

The Role of the Nurse in Supportive Care

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INTRODUCTION

Diagnosis and treatment of patients with cancer are fundamental imperatives, requiring a superior level of interdisciplinary knowledge and skill. However, the effects of a cancer diagnosis on the patient and family require an additional dimension of service called supportive care (Breitbart et al). Supportive care includes activities that help patients and families cope with the burden of the illness: the need to adjust to the physiological and psychosocial effects of a cancer diagnosis, and the need to prevent or withstand the side effects of treatment. The effects from the burden of illness in cancer include not just physical symptoms, but spiritual, emotional, social, and economic as well (Fitch, 2000; Klastersky, Schimpff, & Senn, 1999). Hence, the required focus of a supportive care program is on symptom management, patient/family adjustment, financial stress, community resources, spiritual needs and palliative care.

To be successful in meeting these needs, the focus must be on a supportive care program grounded in the elements of a therapeutic relationship, an evidence-based and family centered approach, and interprofessional collaboration, (Fitch, 2000). The inclusion of well developed supportive care programs have become an essential feature denoting excellence in oncology services, centres and regional networks. Conversely, in programs without adequate supportive care, patients and their families may experience unmet needs to a serious degree (Sanson-Fisher et al, 2000; Whelan et al, 2000).

Since nurses work in all contexts of oncology care, from health promotion and screening to acute care, community programs, inpatient hospitals and regional ambulatory centres, and understand the impact of illness, they are ideally positioned to provide leadership in supportive care. Beyond the delivery of expert clinical care to the individual, nursing considers the oncology patient and their family as a unit. Comprehensive assessment and resolution of patient issues, enhancement of communication, interprofessional team management and coordination of community services are well recognized as legitimate nursing roles in providing supportive care.

In the past two decades, advanced practice roles have

also emerged including that of clinical nurse specialist and nurse practitioner. Nurses in these categories provide additional nursing expertise to patients, families and all members of the health care team (CNA, 2002).

In order to deliver these services, various nursing models have evolved over time.

NURSING MODELS IN SUPPORTIVE CARE

In the inpatient and ambulatory care settings, groups of nurses work collectively to fulfill their accountabilities. While their role is defined by legal and regulatory bodies, the organization of their work, i.e. the care delivery model, is specific to the context and reflects the values of an organization, management philosophies and fiscal considerations (Tiedeman & Lookinland, 2004).

In the earliest care delivery model, total patient care, the nurse assumed responsibility for all aspects of a single patient's care or an assigned group of patients over one complete shift. She/he would not necessarily resume care of the patient on her/his return. In the functional model of care, responsibilities were assigned shift-to-shift, based on the skill of the care giver and the complexity of the patient's problems. Continuity of care for a particular patient by any one nurse was not a feature. Team Nursing provided care to a defined group of inpatients under the responsibility of a team leader who, along with other nursing team members, completed the tasks of patient care, shift to shift. (Tiedeman & Lookinland, 2004). Continuity of care was not a fundamental aspect.

Primary Nursing

The professional role of the nurse evolved from the 1960s, owing to the burgeoning complexities in patient acuity, technology and specialized programs. Practice standards required competence in more areas of nursing. The inclusion of a greater number of allied professionals in the health care team necessitated broader coordination functions. Recognizing the importance of patients and families as partners in care gave rise to an enhanced focus on their expectation and goals and improved family-centredness. Efficiencies in fiscal management resulted in a shorter length of hospital stay and the need for learning about and contributing to

community resources for care, education and coping. The importance of providing continuous care to a patient by the same nurse was becoming recognized.

The Primary Nursing model evolved to meet the new challenges. The shortfalls in old models of care, such as fragmentation, de-personalization, and discontinuity of care were redressed. The Primary Nursing model emphasized the importance of both continuity of care and the accountability of a single nurse for management of the patient's care plan. The Primary Care model has emerged within both the hospital and the ambulatory care setting (Jassek, 2002). Nursing models have evolved from a predominantly task orientation, delivered discontinuously and intermittently, to nursing care being delivered in all of its dimensions by the same individual, thus providing continuity.

The Primary Nursing model has one other important attribute. One of the current major issues in health care is the requirement to maintain a skilled and satisfied pool of nursing staff. To that end, efforts are being made to provide an enriched setting for nursing practice that produces not only safe but also satisfying care. The Primary Nursing care model is considered ideal for meeting this requirement (Allen & Vitale-Nolen, 2005) because nurses report a higher degree of job satisfaction where they have the responsibility, authority and autonomy to execute their professional role. Furthermore, the two constructs, safe care and satisfying care, are positively correlated: more satisfied nurses deliver better care. Most importantly, the result is healthier, more satisfied patients.

Notwithstanding the strengths of Primary Nursing and the high degree of acceptability of the model among nurses, there is a need to refine its role (McFarlane & Bennett, 2006), and support it within the institution. Team commitment, accountability, motivation, and social support from the supervisor and colleagues all have been shown to improve nurses' professional satisfaction (Pearson et al, 2006). Simply put, successful introduction of Primary Nursing has an important pre-requisite: a willingness on the part of other key professionals, particularly physicians, to forge the partnership links needed. Not all jurisdictions have been able or willing to achieve this end.

As a first step in evaluating the status of supportive care for cancer patients within the existing cancer care system, CACC conducted a survey across Canada to determine the extent of Primary Nursing in outpatient cancer clinics.

METHODOLOGY

Nurses were surveyed for their style of practice in large and small cancer centres, across eight provinces. Responses were received from all but Quebec and Newfoundland and Labrador.

A large centre was defined as one that delivers both

radiation and chemotherapy. In provinces where such centres were lacking, the dominant site for cancer care delivery was selected. The distribution of 26 cancer centres selected for the survey captured large and small centres in each province surveyed (where both sizes exist) and broadly reflects the population: ten centres in Western Canada, 11 in Ontario and five in Eastern Canada.

One full time staff nurse working in a medical oncology clinic and one nursing supervisor from each centre were interviewed by an experienced oncology nurse with extensive experience in delivering Primary Nursing. Nurses working in medical oncology clinics were chosen because patients receiving chemotherapy are among those needing the most extensive supportive care. Respondents were assured neither they nor their centre would be identified in the final analysis. The majority of the surveys were conducted by telephone during October and November 2007. A small number of interviews were conducted in person during the 2007 Canadian Association of Nurses in Oncology conference in Vancouver. The survey questionnaire can be found on the CACC Web Site with other background documents related to this Report Card.

Forty-nine interviews were conducted, with 26 staff nurses and 23 supervisors. Thirty-two were with nurses working in large cancer centres and 17 working in smaller centres. Respondents were identified through a network of contacts including senior officials within the cancer system, within the organized nursing community, and at times by direct request to hospital officials.

Both staff nurse and supervisor surveys included questions related to Primary Nursing. Questions probed whether:

- (1) patients were permanently assigned to the nurse and physician
- (2) physicians and nurses worked as a team/partnership
- (3) continuity of care was provided by the same team/partnership after initial treatment had been completed
- (4) the content of the follow-up provided to the patient was beyond medical considerations
- (5) time was spent on clerical and non-nursing duties

The survey questionnaire was developed with the assistance of Dr. Dauna Crooks, Dean of Nursing at the University of Manitoba, and Dr. Margaret Fitch, Head of Oncology Nursing and Supportive Care, Odette Cancer Centre, Sunnybrook Health Science Centre and Leader of the Rebalancing the Focus Action Group of the Canadian Partnership Against Cancer.

Survey results were tabulated into a database and the aggregate data were analyzed by descriptive methods.

The data are therefore reported in an aggregate and qualitative manner.

Data limitations

As a snapshot of nursing practices in cancer clinics, the survey is limited by the relatively small number of individuals interviewed. To improve the reliability of results, a response rate of 80 per cent was set as the minimum for any individual question to be included in this analysis. In fact, the majority of survey questions achieved a response rate of 90 per cent or higher, reinforcing the interviewers' impressions of forthright cooperation with the survey. Nevertheless, a larger survey would be required to confirm these results.

COMMENTS BY NURSES INTERVIEWED

Question: Is there something else you want to add regarding your vision and goals in meeting the supportive care needs of your cancer patients?

Answers:

- "I enjoy Primary Nursing for the continuity provided and am able to see and evaluate outcomes of my efforts."
- "I prefer the independence and collegial relationships of Primary Nursing. Patient and nurse satisfaction are higher. Clinical trials nurses can do primary nursing. Clinic nurses do not."
- "All centres should have Primary Nursing so all patients have full directions and a nurse."
- "Nurse the patient, not the clinic or the doctor."

Question: If more than 25 per cent of your time is spent on non-nursing duties please specify the type of non-nursing work you perform.

Answers:

- File charts
- Serve meals
- Requisitions
- Coffee and cookies
- Escort patients to toilet
- Make beds
- Water plants
- Empty laundry bags
- Fax orders
- Enter doctors' orders into computer system

RESULTS

All staff nurses interviewed worked in an outpatient cancer clinic setting, providing direct care to cancer patients. Slightly more than half of the supervisors (57 per cent) spend at least some of their time providing such services.

Seventy per cent of all respondents said the Primary Nursing model was practiced in their clinic.

Working with oncologists

Whether responding as staff nurses or as supervisors, in large centres or smaller ones, 73 per cent of the nurses reported they worked closely with oncologists as part of a team that was meant to provide continuity of care to their own patients. Staff nurses also reported (84 per cent) that these oncologists have their own patients, as opposed to randomly receiving patients who arrive at the clinic.

Continuity of care

When staff nurses were asked whether they follow their assigned patients from initial contact with the clinic through to the completion of active treatment, 74 per cent said yes, and 86 per cent of their supervisors agreed that this was the case.

One of the ways organizations support the nurse-patient relationship is by providing patients with an email address, phone or pager number to contact their own nurse with questions between appointments. Eighty-five per cent of the nurses and supervisors confirmed this practice was in place at their clinics. In the remaining clinics, patient inquiries are answered by a triage system staffed by health professionals who did not necessarily know the patient.

Following active treatment, the same arrangements for direct patient contact with their own nurse were typically in place. Eighty-three per cent of the respondents said their patients could reach them by email, phone or pager after completion of active treatment for any issues that arose between routine follow-up appointments.

Range of supportive care services

Through a series of questions focusing on all the elements of the Primary Nursing model, the role of nurses was explored in more detail. Table 1 shows the affirmative answers offered by all staff nurses and supervisors, when asked if these elements were incorporated into the role of nurses in their outpatient cancer clinic. Highlighted areas show less than 75 per cent and less than 50 per cent of respondents have a role in delivering that service.

Post-treatment Supportive Care

Supportive care is not limited to the period of active treatment. After active treatment has been completed,

TABLE 1 **AGGREGATE RESULT – Elements of Primary Nursing**

Nursing Role	Symptom Management	Psychosocial Support	Patient Education	Clarify Treatment Plan	Refer to Other Services	Follow Up
Assess Needs	100%	100%	100%	96%	96%	69%
Develop Plan	92%	82%	86%	82%	76%	57%
Coordinate Care	90%	82%	92%	86%	80%	57%
Follow Up On Plan	94%	82%	86%	80%	76%	59%
Evaluate Outcome	76%	67%	63%	67%	57%	51%

Table 1 shows the overall responses for all centres combined. Between 51 and 69 per cent of respondents followed up with their patients to ensure interventions were enacted for almost all aspects of Primary Nursing, except for symptom management (76 per cent).

TABLE 2 **LARGE CENTRES – Elements of Primary Nursing**

Nursing Role	Symptom Management	Psychosocial Support	Patient Education	Clarify Treatment Plan	Refer to Other Services	Follow Up
Assess Needs	100%	100%	100%	94%	94%	59%
Develop Plan	91%	81%	81%	75%	69%	47%
Coordinate Care	88%	75%	88%	78%	72%	50%
Follow Up On Plan	91%	78%	81%	72%	66%	50%
Evaluate Outcome	69%	59%	53%	56%	41%	38%

Tables 2 and 3 portray the data from large and small centres separately. Of note is the fact that nurses in the larger centres appear to have a lower rate of follow-up and a lesser role in evaluating outcomes than nurses in the smaller centres.

TABLE 3 **SMALLER CENTRES – Elements of Primary Nursing**

Nursing Role	Symptom Management	Psychosocial Support	Patient Education	Clarify Treatment Plan	Refer to Other Services	Follow Up
Assess Needs	100%	100%	100%	100%	100%	88%
Develop Plan	94%	82%	94%	94%	88%	76%
Coordinate Care	94%	94%	100%	100%	94%	71%
Follow Up On Plan	100%	88%	94%	94%	94%	76%
Evaluate Outcome	88%	82%	82%	88%	88%	76%

FIGURE 1 **NURSES PROVIDING SUPPORTIVE CARE ADVICE AFTER ACTIVE TREATMENT**

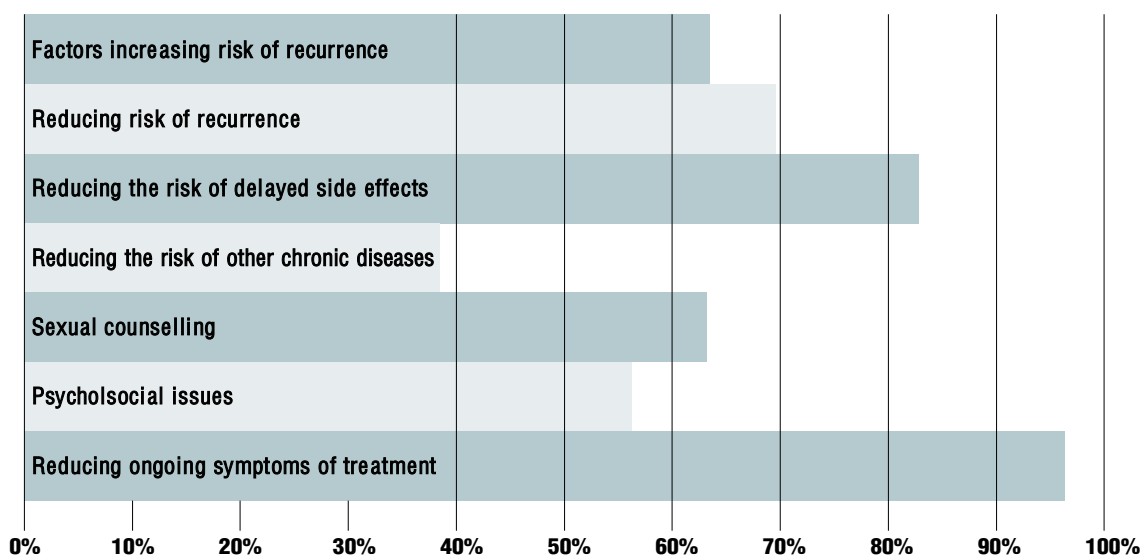


Figure 1 shows the responses when the interviewers asked whether these aspects were personally covered by the nurses in their clinic.

ongoing supportive care can be described as seven major activities:

- Advice on factors increasing the risk of recurrent cancer
- Advice on how to reduce the risk of recurrent cancer
- Advice on reducing the risk of delayed side effects of therapy
- Advice on how to reduce the risk of other chronic diseases
- Sexual counseling
- Advice on unique psychosocial issues facing cancer survivors
- Advice on reducing ongoing symptoms of treatment (fatigue, pain)

Seventy-two per cent of the staff nurses and supervisors interviewed said that ongoing follow-up support for patients continued at their clinic after the completion of active treatment.

Measuring volume and time

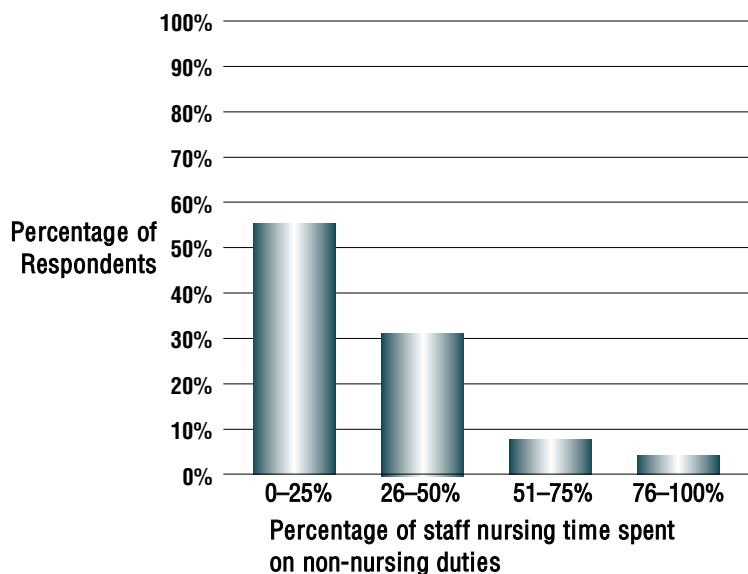
Staff nurses were asked how many patients per week receive their personal supportive care services; 60 per cent of the nurses answered 21–50 patients and 32 per cent answered 51–100 patients. The latter group, with the highest number of patients, were evenly split between large cancer centres and smaller ones.

Seventy-nine per cent of staff nurses and supervisors estimated that more than half their patients receive supportive care and 49 per cent estimated that more than 76 per cent of their patients receive supportive care.

To explore this point further, the survey asked what proportion of nursing time was spent providing supportive care services to patients. Forty-seven percent of staff nurses and supervisors reported that supportive care consumed more than 76 per cent of available nursing time and 40 per cent reported it as between 51 and 75 per cent of nursing time.

From time to time non-nursing duties take these highly trained and valuable professionals away from patient care, reducing the amount of time available for supportive care. The survey asked how much time staff nurses spend on clerical and non-nursing duties, excluding necessary tasks such as documentation of

FIGURE 2 **STAFF NURSING TIME SPENT ON NON-NURSING DUTIES**



47 Respondents	Percentage of staff nursing time spent on non-nursing duties			
	0–25%	26–50%	51–75%	76–100%
Staff nurses (n=25)	15	7	2	1
Supervisors (n=22)	11	8	2	1
Large cancer centres (n=31)	20	9	1	1
Smaller cancer centres (n=16)	6	6	3	1

nursing processes and self-education. The results are shown in Figure 2. A significant minority, 47 per cent of all respondents, estimate more than one quarter of staff nursing time is lost to non-nursing duties. The more detailed breakdown showed 13 per cent believe more than half of available staff nursing time goes to non-nursing duties.

When staff nurses were asked what these non-nursing duties would entail, the tasks included clinic upkeep and cleaning as well as clerical work for the clinic and individual physicians.

DISCUSSION AND CONCLUSIONS

Although the individuals surveyed for this report largely believe their clinics have adopted Primary Nursing, the test questions inserted to explore the elements in place lead to a somewhat different conclusion. The responses shown in Tables 1, 2, and 3 indicate a widespread lack of follow-up to ensure that nursing plans were carried out and the results evaluated. It appears that Primary Nursing may be an operational title rather than a descriptor of roles and responsibilities. In addition, the diminutive involvement of nurses in follow-up and evaluating outcomes of the services they have designed and delivered – notably in large cancer centres – may be viewed as a sign of organizational confusion.

The amount of time lost to clerical and non-nursing duties is similarly disturbing, as it underlines a lack of professional control over the nurses' responsibilities to patients. It can be estimated from a perusal of the data in Figure 2 that, in the aggregate, almost one third of oncology nurses' time is spent on non-nursing tasks – a high rate of time squandered to the detriment of cancer patients.

Health system managers would do well to recall the old adage "nurses should nurse and clerks should clerk." If nurses were able to practice to the full scope of their profession, patient care would improve and no doubt money would be saved by avoiding any further deterioration of the patients' health. The barriers to full adoption of Primary Nursing in cancer clinics could be a combination of organizational and attitudinal factors. Given the increasing strains on the cancer system, the appropriate use of professional resources is overdue.

RECOMMENDATIONS

Follow-up is an integral part of supportive care, along with assessment of patient outcomes and evaluation of care processes. Primary Nursing is impeded without these elements. Cancer centres should identify and remove the barriers to a fully implemented Primary Nursing model of care.

Nurses have a legitimate role in referring patients to supportive care services, in effect navigating patients through the bewildering silos they have to traverse. Failure to maximize this role undermines the goal of

seamless, timely and efficient cancer care.

Nurses must be relieved of the many extraneous tasks that abound in a clinic so their professional time is applied to nursing patients. This fundamental principle needs active support from cancer agencies, clinic managers and physicians. In lieu of the time lost to non-nursing duties, cancer clinics should be organized so that one day of nurses' time per week (in-shift time) is dedicated to patient navigation.

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