Nurses' Reports of Psychiatric Complications in Patients With Cancer

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Increasing acuity of hospitalized patients with cancer has placed greater and more diverse demands on nurses. This is especially true in relation to the management of psychiatric problems that require added time and skills. This study surveyed all nurses (n = 100) working on 15 inpatient units in a 565-bed cancer research hospital on one day regarding psychiatric problems present in 475 patients under their care. Nurses reported that significantly more patients exhibited symptoms requiring psychiatric consultation than did not. Results also indicate that patients who were acutely ill and in need of intensive nursing care had significantly more psychiatric symptoms than patients with low acuity illness. The most prevalent symptoms were depression and/or anxiety and delirium. Nurses who must care for an increasingly ill population with more severe psychiatric symptoms need additional education to manage these problems. Study findings led to increased availability of nurse-to-nurse consultations as well as establishment of a task force to develop a psychosocial teaching manual. (*Oncology Nursing Forum*, Vol. 17, No. 3, pp. 347–353, 1990.)

In recent years, there have been numerous changes in the characteristics of hospitalized patients with cancer. Patients are hospitalized for shorter periods, are more acutely ill, and receive increasingly aggressive treatments in advanced technological settings.[1] According to Paulen, "Patients who remain hospitalized are acutely ill and hospitals in major cities are becoming huge intensive care units." (page 37).[2] A nursing shortage has occurred concurrently with rising acuity of illness in hospitalized patients. It is partly because hospitalized patients require more intensive and sophisticated care that the demand for staff nurses has increased.[3]

It is well-established that psychiatric problems are most prevalent in the seriously ill.[4–8] Unfortunately, the nursing shortage and rising acuity have resulted in less time in which to give adequate psychosocial nursing care. Oncology nurses, placing a high value on their ability to support patients and families through the stresses of cancer, reported to the authors that they often experience limited time to attend to patients' emotional issues because of the need to attend to more pressing medical problems.

For more than a decade the psychiatric care of patients with cancer has been a focus at Memorial Sloan-Kettering Cancer Center. Clinicians on the psychiatry service consult on approximately 10% of new hospital admissions and provide ongoing follow-up. Two experienced psychiatric nurse clinicians provide direct patient consultation to an additional 10% of new admissions in conjunction with nurse-to-nurse consultation regarding the emotional care of patients with cancer. In addition to direct patient services, the psychiatric nurse clinicians lead nursing support groups, provide seminars for new nurses about the psychological needs of patients and their families, and offer empathic support and guidance for nurses giving primary care.

Despite comprehensive attention to psychosocial issues, consultation requests made by nurses to the psychiatric nurse clinicians have continued to escalate over the past three years. Nurses report that the number of patients displaying behavioral problems, adjustment reactions to illness, and psychiatric syn-

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dromes has been rising steadily. In addition, they report a frequent inability to manage the psychiatric complications observed in patients and, as a result, are subject to feelings associated with low morale and decreased job satisfaction. The limited number of psychiatric nurses are receiving increased requests to provide more nursing groups, seminars, and direct patient care.

Based on the increased demand for psychiatric assistance, a hospitalwide assessment of nurses' reports of patients' psychiatric complications was performed to determine the nature, frequency, and severity of psychiatric symptoms as nurses reported them on a single day. Specifically, the researchers wanted to know how many patients:

- exhibited psychiatric symptoms,
- had a psychiatric history,
- were being seen by psychiatric consultants,
- required psychopharmacologic treatment,
- required special nursing observation for suicidal thinking or agitated behavior, and
- had psychiatric symptoms related to acuity of illness.

We believed that answers to these questions would better enable us to consider the effectiveness of existing educational and support programs for nurses and to develop programmatic changes.

Method

The authors developed a questionnaire asking nurses about the psychiatric complications of patients under their care. The survey was conducted on the 15 inpatient units of a cancer research hospital that includes medicine (4 units), surgery (7 units), neurology (1 unit), pediatrics (1 unit), and critical care (2 units, including the bone marrow transplantation unit and the special care area). All nurses working the day shift on all 15 units were asked to provide specific psychosocial information on all the patients they were caring for on a single day.

Subjects: Questionnaires were completed and returned by 100% (n = 100) of nurses working the day shift (98 women, 2 men). There were 28 nurses working in medicine, 47 in surgery, 7 in neurology, 7 in pediatrics, and 11 in critical care.

The mean age of nurses was 28 years (range, 23–54). The ages of nurses working in medicine ($\bar{x}$ = 30.5), surgery ($\bar{x}$ = 28), critical care ($\bar{x}$ = 29.6), and neurology ($\bar{x}$ = 32.3) were quite similar. The mean age of the pediatric staff ($\bar{x}$ = 25) was considerably younger than that of nurses working in other areas of the hospital, representing a recent turnover of staff and the hiring of several new graduates.

Mean number of years' experience in nursing was 6.2 years (range, 6 months–33 years), and mean years' experience on units was 3. Nurses working in neurology had the most experience and had worked on their service for the longest amount of time; pediatric staff had the least amount of experience and time on their unit.

The mean number of patients assigned to each nurse on the day of the survey was 4 (range, 1–8). The critical care nurses had a nurse/patient ratio of 1–1.5 nurses/1 patient; nurses in medicine and surgery cared for 5–8 patients.

Procedure: A pilot questionnaire was tested on one inpatient unit. The pilot indicated a need to educate staff about the use of the form and definition of psychosocial terms. The need for a psychiatric resource person also was identified so that questions and problems could be addressed quickly and accurately. Prior to distributing the final questionnaires, the psychiatric nurse clinicians met with all staff nurses to provide needed training.

The final questionnaires were distributed by a psychiatric nurse clinician, psychiatrist, or psychiatry fellow available to provide assistance throughout the day. All nurses working the day shift were instructed to complete the forms on all of the patients assigned to them on the day of the survey and to return completed forms at the end of the shift. Nurses were given a choice regarding completion of the questionnaire, but all readily complied. Many nurses felt committed to the project because they believed that their reports would lead to increased assistance with management of patients' psychosocial problems.

Instrument: The questionnaire was designed to obtain information on specific psychiatric complications encountered by nurses when providing patient care. In addition to personal demographic data, nurses were asked to give specific patient information: medical diagnosis, stage of illness, psychiatric history, and current psychiatric symptoms and/or problem behaviors exhibited by each patient. Nurses were instructed to check off a psychiatric symptom(s) on the questionnaire only if they felt that the patient required psychiatric consultation for treatment of that symptom(s).

Twenty-five psychiatric symptoms or problems were listed on the survey form. The symptoms listed were generated from a log of problems identified when psychiatric nurse consultations were requested during the previous year (see Figure 1). Symptoms were listed on the questionnaire so that they could be easily grouped into diagnostic categories following data collection. The categories were: depression, anxiety, mixed depression and anxiety, delirium, eating problems complicated by emotional factors, behavioral problems, and family problems. Inclusion of an individual symptom into one of the seven categories was determined prior to distribution of questionnaires. Diagnostic groupings were made following agreement by three psychiatry service clinical staff members regarding categorical assignment and were based on a review of the Diagnostic and Statistical Manual of Mental Disorders III (DSM-III), which contains diagnostic criteria for psychiatric disorders. Although the grouping of individual symptoms into diagnostic categories was in no way meant to achieve diagnostic accuracy, the investigators believed that this method would provide information regarding the nature and severity of psychiatric problems that could be approximated by the number of individual symptoms included in each diagnostic group.