as a group of long term illnesses that have both acute and chronic episodes (Getz,1985). Cancer is perceived differently by different people and has widely varying implications to them. Anxiety is probably the most common emotional reaction people experience when becoming ill. This reaction may be manifested in many ways and may vary in degree, but in relation to the diagnosis of cancer is frequently associated with worry regarding the recurrence of the disease (Litin,1957). Information about aspects of the disease and their medical treatment has been shown to reduce patient's anxiety levels. In some cases, it made the difference between a patient seeking treatment or not (Gillum,1974). In a study done by Johnson (1979), patients' anxiety levels were significantly reduced following their participation in a 12-hour information course about cancer and related concerns.

Cancer may also elicit a sense of helplessness in some patients. The onset of this chronic illness may require them to alter their life style. This, in turn, modifies or causes loss of the sense of meaning and purpose that has been their source of identity and the mainspring of their life in the past. Cancer also forces people to relinquish control of their lives, at least temporarily, to the medical professionals. Feelings of powerlessness and frustration are caused by

loss of control over such things as medical procedures, appointments, and hospital routines. A lack of knowledge about the disease further heightens peoples' fears relative to loss of power and personal control over what is happening to their bodies and to their lives (Johnson,1967).

Each patient is unique and must be regarded as someone reacting to his disease with feelings, attitudes, concerns, and fears specifically his own. The nurse who is knowledgeable and who has adequate understanding and empathy for "what the patient is going through" can provide much assistance for his rehabilitation. Understanding the patient is of the utmost importance--what he knows, what he does not know, and what he really wants to hear. Knowing him as a person and not as a "case" is essential. This means having respect for the dignity of the human being, eliciting his likes and dislikes, and determining what his hopes and plans were before the illness and what his worries are now (Speese-Owens,1981).

It is most vital to foster hope in patients. Coping, as a goal-directed process, allows people to define problems. It brings relief, reward, and equilibrium (Lazarus,1974). The hope that the patient has can be nurtured and developed by comprehensive nursing planning and actions that serve to enhance his life process.

Nurses are in a position to intervene wherever and whenever they can to minimize the despair these individuals experience. They can become readily available resources and provide their patients with an informed listener, correcting misconceptions about cancer, identifying potential resources, and

encouraging the patient to consider one step at a time. It is important to discuss with patients their perceptions of what is happening and the significance that the events have for them, and to reinforce the chronicity of cancer. They must be totally convinced that they will never be abandoned by the health profession.

Talking About The Illness

The concept of comfort as defined above (Schneider, 1978) means that there is a psychological component as well as a physiological component. "Talking about the illness" was ranked as the third area of concern expressed by patients by 49 nurses.

The social stigma that prevails with cancer carries over to the patient, so it is important to find out what the illness means to the patient. For some, it may represent a threat to livelihood to their family's economic security, to self-respect as a productive member of society, or to valued roles such as a parent. The psychological component can be exemplified by aiding patients in disclosing their diagnosis and what it means to their family, their colleagues, and their friends. It is difficult for the patient to disclose their diagnosis and that it might mean disability or even death. Helping the patient decide what and how to tell people can be a valuable professional activity. Supporting them during the disclosure event is also important as is being available to answer questions that may arise. If the patient is willing to disclose this information, the tension and fears that might have been present are minimized as the family and friends once again become involved in the important life events of the patient.

Upset Regarding Medical Treatment

Forty-seven nurses ranked "Upset regarding medical treatment" as the fourth area of concern discussed by patients while in hospital. Certain major forms of cancer require radical surgical intervention in order to dramatically increase chances for recovery. Fears about radical body image changes and methods of functioning can be overwhelming. Stories about the "horrors of chemotherapy" or "radiation burns" abound. Friends of friends of friends relate information about the weeks and months of continuous vomiting, nausea, loss of appetite, loss of hair, and other negative consequences to these major forms of treatment. There is no doubt that some of these side effects do occur but not necessarily to the degree or severity that distorted third hand accounts suggest. Deceiving reports of only the negative side-effects are repeated and elaborated by many people. The person who is in the process of deciding whether or not to participate in a chemotherapy or radiation therapy program may be swayed by these ghastly accounts of misery. Yet, many, many people undergo these treatments and, with assistance, learn to manage adverse side effects. The benefits seem to far outweigh the temporary experiences of discomfort. One very common complaint of patients is a fear that physicians or nurses withhold information about the diagnosis and side effects of specific treatments, or "don't tell the whole truth". Patients can be thoroughly informed about diagnosis, treatment, and prognosis if this is done in a sensitive manner. For the nurse to knowledgeably interact with the patient in reference to his/her treatments, she must keep up to date with the newest development in cancer care. Maintaining

one's knowledge base through self-educative efforts is one aspect of the nurse's professional responsibility.

NURSING CONCERNS

The four areas cited in question # 12 that the nurses have the most difficulty in dealing with in order of priority are discussed below.

"Emotional changes" was ranked by 67 nurses as the most difficult area to discuss with the patient and family. As there are usually a host of personal expressions of anguish and fear demonstrated by the patient before and after the diagnosis of cancer, the nurse is usually the person most frequently exposed to this behavior. When patients are confronted with the diagnosis of cancer or with symptoms of cancer such as a breast lump, anxiety immediately sets in. Cancer equates with death, and patients experience a profound sense of futility, that there is no present or future prospect of resolving the problem (Schnaper and McNamara, 1983).

Enormous stress and a host of mechanisms to deal with that stress accompany such thoughts. Some of these responses are useful and lead the individual to take prompt and necessary action. Other reactions, such as overemphasis of denial or anger can lead to delay in seeking help when time can be critical and also tend to alienate those caring for the patient. Patients describe an emotional paralysis--they feel initially "stunned", or "fragmented". A great number experience guilt or shame, and believe their illness is related to something they did which was bad (Garusi, 1978). Many patients feel ashamed

they have such a frightful illness, and many tend to feel inferior or inadequate (Lewis and Bloom,1979).

In addition to guilt, patients are caught in a maze of fears which relate to death itself. These take various forms but the most common of course, is the fear of the unknown (Schnaper, 1975). Next, are the fears of death that center on loss, of the inevitable separation, being cut off from the nurturing people; of what will be missed; of the loss of body image; or the loss of control over their bodies; and finally of the regression and dependency on others (Parkes, 1972).

People cope with anxieties in their environment and in themselves with a system of defenses. These "mechanisms of defense" can be healthy or pathological, constructive or destructive, and for the most part are normal (Miller and Nygren,1978). Occasionally, a defense is used inappropriately, or it serves to inhibit constructive use of the personality. Despondency, depression, dependency, withdrawal, are but a few of the mechanisms of defense. Denial and anger are the most common defenses the nurse will confront and usually the most difficult to deal with (Waxenberg,1966). Denial in itself is not bad, particularly if the patient is able and willing to participate in the decision making relative to treatment options, and is in most cases temporary. Anger in the patient is more difficult to deal with because it inhibits the exchange of information and support.

The nurse needs to keep in perspective that the anger is not directed at he/she per se, but is more a reflection of what they represent to the patient. Other times, anger may be directed at the nurse as opposed to the physician.

This occurs because a patient is afraid of losing the physician, so will not jeopardize their relationship.

Dependency is a very real problem with cancer patients, and it is important that the nurse encourage independence as well as continue to supply information and support as needed.

Schnaper, Hahn and Devries (1978) define the term "professional" as an expectation that the nurse is a stable, rich source of support for the patient with cancer. In fact, professionals are just as "human" as patients and support can vary from avoidance to overwhelming concern. They too, have defenses and bring to the patient reactions based on their unique background, experiences, and personalities. Some of their responses are helpful, others are not.

In contrast, emotional changes were not identified by the nurse as a problem that the patient population frequently discussed, and was ranked as number eight by 25 nurses. This was likely explained by the philosophy that patients rarely recognize their own process of defense mechanisms (Donovan and Pierce, 1976), and that they usually are not aware of the change in their behavior patterns. It is also possible that some nurses had not been exposed to observable emotional changes in their patients.

The additional issues perceived by the nurses to be most difficult to discuss with the patients were identical to those areas of concern most frequently discussed by the patient and family. Forty-five ranked "worry regarding the disease" along with "upset regarding the medical treatment" as the second most difficult problems to discuss, and "talking about the illness" was seen by 44

nurses as the third most difficult. These data point out that the concerns of the patients that are most frequently presented, are the most difficult for the nurse to manage, and that an educational intervention must be planned and implemented.

A surprising result of this particular question was that although 114 nurses ranked "physical discomfort" as being the most frequently discussed problem by the patient, it was ranked as most difficult by only 36 nurses. One could speculate that the same population of respondents that ranked pain management as less than a high priority are the same nurses who are less concerned about physical discomfort of the patient. Possibly their understanding of physical discomfort does not correlate with the definition of comfort cited previously in the discussion, and that they are uninformed of its' true meaning. Regardless of the answer, corrective action must be realized.

PATIENT/FAMILY CONCERNS ON DISCHARGE

The content of question # 13 addresses the areas of concern most frequently expressed by patients and their family as identified by the nurses on discharge from the hospital.

"Symptoms of recurring illness" was identified by 89 nurses as one of the most frequently expressed concerns by patients and families on discharge. This was not an unexpected result, as the possibility of the above is reinforced to the patient by virtue of the fact that receiving any sort of post surgical treatment labels them as high-risk candidates for tumor recurrence. Even if no treatment is given in follow-up, the reminder that cancer did occur and could recur is

reinforced by the periodic examinations and tests. The concept of "Once you have cancer, you will always have cancer" is never far from their minds.

The nurses' responsibility in this phase centers on helping the patient to minimize the fears of recurring tumor and providing information about tumor control, so that the patient can understand that something can be done if and when there is a recurrence. "How to care for self" was ranked number 2 by 76 nurses, followed by "availability of nursing and household help" as number 3 by 75 nurses, with 60 nurses ranking "availability of medical assistance" as the fourth most frequently expressed area of concern. Rating this particular issue as their fourth concern clearly reflects the lay person's misgivings about the present health care system, and should give the medical profession some food for thought. The remaining issues in the question were identified by a small number of nurses as being a source of distress to the patients.

There are a wide range of patient reactions to the seemingly happy event of the initial discharge that may go unnoticed by many health care providers. The patient may have been in the hospital for weeks and moved from the acute illness state to convalescence and preparation for discharge. During this period, the patient has received a great deal of attention from various health care providers. As unhomelike as the hospital is, it is secure. If something goes wrong, the patient can obtain help with the push of the call light. The patient is well aware of the importance of these resources. The discharge marks a "landmark" in terms of the secondary gains associated with the sick role. During the definitive therapy phase, the patient may be acutely ill and thus unable to

participate in work or family obligations. However, when the patient is well enough to be discharged, the general perception is that the patient has recovered substantially. The courtesies, the special attention from family and friends, and the exemption from responsibility extended to the patient during hospitalization are withdrawn. Depression occurs at the time of discharge in many people, but for the cancer patient who may not be cured or will have to undergo additional treatment, the reaction may be more severe. Others perceive them as well when in fact they are not well.

The hospital can represent many things to patients. Many patients regard the hospital as possessing the capacity for cure or at least having a major impact on illness. Thus, a discharge may inadvertently indicate that "nothing more can be done for me." Depression is a common reaction.

Discharge from the hospital may also cause anxiety because the patient realises that explanations may have to be given to family members, particularly to children, friends and employers. Moreover, being at home may mean the patient is faced with such anxiety-provoking experiences as caring for themselves, looking after their household duties, choosing the correct foods, and seeking transportation to and from the hospital.

It is important for the nurse to determine how the patient feels about the expected discharge and what it means personally to the patient. This provides the nurse with an opportunity to reinforce the long term commitment the health care provider has to the patient and family as well as correcting any misconceptions about the purpose of the discharge. The nurse can be

particularly helpful to patients by exploring with them just how they intend to deal with some of the problems that concern them, so that the appropriate resource can be utilised once the patient is home.

DISCHARGE PLANNING

The content of question # 14 addresses the nurses's knowledge in identifying the correct resource service to implement discharge planning for the patient.

Identifying Resources

When asked to identify the appropriate resource service to provide assistance to a patient on discharge from the hospital, fewer than half of the respondents were able to indicate the correct service for a homemaker, a visiting nurse, a family counsellor, a home assessment, a physiotherapist, or an occupational therapist. In addition, not all nurses were able to indicate the person responsible to implement such important assistance as financial concerns, transportation to and from the hospital, and meals on wheels. These services may be essential to many patients and their families, and will be the mechanism by which they may be discharged home as opposed to remaining in the hospital. Unfortunately, with the acute shortage of beds in all the hospitals today, patients do not have the option to remain as an in-patient, and are quite often discharged before they are ready or before the appropriate community service is in place.

More significant was the fact that for each home care service listed there were nurses that did not respond at all, and particularly for such important resources as meals on wheels, homemakers, and family counsellors.

The needs of people with cancer are many and varied. Many nurses may recognize that help is needed by the patient or his/her family on discharge from the hospital, but are unaware of potential resources within the hospital or the community that are available to them. In many situations, "help is only a matter of a telephone call away". The nurse is in a key position to assist in obtaining information that may be a major factor in rehabilitation and recovery. If it is known in advance that the patient will need help in managing at home after discharge, there are many agencies that will provide various forms of assistance. It is essential however, that the nurse be aware of the types of community resources and services that are available and what is the correct method in which to make the appropriate referral.

REQUESTED ADDITIONAL LEARNING NEEDS

PART 3

Requested additional learning needs identified by the respondents are discussed below.

Chemotherapeutic Agents

Eight respondents indicated that they would like to have additional knowledge on the care and handling of cancer chemotherapeutic agents. This is a very valid request, as chemotherapy drugs are potent medications that can

have lethal effects on the patients, and for this reason they should be administered with respect for what they can do.

Nurses will be called upon to exercise skilled technical knowledge in the administration of chemotherapy. When administering chemotherapy drugs, whether orally, intramuscularly, or intravenously, the nurse must know the type of drug being administered, its toxicities, and the proper route of administration. Before any chemotherapeutic drug can be given, all clinical parameters appropriate for the specific drug or drugs must be evaluated; the patient and family must be properly informed regarding the drug regimen and its toxicities, and any measures that can prevent toxicities must be considered. Administration of these drugs requires the nurse to be experienced and knowledgeable, and only those nurses educated to properly and safely administer these drugs should do so.

Once again, the present curriculum in the nursing schools does not include instruction on adequate handling, or administration of chemotherapeutic agents, so on site instruction must be provided.

Relevant to this particular topic were several queries about investigational chemotherapeutic trials, how specific drugs were selected for specific tumors (7 respondents), the effects of chemotherapy on normal cells, and the danger involved for those administering the drugs.

Investigational Trials

An investigational trial is an experiment that is designed to answer a question that has therapeutic implications. A successful trial produces a valid

answer that is biologically, ethically, and legally correct. These trials are performed at the bedside and have always required the tacit participation of nurses who provide essential supportive care for patients participating in these studies. In recent years, nurses have recognised that tacit participation in clinical research is inadequate in terms of optimal patient care, fulfilment of the nurse's professional goals, and the execution of good clinical research (Hubbard,1977). This recognition has philosophical and practical implications for nursing as a profession. Philosophically, it has meant that nurses must abandon passive, dependent roles in research and assume responsibility for full collaboration with physicians in the conduct of clinical trials. Practically, it has meant that nurses must become highly sophisticated, both intellectually and technically, in order to actively participate in the research process. Clinical specialization in cancer nursing has facilitated the active participation of nurses in this process.

Chemotherapeutic Effects On Normal Cells

The basic principles of chemotherapy drugs are that they affect all dividing cells, normal and abnormal. The goal of chemotherapy is to rid the body of all cancer cells without producing irreversible damage to normal cells. If the tumor cells could be continually subjected to the chemotherapy drug, the tumor mass could be eradicated. However, normal cells are also susceptible to the damaging effects of the drug. Consequently, a period of time must lapse between exposures of the drug to allow the normal cells (cells of bone marrow, hair follicle, gastrointestinal tract) to recuperate. Unfortunately, while normal cells

are repopulating, tumor cells surviving the effects of chemotherapy are also growing.

The nurse in this role must have an adequate knowledge of the principles and rationale of chemotherapy in order to provide the patient and family with teaching and support.

Safe Handling Recommendations

Although the topic of antineoplastic exposure remains controversial, sufficient scientific data substantiates the need for the health care provider to exercise caution when handling these drugs. This practice also includes the handling of excreta, body fluids, or other contaminated materials (Crudi,1980). Current guidelines are based on what is known about these drugs, what is not known, and what is suspected based on studies supported in the literature, and recommended by the Occupational Safety and Health Administration Board (Gullo,1988). Keeping current with evolving knowledge in this important area and appropriately adjusting the guidelines is an ongoing responsibility of the nurse, and ultimately the health institution in which the nurse is employed.

Surgical Procedures

There were 3 nurses who expressed a need for more knowledge in relation to new surgical approaches and their implications for nursing. I would suspect however that although not indicated in the responses, there are many more that are concerned about the new technology and advances evolving in surgery.

Statistics reveal that in 80% to 85% of cancers the treatment of choice is surgery (Bouchard-Kurtz,1981). When an operation is indicated, the surgical

approach will depend on the primary purpose of surgery:(1) as a means to establish a definitive diagnosis, (2) as a means of staging of disease, (3) as a curative resection, (4) as a palliative procedure, or (5) as a combination or two or more of these. With the advent of many more aggressive surgical procedures, all members of the health team must be well informed regarding the various therapeutic measures in order to assist the patient in his adjustment to the physiologic and psychologic alterations as well as the other difficulties that may arise from the therapy.

Radiation Therapy

Six respondents indicated that they would like more information on the types of radiotherapy equipment, so better teaching could be given to patients prior to treatments.

As cited previously in the discussion, myths have developed over the years about radiotherapy and the whole process was seen as a rather crude treatment (Battles,1985). Nurses often have a minimal knowledge of radiotherapy and find the concepts difficult to understand. Few basic nursing education programs explain safety precautions and nursing care, and offer little about the physics of radiation therapy or its biologic consequences. The physical arrangement of the radiotherapy department is generally not an area included in the orientation plan of the nurse, and it is doubtful that more than a handful of the respondents could describe the equipment used, to the patient. The nurse who is interested in the field of oncology needs to make the extra effort required to become more

thoroughly acquainted with radiotherapy, so that improved and more comprehensive nursing interventions can be planned.

Several topics within the psychosocial realm of cancer nursing were identified by the respondents as being areas in need of additional knowledge. They are discussed below.

Promoting Effective Goals

Four respondents identified making goals with the patient/family in order to affect psychosocial adjustment to his/her disease.

One of the assumptions of psychosocial nursing interventions is that people can sometimes be helped to cope better with their diagnosis, if some goals are established (Cain and Henke, 1978). Burns (1982) defines coping as problem resolution that entails changes in both the situation and the person involved in the situation. It is based on the philosophy that change is possible.

The process of intervention, then, is to help the patient achieve a higher level of coping. Included in this framework are actions to identify and examine problems so that they can be solved, and making goals or objectives. Achieving this aim requires discipline and knowledge to fit one's intuitions into the framework in order to intervene effectively. However, one must keep in mind that any intervention designed to improve coping should be oriented toward accomplishing small steps, not great leaps.

Assisting Colleagues In Communication

Four respondents requested methods to deal with professional staff and colleagues who have problems communicating with cancer patients and tend to avoid them.

Therapeutic communication by health professionals requires that they be aware of their own personal feelings, body language, and expected effect of messages on the patient and at the same time be attentive to the patients words, body language, and responses to their communication. This requires considerable energy expenditure and can be very tiring, especially to the inexperienced. Styles of communication vary from one person to another. There is no one right thing to say or way to say it. An approach used by one person may be totally ineffective if used by another person. Some techniques may be helpful in developing an effective personal approach, such as self-awareness training, classes on communication skills, and study of counselling skills. In communicating, the nurse is using the self in a therapeutic way. In psychiatric nursing, this is a common and consciously developed practice. Unfortunately, in medical-surgical nursing, this art has not been as well developed.

However, one must be aware that communication may involve a greater degree of self-disclosure than one is used to or is willing to risk. Learning to actively listen, reflect, and convey understanding of the patient's feelings may be more than some health professionals can deal with.

Support Care Services

Twenty-six respondents identified support care services in the community as being an area in which they needed additional information. These were in relation to transportation, visiting nurses, psychosocial support groups, and the concept of palliative care in the home.

The complex medical therapies now utilized, curing some and greatly prolonging the life of others, bring with them the need for more involved care and support in the community setting. Today there is also a stronger focus in health care on quality of life. The patient is more likely to be supported in efforts to stay at home whenever possible. Support care services in relation to the identified needs of the nurses in this study can affect significantly the quality of living for persons with cancer and their families. The increase in quality of outcomes is based on the assumption that the nurse is well prepared to be responsible for the coordination of care and support in order to ensure continuity, which is possible only if information is exchanged on an ongoing basis among all professionals and family caretakers involved in the patient's care.

Individual Comments

Six individual comments emerged from a number of different questions pertaining to the personal and psychosocial phenomenon experienced by the care-giver of cancer patients.

To care for someone who has a life-threatening illness such as cancer is to continually confront issues of living and dying, of success and failure, of control and loss of control, of freedom and dependence. Giving of oneself, as the

cancer patient is cared for, provides the nurse with an opportunity to become intensely aware of personal fears, frustrations, hopes, fantasies, and goals (Patrick,1981). This statement reflects the emotional concept of the individual comments referred to in the questionnaire.

Repeated or continuous contact with life-threatened persons requires activation of psychologic coping mechanisms. These emotional protections make it possible for the nurse to initiate and maintain meaningful relationships with cancer patients. While the coping strategies help the nurse manage feelings related to patient care situations, their implementation and output require steady production of emotional energy.

The delivery of cancer care has undergone significant change. The disease is discussed openly and realistically in the majority of cases, and patients have become active participants in their care. Today's nurses caring for the cancer patient are eager to demonstrate their contributions in this changing attitudinal and structural context. Typically concerned with caring and comfort issues, nurses see the therapeutic environment as an opportunity for fulfilment of their professional role. Innovative therapeutic settings can provide a mechanism for nursing to establish an independent function in oncology.

SUMMARY

The difficulty we are experiencing in meeting the educational needs of the staff come from these principle areas: the increasing shortage of available nurses in health care institutions; the impact of technology on the health care system in general, with resultant impact on the nursing profession; the varied

backgrounds and preparation of the staff; the addition of older beginning employees; and the rising cost of health care, with its impact on the budget available for staff development.

It is clear that we must assess current educational practices and suggest alternate programs. How to provide educational programs that will help each practitioner is a challenge for today's health -care educator.

The findings of this study lent support to previous reports in the literature that many nurses tend to have difficulty caring for cancer patients, and are not as comfortable dealing with physical care as they might be. They also support the belief that an educational intervention tailored to the specific needs of the respondents can result in improved care of the cancer patient, and lead to an increased degree of comfort and security for the caregivers.

In response to the needs assessment, as discussed above, the specific areas identified by the nurses as most in need of additional knowledge, and those that they have the most difficulty with are summarized below. These items, listed in order of importance, represent areas where the educational system would concentrate.

Physical

- Management of pain
- Dealing with the side effects of chemotherapy
- Dealing with the side effects of radiotherapy
- Helping the patient accept the medical treatment

Psychosocial

- Helping the patient accept diagnosis of cancer
- Talking about death and dying
- Emotional changes in the patient
- Talking about the illness
- Dealing with the patient worrying about the disease
- Discharge planning

Additional Needs Identified

- Handling and administration of chemotherapeutic agents
- Investigational trials
- New surgical approaches and their implications for nursing
- Information on radiotherapy equipment
- Promoting effective goals for the patient
- Communication skills
- Support care services in the community

The focus of educational intervention as discussed in the following recommendations will be on these areas.

RECOMMENDATIONS

Educational Approaches

It is difficult to meet the required needs and to offer educational programs in any environment where provision of patient care services is required 24 hours a day, 7 days a week. Add to that the particular problems of staff shortages and the high acuity of illness present when caring for the patient with cancer,

and the difficulty becomes more severe. It is frustrating for those who want and need to learn but cannot attend scheduled classes and are unable to obtain the information any other way. For all the reasons cited, it appears that traditional methods of education no longer meet all the needs of the nursing staff in an acute care setting. However for those that are free and wish to participate in educational endeavors in the traditional sense, activities such as the lecture or lecture-discussion method which is offered by the McGill Department of Oncology as a public lecture series is appropriate. Another traditional technique is a discussion group, which arises out of the need to keep up with the latest literature, or to study difficult or unusual cases. A journal club, a meeting of a local society, or a "grand rounds" presentation and discussion are all examples of this way of learning. All of the above are available at the Montreal General Hospital for those that have both the interest and the time.

An alternative to that is the nontraditional approach, which incorporates some form of self-directed learning, in which the learner takes the initiative and the responsibility for the learning process (Houle,1980).

Developing program content and structuring learning experiences in a way that acknowledges the nurse as an adult learner may provide a viable and attractive addition to the traditional approach of classroom teaching. Programs that use a problem-centered approach to teaching, immediate application of knowledge, encourage self-direction, acknowledge individual experiences, and allow for scheduling flexibility should meet the needs of most learners today.

The intervention must incorporate the self-directed philosophy within organizational constraints and work for the individual in a particular setting.

IMPLEMENTATION

The selection and effective implementation of an appropriate teaching strategy are critical to the success of an educational endeavor. Our approach will focus on the implementation of a Support Care Consult Service which will function as a multidisciplinary team consisting of members of diverse disciplines in the same setting interacting informally. Our aim will be to assist the professional staff caring for the cancer patient to investigate the nature and elements of problems with which they are confronted and ways of dealing with these problems. We will also collaborate in the design of educational activities to which the learner has direct access. The types of strategies which could be used include self-instructional modules, videotapes, film/tape, slide/tape, case studies, problem-based learning, teaching cards/booklets, and demonstrations. Inservice programs at the unit level which introduces a principle in a nonthreatening way, such as using a videotape to introduce a new procedure and making it available as each individual has time to review it will be introduced. If a need is identified about a specific content area that a particular group or person requires information about, individualized assessment will be offered. A visit to unfamiliar units within the hospital such as the radiotherapy or chemotherapy clinic or a community resource service if time permits, will be encouraged for those interested nurses. Numerous other learning activities such as study days, seminars, short courses, workshops, and updating programs will

provide further teaching on cancer and cancer nursing. Some of these are run by individual general hospitals, and some by specialized cancer centres. Many others arise from the initiatives of individual enthusiastic and committed cancer nurses/teachers, and increasingly through cancer nursing societies and associations in Canada and the United States. These programs are designed to keep nurses abreast of their particular field of interest, and vary considerably in terms of their content, structure, length, and emphasis. The availability and frequency of such programs also varies considerably from country to country, and within each country. The potential strength of such programs, however, is that they are available to large groups of nurses from both hospital and community and may not only be attended by hospital nurses but often by nurses from elsewhere, within and outside the region.

The advantage of supporting the nurses in attending programs in the form of pedagogical days is that it provides incentive and opportunity to pursue continuing education outside of their own setting so that they can fill the void in their own cancer nursing skills, and share knowledge and ideas with those from other institutions. The disadvantage is that the acute shortage of nurses within all the hospitals does not realistically lend itself to promoting this kind of activity as few nurses can be freed from any given unit. Nevertheless, nursing administration will have to continue to address this problem in an attempt to provide this sort of learning opportunity on a limited basis.

This service could be implemented in a hospital that is committed to education as an essential requirement for the delivery of patient care services.

One must keep in mind that this type of educational intervention should be initiated only if nursing service administration supports the concept and is prepared to change. Without administrative support and willingness to change, the concept will not be conducive to the facilitation of learning and the program will be set up for failure.

CONCLUSION

The opportunities for cancer nursing experience in an acute care hospital are limited. They are limited by the overall widespread lack of focus on the cancer patient, who usually is nursed within general rather than specialized nursing units, and the overall lack of emphasis and time given to the teaching of cancer in the basic training syllabus. It stands to reason, therefore, that in order to improve the quality of cancer nursing for as many cancer patients as possible, we have to improve the quality of cancer education for as many nurses as possible. Cancer nursing must develop the nurse beyond the level of mere training in practical tasks. The priority must be to develop a sound knowledge base in general cancer nursing. We must address the needs of nurses at all levels of basic and post-basic nursing education, and include those in the community as well as the hospital setting.

The Supportive Care Consult Service will suggest principles for the content and structure of cancer teaching where there is a lack of teacher experience or knowledge, and provide the means of mobilising existing skills and resources where cancer teaching initiatives presently exist.

The Supportive Care Consult Service has the potential to be adopted at a variety of levels in a variety of settings, and thus could support hospital-based cancer teaching programs. It could, therefore, meet the continuing educational needs of **all** nurses involved in the daily care of cancer patients.

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APPENDICES

APPENDIX A

Covering Letter for the Survey Instrument

THE MONTREAL GENERAL HOSPITAL
SUPPORTIVE CARE CONSULT SERVICE

The Supportive Care Consult Service is designed to increase nurses' involvement in cancer cases and ultimately improve the quality of that care by upgrading nurses' skills and increasing the degree of satisfaction from their work with cancer patients. This service is interested in developing continuing education programmes for nurses working with cancer patients. We would like your co-operation in completing the questionnaire.

Your participation in this project is voluntary and will in no way affect your position on your nursing unit, whether or not you decide to participate. All information is confidential and your identity will not be revealed. You will be free to refuse to complete the questionnaire without explanation.

The completed questionnaires will be collected in two weeks time by your head nurse in the original envelope. Please seal it after you have completed the Needs assessment. If there are other questions or concerns please call me in the Oncology-Chemotherapy centre.

Lois Hollingsworth
Head Nurse,
Division of Medical Oncology
Co-ordinator,
Supportive Care Consult Service

APPENDIX B
Survey Instrument

card $\frac{1}{1}$
 ID $\frac{1}{(3-5)}$
 Time $\frac{1}{(6)}$

**THE MONTREAL GENERAL HOSPITAL
SUPPORTIVE CARE CONSULT SERVICE**

1. Unit (write in unit or "F" for float) (7-9)
2. Nursing Education (check off as many as apply)
 - a) Diploma (10)
 - b) Degree (11)
 - c) Masters (12)
3. Number of Years in Nursing (13-14)
4. Number of years caring for cancer patients (15-16)
5. Age (17-18)
6. Position (check off appropriate answers)
 - a) Full time__(1) or Part-time__(2) (17)
 - b) Permanent unit assignment__(1) or Float__(2) (18)

7. Please indicate the areas in which you feel most in need of additional knowledge by placing a "1" beside the most needed area, a "2" beside the next most needed area, and so on through "8" as the least important.

Physical

- (19)_____ a) Management of pain
- (20)_____ b) Dealing with the side effects of Chemotherapy
- (21)_____ c) Dealing with the side effects of Radiotherapy
- (22)_____ d) Nausea and vomiting
- (23)_____ e) Stomatitis
- (24)_____ f) Anorexia
- (25)_____ g) Constipation
- (26)_____ h) Shortness of breath

8. Please indicate the areas in which you feel most in need of additional knowledge by placing a "1" beside the most needed area, a "2" beside the next most needed area, and so on through "8" as the least important.

Psychosocial

- (27)_____ a) Dealing with your own feelings about cancer.
- (28)_____ b) Helping the patient come to terms with the fact that he/she has cancer.
- (29)_____ c) Helping the patient deal with an uncertain future.
- (30)_____ d) Talking about death and dying.
- (31)_____ e) Communicating with family and/or significant others.
- (32)_____ f) Involving family and/or significant others in the planning and care of the patient.
- (33)_____ g) Discharge planning including referrals.
- (34)_____ h) Giving information about hospital procedures. i.e. diagnostic tests, etc.

9. If there are other areas of knowledge needed than these listed on question 7 or 8, please list them here:

_____ (35)

_____ (36)

_____ (37)

10. What kinds of issues do patients and their families and/or significant others talk to you about during hospitalization? Please check all that apply:

- a) Physical discomfort____(38)
- b) Sexuality____(39)
- c) Upset re: medical treatment____(40)
- d) Dissatisfaction with the medical treatment____(41)
- e) Mobility____(42)
- f) Work____(43)
- g) Finances____(44)
- h) Changes in family role____(45)
- i) Change in social life____(46)
- j) Worry re the disease____(47)
- k) Emotional changes____(48)
- l) Body image____(49)
- m) Talking about the illness____(50)
- n) Myths and beliefs____(51)

11. Of the issues listed above in question 10, please write the letter to indicate the **four** areas of concern most frequently expressed by patients and their families and/or significant others in the space provided:

1. _____(52)

2. _____(53)

3. _____(54)

4. _____(55)

12. Of the issues listed in questions #10, please write the letters to indicate the **four** areas with which **you** have the most difficulty.

1. _____(56)

2. _____(57)

3. _____(58)

4. _____(59)

13. What areas of concern are most frequently expressed by patients with cancer and their families and/or significant others upon discharge from hospital? Please check off the four most frequently occurring areas of concern.

(60) _____ a) Symptoms of recurring illness

(61) _____ b) Availability of financial assistance

- (62) ____ c) Availability of medical assistance
- (63) ____ d) Type and amount of work the patient can do
- (64) ____ e) Amount of recommended exercise
- (65) ____ f) How to choose foods to help maintain weight
- (66) ____ g) How to care for self
- (67) ____ h) Availability of nursing and household help
- (68) ____ i) How to talk to family and friends about illness
- (69) ____ j) Transportation

14. Patients being discharged from hospital sometimes need assistance in the areas listed below. For each area write the name of the resource service you would contact to organize assistance.

	<u>AREA</u>	<u>RESOURCE SERVICE</u>
a)	Financial concerns	_____(70)
b)	Transportation	_____(71)
c)	Physiotherapy	_____(72)
d)	Meals on wheels	_____(73)
e)	Home assessment	_____(74)
f)	Homemaker	_____(75)
g)	Visiting Nurse	_____(76)
h)	Occupational Therapy	_____(78)
i)	Family counselling	_____(79)

APPENDIX C

Frequency of Problem Identification Tables

Table 1

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
OF IMPORTANCE BY YEARS OF NURSING**

MANAGEMENT OF PAIN

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 - 19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	29	10	3	4	8	54
2	5	1	1	1	-	8
3	9	3	-	1	3	16
4	2	1	2	-	1	6
5	9	1	-	1	1	12
6	-	4	1	-	1	6
7	5	1	-	-	-	6
8	4	1	1	-	2	8
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	63	22	8	7	16	116

Table 2

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
OF IMPORTANCE BY TYPE OF NURSING UNIT**

MANAGEMENT OF PAIN

<u>TYPE OF UNIT</u>	<u>SURGICAL</u>	<u>MEDICAL</u>	<u>TOTAL</u>
RANK			
1	38	16	54
2	4	4	8
3	10	6	16
4	6	-	6
5	10	2	12
6	4	2	6
7	4	2	6
8	7	1	8
	<hr/>	<hr/>	<hr/>
	83	33	116

Table 3

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
 OF IMPORTANCE BY YEARS OF NURSING
 DEALING WITH CHEMOTHERAPY SIDE EFFECTS**

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 -19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	24	7	2	2	3	38
2	22	10	5	4	6	47
3	8	2	1	-	1	12
4	6	-	-	-	3	9
5	2	2	-	-	1	5
6	2	-	-	-	-	2
7	-	1	-	1	1	3
8	-	-	-	-	1	1
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	64	22	8	7	16	117

Table 4

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
 OF IMPORTANCE BY YEARS OF NURSING
 DEALING WITH RADIOTHERAPY SIDE-EFFECTS**

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 - 19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	7	2	3	1	1	14
2	18	8	3	1	4	34
3	16	7	2	2	5	32
4	8	2	-	2	-	12
5	7	-	-	-	4	11
6	5	1	-	1	1	8
7	2	-	-	-	-	2
8	-	2	-	-	1	3
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	63	22	8	7	16	116

Table 5

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
 OF IMPORTANCE BY TYPE OF NURSING UNIT
 DEALING WITH RADIOTHERAPY SIDE EFFECTS**

<u>TYPE OF UNIT</u>	<u>SURGICAL</u>	<u>MEDICAL</u>	<u>TOTAL</u>
<u>RANK</u>			
1	12	2	14
2	25	9	34
3	25	7	32
4	5	7	12
5	8	3	11
6	4	4	8
7	2	-	2
8	2	1	3
	<hr/>	<hr/>	<hr/>
	83	33	116

Table 6

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
OF IMPORTANCE BY YEARS OF NURSING
HELP PATIENT ACCEPT FACT OF CANCER**

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 - 19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	24	8	5	4	7	48
2	14	5	2	3	2	26
3	12	3	1	-	4	20
4	6	2	-	-	-	8
5	3	3	-	-	1	7
6	2	-	-	-	2	4
7	2	-	-	-	-	2
8	1	1	-	-	-	2
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	64	22	8	7	16	117

Table 7

FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
OF IMPORTANCE BY YEARS OF NURSING
TALKING ABOUT DEATH AND DYING

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 - 19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	15	7	1	2	5	30
2	12	3	1	2	3	21
3	12	3	3	-	3	22
4	8	1	1	1	1	11
5	3	1	1	1	2	8
6	6	3	1	1	1	12
7	3	2	-	-	-	5
8	4	2	-	-	1	7
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	63	22	8	7	16	116

Table 8

**FREQUENCY OF PROBLEM IDENTIFICATION IN ORDER
OF IMPORTANCE BY YEARS OF NURSING**

DISCHARGE PLANNING

<u>YEARS</u>	<u>0 - 4</u>	<u>5 - 9</u>	<u>10 - 14</u>	<u>15 - 19</u>	<u>20+</u>	<u>TOTAL</u>
<u>RANK</u>						
1	5	3	-	1	2	11
2	4	3	1	1	2	11
3	4	-	1	-	-	5
4	6	1	-	-	1	8
5	6	1	1	-	1	9
6	5	2	-	-	1	8
7	20	7	5	5	9	46
8	13	5	-	-	-	18
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
	63	22	8	7	16	116