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Cancer patient and clinician acceptability and feasibility of a supportive care screening and referral process

Eli Ristevski BHlthSci (Hons) PhD,* Melanie Regan RN BHlthSc GradDip Cancer Care MN,*†
Rebecca Jones BA (Hons) MA PhD,*‡ Sibilah Breen BSc (Hons) PhD,§
Angela Batson BBus¶ and Matthew R. McGrail BSc (Hons) GradDipIT PhD**

*Research Fellow, Department of Rural and Indigenous Health, Faculty of Medicine, Nursing and Health Sciences, Monash University, Melbourne, Vic., †Regional Cancer Nurse Coordinator, Gippsland Regional Integrated Cancer Services, Latrobe Regional Hospital, Traralgon, Vic., ‡DECRA Postdoctoral Fellow, School of History, College of Arts and Social Sciences, Australian National University, Canberra, ACT, §Supportive Care Coordinator, Gippsland Regional Integrated Cancer Services, Latrobe Regional Hospital, Traralgon, Vic., ¶Research Assistant, Loddon Mallee Integrated Cancer Services, Bendigo, Vic., and **Research Fellow, Gippsland Medical School, School of Rural Health, Monash University, Churchill, Vic., Australia

Correspondence
Eli Ristevski
BHlthSci (Hons) PhD
Research Fellow
Department of Rural and Indigenous Health
Monash University
PO Box 973
Moe
Vic.
Australia
E-mail: eli.ristevski@.monash.edu

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Abstract

Background Incorporating supportive care into routine cancer care is an increasing priority for the multi-disciplinary team with growing evidence of its importance to patient-centred care. How to design and deliver a process which is appropriate for patients, clinicians and health services in rural areas needs further investigation.

Objective To (i) examine the patient and clinician acceptability and feasibility of incorporating a supportive care screening and referral process into routine cancer care in a rural setting, and (ii) explore any potential influences of patient variables on the acceptability of the process.

Methods A total of 154 cancer patients and 36 cancer clinicians across two rural areas of Victoria, Australia participated. During treatment visits, patients and clinicians participated in a supportive care process involving screening, discussion of problems, and provision of information and referrals. Structured questionnaires with open and closed questions were used to measure patient and clinician acceptability and feasibility.

Results Patients and clinicians found the supportive care process highly acceptable. Screening identified relevant patient problems (90%) and problems that may not have otherwise been identified (83%). The patient–clinician discussion helped patients realize help was available (87%) and enhanced clinician–patient rapport (72%). Patients received useful referrals to services (76%). Feasibility issues included timing of screening for newly diagnosed patients, privacy in discussing problems, clinician time and availability of referral options. No patient demographic or disease factors influenced acceptability or feasibility.

Conclusions Patients and clinicians reported high acceptability for the supportive care process, although mechanisms for incorporating the process into health care need to be further developed.

Introduction

Supportive care aims to prevent, reduce and alleviate the symptoms of treatment, enhance communication between patients and clinicians and assist patients and their family to manage the social, physical, emotional, spiritual and information needs associated with the diagnosis and treatment of cancer.[1] Screening patients for unmet supportive care needs has been associated with better patient health outcomes, improved quality and efficiency in service delivery, and planning and decreased costs and usage of the health-care system.[2–5] Screening has also been found to enhance patient satisfaction with care,[6,7] and to encourage greater involvement in the care process, for example, by increasing participation in decision making.[8]

While the need for routine supportive care screening and referral is acknowledged, several studies show patients' supportive care needs are not adequately identified in the clinical setting.[9–11] At the patient level, patients are often tentative to raise issues with clinicians, while clinicians defer to patients to initiate discussion about their supportive care needs.[12,13] Although clinicians recognize that screening for the need of supportive care services is important, the use of validated screening tools is low, with many indicating that they prefer to rely on their own clinical skills and knowledge.[14–16] Clinicians' attitudes, beliefs and expectations regarding supportive care and training and educational needs have also been found to impact on implementation into clinical care. At an organizational level, issues such as time, resources, peer support and support from managers and hospital administrators have been identified as important influences on the implementation of supportive care.[17–21] For health services and clinicians in rural areas, shortages in service availability and the health workforce will also influence how and where supportive care is implemented.[22]

With growing recognition that supportive care is an integral part of the cancer patients' treatment pathway, the issue of how to successfully embed these processes into routine cancer care requires further investigation.[23,24] In Victoria, Australia, the Victorian Government has set targets for patient supportive care screening and clinician training. Guided by the Victorian Cancer Action Plan (VCAP), health services in Victoria will be required to show evidence of how they have responded to implementing the VCAP targets into routine cancer care.[25]

In response to the VCAP targets, the researchers, in partnership with staff from the Integrated Cancer Services network, developed a supportive care screening, information and referral process and resource kit to guide the implementation of supportive care into clinical practice. Previous piloting of the supportive care process and resource kit in the chemotherapy and radiotherapy units of one treatment facility indicated a high level of patient and clinician acceptability.[21,26] The literature to date is also lacking in data on the feasibility of implementing screening and referral process across different clinical service models and clinical care settings (e.g. acute, ambulatory, community). The majority of published studies have also been limited to single clinical sites with only one study published in Australian in a rural setting.[27] This study examines patient and clinician acceptability and feasibility of implementing a supportive care screening and referral process across a wide range of clinical settings, service models and geographical locations in Australia. As little is known about implementing supportive care within rural health services, it was important to establish that the design and the delivery of the supportive care process were appropriate and applicable to patients and clinicians within these population and geographical settings. This study also seeks to extend the findings of previous studies by exploring any potential influences of patient disease or demographic variables on the acceptability of the screening and referral process.

Methods

The Supportive Care Resource Kit

To enable the supportive care process, the authors developed the Supportive Care Resource Kit (SCR Kit). This resource provided health-care professionals with the tools and resources required to complete the supportive care process. A multi-disciplinary advisory group of 22 health-care professionals involved in cancer care were involved in selecting the screening tools and reviewing the referral protocols. A detailed description of the SCR Kit is described in Breen *et al.*[26] In summary the SCR Kit contains:

1. Screening tools: The Distress Thermometer and Problem List [28] was chosen as the primary screening instrument. Members of the advisory group recommended the use of a secondary screening tool for patients who scored ≥ 4 on the Distress Thermometer to increase the specificity of screening for distress. The Kessler Psychological Distress Scale (K10) [29] was recommended as it is widely used in the primary care setting and in hospital discharge planning in Australia. This two-stage system also ensured the minimizing of inappropriate and unnecessary referrals to limited psycho-oncology services.
2. Evidence-based referral protocols: The referral protocols were based on current Australian psychosocial guidelines for the care of cancer patients [30] and were examined by the advisory group to ensure local and clinical relevance.
3. A Supportive Care Service Directory: The service directory contained information on the supportive care practitioners and services in each region.
4. A training module: The training included a theoretical overview of the principles of supportive care, how to use the screening tools, referral protocols and service directory, and steps in documenting the episode of care.
5. Resources: A patient notes sheet was designed to record any information and/or referrals given to patients during their discussions with their clinician. A clinician action and referral checklist were developed for clinicians to keep a record of their discussion with the patient. A number of brochures for local services were included as well as patient information booklets. Clinicians could also add their own resources for local services.

Setting and participants

The study was conducted in two rural areas in Victoria, Australia; Gippsland (located in South East Victoria) and Loddon Mallee (located in North West Victoria). Distance to the nearest capital city from these areas ranged between 80 and 475 km. A convenience sample of cancer patients and clinicians was recruited from five chemotherapy, two radiotherapy and three surgical units over a period of 7 months. Patient eligibility criteria included a confirmed diagnosis of cancer (invasive or in situ), from any tumour type and at any disease stage, aged 18 years and over, able to read English and give informed consent, and were receiving treatment in a participating unit. Clinician eligibility criteria included practising as a qualified nurse or allied health professional in a participating unit, able to give informed consent and considered by their unit manager as a person who would be involved in providing supportive care as part of their routine work. The study was approved by Human Research Ethics Committees at Monash University and three regional hospitals. All participants were given an information and consent form to read and sign prior to their participation in the study.

Intervention implementation

Prior to the study, clinicians completed the training workshop. Patients were identified at the participating sites and recruited for the study by the researchers. During their treatment visit, the researchers gave each patient a copy of the primary screening tool (the Distress Thermometer and Problem List) to complete. A trained clinician then reviewed the tool and the patient and clinician participated in a screening discussion. This discussion occurred either on the day of the treatment visit or prior to the patient's next appointment. During this discussion, the clinician reviewed and clarified the problems identified on the screening tool, determined if the patient needed to complete a further assessment for psychological problems using the K10 and provided the patient with information and, if necessary, referrals based on the protocols outlined in the SCR Kit. Clinicians then documented the outcomes of the discussion.

Acceptability questionnaires

Three days after the patient–clinician discussion, patients were contacted by telephone to complete a patient acceptability questionnaire about the supportive care process. At the end of the participant recruitment period, clinicians were contacted by telephone or in person to complete the clinician acceptability questionnaire. The data collection tools were piloted in a previous study.[26]

Patient acceptability questionnaire

The patient acceptability questionnaire was a 31-item questionnaire examining patients' experiences of (i) screening, (ii) patient-clinician discussion, and (iii) information provision and referrals. Patients were asked to rate their agreement with statements on a five-point Likert scale ranging from 1 – 'Strongly Agree', 2 – 'Agree', 3 – 'Unsure', 4 – 'Disagree' and 5 – 'Strongly Disagree'. Example statements included "Completing the tool helped me communicate my needs", "I appreciated the opportunity to talk" and "Happy to complete tool again in future". Two questions asked for numeric answers;time to complete screening tool and number of referrals given, and four open-ended questions related to patient use of referrals or information given by the clinicians. Patients were also invited to make any other comments about the process.

Clinician acceptability questionnaire

The clinician acceptability questionnaire was a 33-item questionnaire which contained questions about the clinician's experience of (i) screening, (ii) patient–clinician discussion, and (ii) use of the referral protocols, service directory and SCR Kit, and feedback on the training. Clinicians were asked to rate their agreement with statements on a five-point Likert scale ranging from 1 – 'Strongly Agree', 2 – 'Agree', 3 – 'Unsure', 4 – 'Disagree' and 5 – 'Strongly Disagree'. Example statements included "Tool helped patients to communicate their needs to me" and "Happy to administer tool to future patients". Three questions asked for numeric answers; number of patients screened, number of patients completing the discussion and average time taken for the discussion. One open-ended question asked for overall comments about the screening and referral process being trialled and ways in which it could be improved.

Additional comments made by patients and clinicians to each of the questions were written down verbatim by the researchers.

Data measures and analyses

Participant agreement (acceptability) was measured using a five point scale, which were collapsed for presentation into three categories: 'Strongly agree' and 'agree' were combined, 'unsure' responses remained as is, and 'disagree' and 'strongly disagree' were also combined. Unsure responses were regarded as missing values for bivariate and multivariate analyses. Seven key patient demographic characteristics were assessed for differences of agreement: age (<60, 60–74, 75+), marital status (married/partnered, not partnered), gender (male, female), cancer stage (early/local, metastatic), type of treatment (chemotherapy, radiotherapy or surgery), employment status (employed, not employed) and place of residence (Inner Regional, Outer Regional) (based on Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).[31] The ASGC-RA is a geographical classification system used by the Australian Government to describe 'remoteness' (distance) of a location from larger urban centres. Fisher's exact test was used to test bivariate differences of agreement between patient demographics and each agreement statement, whilst multivariate logistic regression models were additionally tested for significant associations. All calculations were performed using IBM SPSS Statistics 19 (IBM, Armonk, NY, USA) with a smaller significance level of 1% chosen due to the multiple statistical tests undertaken. No clinician sub-groups analysis was conducted due to the low number of participants and only one possible sub-group comparison (department of work). Besides gender, no other data were collected on clinician demographics.

Taylor & Bogdan's [32] three phased approach to thematic analysis was used to analyse the open-ended responses. Phase one (*discovery*) involved identifying preliminary themes. To do this, two researchers (ER, RJ) read through the responses to the open-ended questions, looking at the individual words and phrases used by participants in response to each of the questions. The responses to each question were group for similarities and differences, and the emerging patterns in the themes were identified. At this stage the concepts were based on the participants' own words as well as the researcher's theoretical interpretation of the data. In phase two (*coding*), the themes were further refined by three researchers (ER, RJ and MR) looking at relationships, making comparisons and noting counter occurrences (or negative cases) within and between the themes. These themes were compared for similarities and differences, then condensed or expanded. The data were scrutinized until no new themes or 'negative' cases emerged (i.e. data saturation). The data were also presented at a scientific conference; this process provided peer feedback as part of the member checking process. The final phase (*discounting*) involved looking for variation and anomalies in the data, addressing issues of analytical rigour. As data collection and analysis involved multiple researchers, this stage of the analysis involved the three researchers (ER, RJ and MR) examining and discussing their own roles in the data collection and analysis, and identifying any personal or professional bias in developing the themes (reflexivity). This process ensured the final themes provided a holistic picture of the research study and the quotations were not skewed. The final themes were also compared within the context of the broader research literature.

Results

Of the 170 patients who approached about the study, 159 consented to participate (RR = 93%). An additional five patients could not be contacted at the data collection point to complete the questionnaire. Patient demographics are represented in Table 1. Patients were recruited from a range of tumour types with the majority from colorectal, breast, genito-urinary, haematological and lung cancers. Half of the patients were undergoing chemotherapy treatment, with a large majority being aged over 60 years, married and not in employment. A total of 36 clinicians were invited to participate in the study, with all agreeing to participate (RR = 100%). Participating clinicians were chiefly nurses (89%), all were female, and on average, undertook the supportive care screening process with four patients each (Table 1).

Screening

Overall, patients and clinicians found the screening process to be highly acceptable (Table 2). They found the screening tool highly relevant, beneficial in identifying patient issues and facilitating communication of problems. Twenty-one percent of patients needed assistance in completing the screening tool. While the majority of patients and clinicians indicated the tool assisted in communicating needs, 22% of patients and 20% of clinicians

Table 1 Participant profile

	n	%
Patients (*n* = 154)		
Gender		
Female	83	54
Male	71	46
Age		
<60	41	27
60–74	67	44
75+	45	29
Marital status		
Married/partnered	107	70
Not partnered/Single/separated/widowed	46	30
Employed status		
Employed (including. sick/unpaid leave)	37	24
Not employed	117	76
Place of residence (ASGC-RA)		
Inner Regional	119	77
Outer regional	35	23
Cancer stage		
Early/local	85	61
Metastatic	55	39
Type of treatment		
Chemotherapy	77	50
Radiotherapy	40	26
Surgery	37	24
Type of cancer		
Colorectal	53	34
Breast	39	25
Genito-urinary	19	12
Haematological	13	9
Lung	12	8
Other	18	12
Clinicians (*n* = 36)		
Gender		
Female	36	100
Male	0	0
Clinician disciplines		
Chemotherapy nurse	17	47
Nurse Cancer Care Coordinator	2	6
Ward nurse	11	30
Social Worker	1	3
Radiation therapist	3	8
Radiotherapy nurse	2	6

ASGC-RA – Australian Standard Geographical Classification – Remoteness Areas.

were unsure or disagreed about improved communication. Although 91% of patients indicated they would repeat screening in future care, 28% of clinicians said they were unsure or disagreed with administering the tool to patients as part of routine care.

Table 2 Screening

	Strongly agree & agree (%)	Unsure (%)	Strongly disagree & disagree (%)
Patients (*n* = 154)			
The tool covered issues relevant to me	90	5	5
Completing the tool helped me communicate my needs	78	11	11
Needed help to complete the tool	21	1	78
Liked to complete the tool in a more private location	4	1	95
Happy to complete tool again in future	91	5	5
Clinicians (*n* = 36)			
The tool quickly identified patient problems	92	3	6
The tool helped me identify problems I may not have otherwise identified	83	6	11
The tool covered issues that I thought were important	100	–	–
Tool helped patients to communicate their needs to me	81	14	6
Happy to administer tool to future patients	72	22	6

Discussion of problems

Patients and clinicians also reported high acceptability for the patient–clinician discussion of problems (Table 3). Patients appreciated the opportunity to talk to the clinician, felt the discussion helped to identify needs, realized help was available when needed and would repeat the discussion as part of future care. Clinicians reported the discussion improved rapport with their patients. Most clinicians would have liked to hold the discussion in a more private location, yet this was supported by only 10% of patients. While both groups indicated they thought the

Table 3 Discussion of problems

	Strongly agree & agree (%)	Unsure (%)	Strongly disagree & disagree (%)
Patients (*n* = 154)			
The length of the discussion was appropriate	100	–	–
I appreciated the opportunity to talk	93	6	1
The discussion helped me identify my needs	87	10	3
The discussion helped me realise there was help available	87	9	4
I would have liked the discussion in a more private location	10	5	85
I would be happy to complete another similar discussion as part of future care	93	3	4
Clinician (*n* = 36)			
The length of the discussion was appropriate	89	6	6
The discussion improved rapport with patients	72	17	11
I would have liked to held the discussion in a more private location	66	3	31

time spent on the discussion was appropriate, perceptions of time differed between the groups. Patients reported a mean discussion time of 17 min (SD = 9.8), while clinicians reported a mean time of 25 min (SD = 10.4).

Information and referrals

Table 4 Information & referrals

	Strongly agree & agree (%)	Unsure (%)	Strongly disagree & disagree (%)
Patients (*n* = 154)			
I received referrals that were useful	76	24	–
I would appreciate opportunity to get similar information/ referrals as part of future care	75	12	12
Clinicians (*n* = 36)			
The types of referrals were appropriate	77	17	6
The number of referral options was helpful	57	37	6

While all patients had their problems discussed, information provision and referrals were much less than discussion of problems (Table 4). Only 47% of patients reported receiving information; either verbal (60%) or written (40%). Twenty-one percent of patients reported being offered a referral, of these 76% reported the referral offered was useful. Overall, 75% of patients supported the opportunity to get similar information and/or referrals as part of future care. Clinicians reported the types of referrals listed in the protocols as appropriate, yet only 57% agreed that the number of options were helpful.

Training and use of Supportive Care Resource Kit

There was high support from clinicians regarding training and using the SCR Kit (Table 5). They reported the amount of training to be appropriate, found the SCR Kit easy to use, the instructions helpful and felt adequately supported to use the Kit. While 77% agreed it was worthwhile to use for future patient care, 36% were unsure or disagreed that the Kit fitted in with patient care. Only 44% of clinicians reported using the service directory. Of these, 69% percentage reported it was easy to use, yet only 43% found it was useful in their discussion with patients.

Table 5 Training, use of service directory & Kit

Clinicians (n = 36)	Strongly agree & agree (%)	Unsure (%)	Strongly disagree & disagree (%)
Comfortable with the amount of training received	94	–	6
The Kit was easy to use	83	3	14
The Kit's instructions were useful	77	17	6
I need more support using the Kit	14	–	86
Future use of the Kit would be worthwhile	77	20	3
Kit fitted in well with patient care	64	25	11
The service directory was easy to use	69	31	–
The service directory was useful in my screening discussions	43	50	7

Bivariate and multivariate analyses

All differences of acceptability of the screening (5 statements), discussion of problems (6 statements), and information and referrals (2 statements) between patient subgroups (age, gender, marital status, cancer stage, type of treatment, employment status and place of residence) were not statistically significant ($P > 0.01$). Both bivariate and multivariate analyses revealed no significant associations between these seven patient characteristics and the 13 acceptability outcome statements. A key explanation for this result is the relatively high acceptability (>90%) across most of the 13 statements.

Implementation and practice issues

Thematic analysis of the open-ended questions provided more insight into the feasibility and practical application of the process. The following themes were identified (Table 6).

Communication and rapport

Patients and clinicians felt the screening and discussion enhanced patient care. Rather than being solely focussed on administering drugs or procedures, the process re-established the focus of care back to the patient The process prompted patients to identify and communicate their needs, allowed them to ask for help and information, not to feel they had to 'soldier on' with problems and to raise issues without having to initiate or prompt a discussion with the clinician. Clinicians felt the process built rapport with patients and encouraged discussion about sensitive issues.

For some patients and clinicians, communication and rapport were not necessarily enhanced, as they felt they already had good communication skills and processes, and an established rapport. Some clinicians also commented that the process reinforced what they already did with patients; 'talking, listening and interviewing'.

When to implement screening

Patients and clinicians in the surgical units commented that the supportive care process should not be introduced too early in the treatment pathway as patients were overwhelmed and felt anxious about starting a new treatment and concentrating on dealing with the physical side effects of the treatment.

Where to discuss problems

Where to conduct the discussion was more of an issue for clinicians than patients, particularly in the chemotherapy units. For clinicians, it was the discussion around issues which were viewed as sensitive, such as sexual problems, which they felt uncomfortable discussing as they felt other patients could overhear. They believed patients might be embarrassed to discuss these in public. However, most patients indicated their willingness to discuss their problems. They recognized that there were no rooms or places in the treatment unit and the clinician did their best to respect their privacy.

Information and referral

The information and referral part of the process raised divided views among patients and clinicians. For some patients, the process

Table 6 Description of patient and clinician themes

Patient quotations	Clinician quotations
Theme: Communication & rapport	
Enhanced care	
This gives opportunity to discuss problems without having to 'put myself out there.' The opportunity comes to the patient rather than the patient having to seek it out which they may not (surgical patient).	Ticking the boxes is something they can do in private, they can say something without having to say it. It requires a one word answer but it makes them think a bit more (chemotherapy nurse).
Did not enhance care	
I am quite an assertive person and don't hesitate to ask a lot of questions so all these things have already been covered. A less assertive person may find it useful to complete a questionnaire then the nurse can initiate a discussion about relevant things (chemotherapy patient).	It was a prompt but I found it interrupted the flow of the conversation and made it unnatural. I felt more comfortable with my own model of discussion (surgical ward nurse).
Theme: When to implement screening	
It was only 2 days after surgery and I was in hospital and feeling groggy and didn't really know what I needed. A few days later would have been better. It was just a bit much so early on to have to do this. I wasn't given any referrals or written information because at this early stage I didn't have any issues (surgical patient).	It would be great to do it 1 month after the treatment commences. Initially they have nausea, anxiety then after they deal with that they will be in a place to take it on board (chemotherapy nurse).
Theme: Where to discuss problems	
The curtain was pulled and I wasn't worried about it. I don't care if anyone else hears (chemotherapy patient). The chemo room is very crowded. It would be better in a private room, but I don't think there is one (chemotherapy patient).	We can't really pry into issues such as diarrhoea, because it is so crowded. I felt uncomfortable talking about sex in a crowded room although they seemed okay about it. I think I felt worse about it than them (chemotherapy nurse).
Theme: Information and referrals	
Enhanced information and referrals	
The nurse wrote a letter to the doctor (regarding blood pressure) who saw me that afternoon. It was excellent (chemotherapy patient).	It made me more aware of the facilities and services available and around here (surgical ward nurse).
Did not enhance information and referrals	
I don't have too many concerns but I think it probably would be for people who aren't dealing with it as well (chemotherapy patient).	I didn't use them much because I already have it in my head. I work in other departments around the hospital so I know what is available and I didn't come across any problems which I didn't know what to do (chemotherapy nurse). They are redundant here. The services here are so limited. We already routinely refer to physio, OT, stomal, etcetera if necessary and we don't really have many of the others, particularly the counsellors, etcetera. So this list didn't really offer anything new (surgical ward nurse).
Theme: Time	
	If we had a lot of time it was okay but it was difficult on our busy days. Discussing the issues was the time consuming bit because patients go off on tangents and it was a bit hard to keep them on track. Even some of the easy ones without many issues liked a chat (chemotherapy nurse).

enabled timely and useful information and referrals, for others it reinforced existing knowledge and information. Some patients commented that they did not have any problems, or they already had adequate information or access to services, however, saw the value that others might gain from this process. For clinicians, some felt that information provision and referral was enhanced, others saw this as an area that was already adequate. Some clinicians felt they already knew about services, referrals and giving information - it was what they already did. It was also noted by some clinicians that they did not use the referral protocols, they used their own personal or clinical knowledge and commented that there were no appropriate services to refer to.

Time

Adequate time to fit the discussion into routine care emerged as a key issue for clinicians. There was a dilemma in not wanting to rush the discussion with patients, yet, clinicians felt stretched when patients identified many problems on the tool, or went off on a tangent, or just wanted to talk. They wanted to do a comprehensive job in reviewing the tool and discussing the patient's problems but felt they were already too busy, there were problems with staffing levels and while they supported the idea in theory, it was not always seen as practical.

Discussion

The findings of this study indicate clinicians and patients across a range of clinical settings found the process of supportive care screening, discussion of problems, and the provision of information and referrals highly acceptable, with both groups reporting numerous benefits for patient care and clinical practice. The process was feasible to implement within a range of clinical settings (chemotherapy, radiotherapy, surgical care) and service models (ambulatory and acute care). In bivariate analysis, patient demographic or disease factors were not found to influence acceptability or feasibility of the supportive care process. Clinicians felt adequately supported with the training they received and found the SCR Kit contained the necessary tools to undertake the supportive care process. Clinicians also saw that there were some aspects of the design and delivery of the process which needed to be improved to increase the feasibility of incorporating the process into routine care. The findings of this study also need to be viewed within the context of a limited sample of cancer patients and clinicians in Australia.

Overall, there was high acceptability from patients and clinicians of the screening and discussion process. Screening and discussion assisted in identifying patient problems, initiating discussion, enhancing communication and rapport, and encouraging patients and clinicians to discuss problems and concerns which they may have otherwise been hesitant to do so. Similar benefits have been found in studies by Velikova *et al.*,[4] Zachariae,[7] Arora [33] and Arving *et al.*[34] The screening and discussion process also assisted both groups to have a more focussed identification of needs and actions. This is supported in a number of studies which have found asking the right questions, taking a positive approach to communication of psychosocial issues and encouraging open communication increases patients' willingness to discuss and disclose concerns to help clinicians provide focussed solutions to unmet needs.[12,33,35–37] For those patients and clinicians who did not feel the screening process enhanced communication, they commented that they already had good communication avenues, rapport and skills.

Three key feasibility issues emerged from the study: when to undertake screening, where to discuss problems and time for discussion. Surgical patients and clinicians raised issues of implementation of screening in newly diagnosed patients. This finding is of interest as current guidelines specify that this is a particularly important time for patients to be screened,[25,28,38] and VCAP targets for screening have been set for newly diagnosed patients. Yet, Jacobson [39] argues that the case for "when, for what, and for whom" screening is beneficial and is still limited by the empirical evidence currently available. Where to conduct the discussion and lack of privacy were considerably a higher concern for clinicians than patients. Overcoming the lack of private space was logistically difficult, especially in the shared spaces such as the chemotherapy unit or shared rooms on the ward; drawing the dividing curtain was the most practical means of creating privacy. While studies of patient–clinician communication identify walled cubicles and private rooms to achieve greater privacy, studies also report that patients still report satisfaction with their care, confidentiality of their information, trust in the staff and feel respect for privacy by staff when only a dividing curtain existed.[40–43] Time to conduct the discussion emerged as a third feasibility issue, particularly for clinicians. Clinicians wanted to spend the time with their patients but felt their current workload was already stretched. This finding is also reported in other studies of cancer supportive care.[15,17,18,44] Changing roles in nursing practice have seen greater emphasis on symptom management and less time for dealing with patients' psychosocial needs, a conflict in practice faced by many nurses.[19,45]

Finally, there were mixed views on acceptability and feasibility between patients and clinicians on the information and referral process. Whilst only 47% of patients reported formally receiving written or verbal information, there was high acceptability from patients that they would like to receive similar information and/or referrals as part of future care. For clinicians, while there was support that the information and referrals listed in the SCR Kit were appropriate, there were questions about the feasibility of using and following the suggested information and referral pathways.

Some clinicians perceived their existing processes and clinical knowledge to be adequate. Others wanted more referral options to be listed, particularly, the referral sources they usually refer to. Belief in the lack of services was particularly an issue when the referral options were available in the community rather than the acute health service, suggesting either a lack of knowledge of community services, a lack of co-ordination between acute and community based services and perhaps poor use of the service directory. It is unclear whether accessing referrals is specific to the rural health services which participated in the study, as shortage of, and access to, cancer services is an issue for people in rural areas,[22] or whether it was a change management issue.

This study is limited by its use of a small sample size and convenience sample, patients that agreed to participate may have been more open to investigating and discussing supportive care needs and clinicians may have been more open to investigating and discussing supportive care needs of patients, or changes in practice. The study findings might also have been different with the inclusion of other types of clinicians, for example medical specialists such as oncologists and radiologist, and allied health professionals. Ideally, initial training should be accompanied by reinforcement and assessment of skills accompanied by feedback and support. Actual discussion times were not recorded and therefore were based on perceived time. The patient bivariate and multivariate analysis might also be underpowered to detect significant differences between patient groups; especially as there was high agreement across most items. Also patients with metastatic disease with a shorter survival time were not compared with patients with a longer survival time. However, the study was only designed to be descriptive and aimed to examine patient and clinician perspectives on the first phase of implementing a new process.

Conclusion

This study interrogated the acceptability and feasibility of incorporating a supportive care process into routine care for both clinicians and patients. Overall, patients and clinicians supported the supportive care process. Exploring ways to incorporate supportive care into routine cancer care must seek and acknowledge the reality of both patient and clinical experience. Future work needs to be undertaken to accurately assess the impact of time on clinical practice and to quantify extra resources which may be required to implement supportive care screening. Where to conduct screening and discussion of patient problems also needs further investigation, as this was a considerably higher feasibility issue for clinicians and patients. This study also suggests that additional research needs to be undertaken to determine at what stage the initial screening should take place. While more work needs to be carried out in developing ways to integrate supportive care into stretched health-care systems, this study has begun this process by openly discussing its acceptability and feasibility with patients and clinicians. A further step to implementation will be testing proof of efficacy by measuring patient outcomes in a future study.

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Conflict of interest

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