

Symptom Assessment in Hospitalized Older Palliative Patients With Cancer: Agreement Among Patients, Nurses, and Proxies

Aurélie Van Lancker, MSc, RN, Stephanie Cypers, MSc, RN, Elke Vanwynsberghe, MSc, RN, Sofie Verhaeghe, PhD, RN, Ann Van Hecke, PhD, RN, and Dimitri Beeckman, PhD, RN

Palliative care is defined as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (World Health Organization [WHO], 2002, pp. 15–16). Cancer remains one of the leading causes of death (Ferlay et al., 2010); therefore, patients with cancer represent an important proportion of the patients in the palliative care setting.

Palliative patients with cancer suffer from multiple symptoms and, at times, with high prevalence (Teunissen et al., 2007; Van Lancker et al., 2014). Subsequently, symptom management is seen as the most important aspect of palliative care (WHO, 2002). This requires adequate symptom assessment, which allows identification of symptoms in multiple domains, such as physical, psychological, social, functional, and existential (WHO, 2002). Like palliative care, care of older adults requires a multifaceted approach. Older adults often are confronted with comorbidities, polypharmacy, functional decline, cognitive problems, and loss of homeostatic reserve, which can result in symptoms in multiple domains (Depp & Jeste, 2006; Marengoni et al., 2011). Adequate symptom assessment is essential to be able to implement appropriate interventions to control symptoms.

Patient self-reported symptoms are seen as the gold standard in symptom assessment (Pautex, Berger, Chatelain, Herrmann, & Zulian, 2003). However, patients are not always able to report their symptoms because of a variety of reasons that are particularly relevant for older adult patients in palliative care (Kaye, Baluch, & Scott, 2010). Patients are, for instance, not able to report their symptoms if they experience cognitive problems, confusion, and weakness (Kaye et al., 2010;

Purpose/Objectives: To evaluate the level of agreement of symptom assessment among older adult palliative patients with cancer, nurses, and patients' proxies.

Design: A cross-sectional study.

Setting: Two general hospitals in Flanders, Belgium.

Sample: 120 palliative patients with cancer, aged 65 years and older.

Methods: A validated 36-item instrument developed to assess physical, psychological, functional, social, and existential symptoms in older palliative patients with cancer was independently completed by patients, the nurses, and proxies.

Main Research Variables: Frequency and intensity of 36 symptoms.

Findings: The study indicates that nurses and proxies tend to underestimate physical and social symptoms and overestimate psychological, functional, and existential symptoms. Agreement scores between patients and nurses and patients and proxies were only significantly different in 39% and 20% of the cases, respectively. Higher intraclass correlation coefficients were measured between patients and proxies compared to patients and nurses. Agreement was associated with demographic and clinical factors, such as gender and prognosis.

Conclusions: This study indicates discrepancies among patient, nurse, and proxy in the assessment of symptoms.

Implications for Nursing: Patients should be encouraged to report their true experiences. Nurses and proxies should be taught to recognize and assess symptoms and to communicate about them with patients.

Key Words: signs and symptoms; palliative care; symptom assessment; neoplasms

ONF, 42(2), E73–E90. doi: 10.1188/15.ONF.E73-E90

Nekolaichuk et al., 1999). For those patients, symptoms can only be assessed indirectly or estimated by a formal (nurse and physician) or informal (proxy) caregiver. The validity and reliability of those assessments are