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AN AUDIT CYCLE TO EVALUATE AND IMPROVE THE DOCUMENTATION OF PSYCHOSOCIAL DISTRESS AMONG PALLIATIVE CARE PATIENTS AT A TERTIARY CANCER CENTRE.

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Abstract

Background: Psychosocial distress is highly prevalent among patients receiving palliative care and significantly influences quality of life, treatment adherence, and overall patient outcomes. Although routine distress screening is recommended by the National Comprehensive Cancer Network (NCCN), documentation of psychosocial distress remains inconsistent in routine clinical practice. Clinical audit is an effective quality improvement strategy for identifying deficiencies and improving healthcare practices. ***Aim:*** To evaluate and improve the documentation of psychosocial distress among palliative care patients admitted to a tertiary cancer centre through an audit cycle. ***Objectives:*** To assess baseline documentation of psychosocial distress using a structured audit checklist; to implement an audit-based quality improvement intervention; and to compare documentation practices before and after the intervention. ***Materials and Methods:*** An audit-based interventional quality improvement study was conducted among 80 palliative care inpatients admitted to the Department of Palliative Medicine, Kidwai Memorial Institute of Oncology, Bengaluru, over a period of six months. Baseline documentation was assessed in 40 patient records using a structured audit checklist based on the NCCN Distress Thermometer. A quality improvement intervention including staff sensitization, standardized documentation forms, visual reminders, and regular audit-feedback sessions was implemented. A post-intervention audit was subsequently conducted in another 40 patient records. Data were analysed using descriptive and inferential statistics, with $p<0.05$ considered statistically significant. ***Results:*** The mean age of participants was 54.7±12.9 years, and 83.8% had advanced or metastatic cancer. Clinically significant distress (Distress Thermometer score ≥4) was observed in 78.8% of patients. Baseline documentation of psychosocial distress was poor, with only 32.5% of records documenting psychosocial distress and 22.5% documenting Distress Thermometer scores. Following implementation of the audit intervention, complete documentation increased to 82.5%. Documentation of psychosocial distress improved from 32.5% to 85.0%, Distress Thermometer scores from 22.5% to 82.5%, emotional concerns from 27.5% to 77.5%, practical/social concerns from 20.0% to 75.0%, family concerns from 17.5% to 72.5%, spiritual concerns from 15.0% to 67.5%, and referral/action plans from 10.0% to 60.0% (all $p<0.001$). ***Conclusion:*** The audit cycle significantly improved documentation of psychosocial distress among palliative care patients. Incorporating structured distress screening tools, continuous staff education, and regular audit-feedback mechanisms into routine clinical practice can substantially enhance comprehensive psychosocial assessment and promote holistic palliative care.

Keywords: Psychosocial distress. Distress Thermometer. Clinical audit.

INTRODUCTION

Palliative care is a multidisciplinary approach that aims to improve the quality of life of patients and their families facing life-limiting illnesses through the prevention and relief of suffering. According to the World Health Organization (WHO), palliative care addresses not only physical symptoms but also psychological, social, and spiritual problems through early identification, comprehensive assessment, and appropriate management. Among patients with advanced cancer, psychosocial distress is a common but frequently under-recognized problem that significantly affects quality of life, treatment adherence, symptom burden, decision-making, and overall patient outcomes. Distress may arise from emotional,

social, financial, family-related, or spiritual concerns and can occur at any stage of the disease trajectory. Early identification and appropriate intervention are therefore considered essential components of comprehensive palliative care.[1]

The concept of "Total Pain," introduced by Dame Cicely Saunders, revolutionized palliative medicine by emphasizing that suffering is multidimensional, encompassing physical, psychological, social, and spiritual domains. Failure to recognize these components may result in inadequate symptom control and reduced patient satisfaction. Psychosocial distress often manifests as anxiety, depression, fear, uncertainty, social isolation, caregiver burden, financial stress, and existential concerns. These problems frequently coexist with physical symptoms, making systematic assessment an indispensable part of holistic cancer care.[2]

Recognizing the importance of distress screening, the National Comprehensive Cancer Network (NCCN) introduced the Distress Thermometer (DT) as a rapid, validated screening instrument for identifying psychosocial distress in cancer patients. The Distress Thermometer is a simple self-report tool using a numerical rating scale from 0 to 10 accompanied by a Problem List covering practical, family, emotional, spiritual, and physical concerns. A score of 4 or above generally warrants further assessment and appropriate referral. The tool has demonstrated good reliability, validity, and clinical utility across various oncology settings and has become an internationally accepted standard for routine distress screening.[3]

Despite clear recommendations, documentation of psychosocial distress remains inconsistent in many oncology and palliative care settings. Clinical documentation often focuses primarily on physical symptoms while emotional, psychological, and social issues receive comparatively less attention. Incomplete documentation limits continuity of care, multidisciplinary communication, timely psychosocial interventions, and quality improvement initiatives. Clinical audits have emerged as an effective strategy for identifying deficiencies in healthcare practice, implementing targeted interventions, and reassessing outcomes through an audit cycle. Such quality improvement processes enhance compliance with evidence-based standards and promote sustainable improvements in patient care.[4]

The present audit cycle aims to evaluate the current practice of documenting psychosocial distress among palliative care patients admitted to a tertiary cancer centre and to implement structured interventions to improve documentation practices. By completing the audit cycle, the study intends to strengthen holistic patient assessment, improve interdisciplinary communication, facilitate timely psychosocial support, and establish a sustainable quality improvement model within the Department of Palliative Medicine. The findings may contribute to improving patient-centred cancer care and serve as a framework for routine psychosocial distress assessment in similar healthcare settings.5]

AIM

To evaluate and improve the documentation of psychosocial distress among palliative care patients admitted to a tertiary cancer centre through an audit cycle.

OBJECTIVES

1) To assess the baseline documentation of psychosocial distress among palliative care inpatients using a structured audit checklist.
2) To implement an audit-based quality improvement intervention to enhance documentation of psychosocial distress.
3) To compare documentation practices before and after the intervention and evaluate improvement in compliance with predefined audit standards.

MATERIALS AND METHODS

Source of Data

The data were obtained from inpatient medical records of eligible patients admitted to the Department of Palliative Medicine. Patient case records, psychosocial assessment forms, Distress Thermometer documentation sheets, nursing records, and multidisciplinary clinical notes were reviewed using a structured audit checklist developed for the study.

Study Design

An audit-based interventional quality improvement study (clinical audit cycle) was conducted.

Study Location

The study was conducted in the Inpatient wards of the Department of Palliative Medicine, Kidwai Memorial Institute of Oncology, Bengaluru.

Study Duration

The study was conducted over a period of 6 months.

Sample Size
A total of 80 eligible inpatient case records/patients were included in the study using consecutive sampling during the study period.

Inclusion Criteria
- Adult patients aged 18 years and above admitted to the inpatient wards of the Department of Palliative Medicine.
- Patients diagnosed with malignancy and receiving palliative care.
- Patients admitted during the study period whose medical records were available for complete audit.
- Patients or legally authorized representatives who provided informed consent, wherever applicable.

Exclusion Criteria
- Patients aged below 18 years.
- Patients with severe cognitive impairment, advanced dementia, altered sensorium, or Glasgow Coma Scale (GCS) <12.
- Patients who were haemodynamically unstable or critically ill, making psychosocial assessment impractical.
- Incomplete or unavailable medical records.

Procedure and Methodology
After obtaining approval from the Institutional Ethics Committee, the study was initiated in the inpatient wards of the Department of Palliative Medicine. A baseline clinical audit was performed by reviewing the documentation of psychosocial distress in eligible inpatient records using a standardized audit checklist based on the NCCN Distress

Thermometer and institutional documentation standards. Baseline compliance with documentation practices was recorded. Following completion of the baseline audit, a structured quality improvement intervention package was implemented. The intervention included educational sessions for doctors and nursing staff regarding psychosocial distress assessment, orientation on the proper use of the Distress Thermometer, availability of standardized documentation formats in inpatient case records, visual reminders within the ward, and periodic audit feedback sessions with the clinical team.

Following implementation of these interventions, documentation practices were reassessed prospectively using the same audit checklist among subsequent eligible patients admitted during the study period. The post-intervention audit evaluated the completeness, consistency, and quality of psychosocial distress documentation. Compliance before and after intervention was compared to determine the effectiveness of the audit cycle.

Sample Processing
All collected data were checked daily for completeness and consistency. Individual patient identifiers were removed and each participant was assigned a unique study identification number to maintain confidentiality. Data were entered into a pre-designed Microsoft Excel spreadsheet, verified for accuracy by double entry, and subsequently exported for statistical analysis.

Statistical Methods
The collected data were analyzed using IBM SPSS Statistics version 26.0.
- Continuous variables were summarized as mean ± standard deviation (SD) or median with interquartile range (IQR), depending on data distribution.
- Categorical variables were presented as frequencies and percentages.
- Baseline and post-intervention documentation compliance were compared using the Chi-square test or Fisher's exact test, wherever appropriate.
- Changes in documentation scores before and after intervention were assessed using the McNemar test or paired statistical methods, wherever applicable.
- A p-value <0.05 was considered statistically significant.

Data Collection
A structured audit checklist based on the NCCN Distress Thermometer documentation standards was used for data collection. The following information was recorded:
- Demographic details (age, gender)
- Primary cancer diagnosis
- Performance status
- Documentation of psychosocial distress
- Distress Thermometer score
- Emotional, social, family, practical, physical, and spiritual concerns

- Referral to psychology, psychiatry, social work, or spiritual care services
- Completeness of documentation
- Compliance with institutional documentation standards
- Pre-intervention and post-intervention audit findings.

RESULTS

Table 1. Baseline clinico-demographic and psychosocial profile of palliative care patients admitted to a tertiary cancer centre (N=80)

Variable	n (%) / Mean ± SD	Test value	95% CI	p-value
Age (years)	54.7 ± 12.9	t=37.90	51.8–57.6	<0.001*
Male	43 (53.8%)	χ^2=0.45	42.9–64.2%	0.502
Female	37 (46.2%)		35.8–57.1%	
ECOG performance status ≥3	49 (61.3%)	χ^2=4.05	50.3–71.2%	0.044*
Advanced/metastatic disease	67 (83.8%)	χ^2=36.45	74.2–90.3%	<0.001*
Mean Distress Thermometer score	6.4 ± 2.1	t=27.27	5.9–6.9	<0.001*
Clinically significant distress (DT ≥4)	63 (78.8%)	χ^2=26.45	68.6–86.3%	<0.001*
Emotional concern present	57 (71.3%)	χ^2=14.45	60.5–80.0%	<0.001*
Practical/social concern present	46 (57.5%)	χ^2=1.80	46.6–67.8%	0.180
Spiritual concern present	29 (36.3%)	χ^2=6.05	26.6–47.2%	0.014*

Table 1 presents the baseline clinico-demographic and psychosocial characteristics of the study participants. The mean age of the patients was 54.7 ± 12.9 years (95% CI: 51.8–57.6), which was statistically significant (t=37.90, p<0.001). There was a slight male predominance, with 43 (53.8%) males and 37 (46.2%) females, although the difference was not statistically significant (χ^2=0.45, p=0.502).

A majority of the patients (49; 61.3%) had poor functional status with an ECOG performance score ≥3, which was statistically significant (χ^2=4.05, p=0.044). Most participants (67; 83.8%) had advanced or metastatic disease (χ^2=36.45, p<0.001). The mean Distress Thermometer score was 6.4 ± 2.1 (95% CI: 5.9–6.9), indicating a high burden of psychosocial distress (t=27.27, p<0.001). Clinically significant distress (DT score ≥4) was observed in 63 (78.8%) patients (χ^2=26.45, p<0.001).

Emotional concerns were documented in 57 (71.3%) patients (χ^2=14.45, p<0.001), while practical or social concerns were present in 46 (57.5%), though this was not statistically significant (χ^2=1.80, p=0.180). Spiritual concerns were reported by 29 (36.3%) patients and showed statistical significance (χ^2=6.05, p=0.014).

Table 2. Baseline documentation of psychosocial distress using structured audit checklist (Baseline audit, n=40)

Documentation parameter	Documented n (%)	Test value	95% CI	p-value
Any psychosocial distress documented	13 (32.5%)	Z=-5.06	20.1–48.0%	<0.001*
Distress Thermometer score documented	9 (22.5%)	Z=-7.19	12.3–37.5%	<0.001*
Emotional concerns documented	11 (27.5%)	Z=-6.02	16.1–42.8%	<0.001*
Practical/social concerns documented	8 (20.0%)	Z=-7.91	10.5–34.8%	<0.001*
Family concerns documented	7 (17.5%)	Z=-8.74	8.7–31.9%	<0.001*
Spiritual concerns documented	6 (15.0%)	Z=-9.74	7.1–29.1%	<0.001*
Referral/action plan documented	4 (10.0%)	Z=-12.65	4.0–23.1%	<0.001*

Table 2 summarizes the baseline audit of psychosocial distress documentation before implementation of the quality improvement intervention. Documentation of any psychosocial distress was observed in only 13 (32.5%) patient records, which was significantly below the expected audit standard (Z=-5.06, p<0.001).

Documentation of the Distress Thermometer score was present in merely 9 (22.5%) records (Z=-7.19, p<0.001). Emotional concerns were documented in 11 (27.5%) patients, while practical or social concerns were documented in only 8 (20.0%) cases (both p<0.001).

Family-related concerns were recorded in 7 (17.5%) patients and spiritual concerns in 6 (15.0%), both demonstrating highly significant deficiencies in documentation (p<0.001). Referral or action plans addressing psychosocial issues were documented in only 4 (10.0%) patient records, representing the lowest compliance (Z=-12.65, p<0.001).

Table 3. Implementation of audit-based quality improvement intervention to improve documentation (Post-intervention audit, n=40)

Intervention-related parameter	Achieved n (%)	Test value	95% CI	p-value
Staff sensitization completed	37 (92.5%)	Z=3.11	80.1–97.4%	0.002*
Standard DT form attached to records	34 (85.0%)	Z=2.07	70.9–92.9%	0.038*
DT score documented after intervention	33 (82.5%)	Z=1.73	67.9–91.3%	0.084
Problem list completed	31 (77.5%)	Z=1.04	62.5–87.7%	0.299
Weekly audit-feedback completed	29 (72.5%)	Z=0.35	57.2–83.9%	0.729
Psychosocial referral/action noted	27 (67.5%)	Z=-0.35	52.0–79.9%	0.729
Complete documentation achieved	33 (82.5%)	Z=1.73	67.9–91.3%	0.084

Table 3 presents the implementation outcomes of the audit-based quality improvement intervention. Staff sensitization sessions were successfully completed for 37 (92.5%) participants and were statistically significant (Z=3.11, p=0.002). A standardized Distress Thermometer (DT) form was attached to 34 (85.0%) patient records, demonstrating significant improvement (Z=2.07, p=0.038). Documentation of the DT score after intervention was achieved in 33 (82.5%) records, while completion of the problem list was observed in 31 (77.5%) records; however, these did not reach statistical significance (p=0.084 and p=0.299, respectively).

Weekly audit-feedback sessions were completed in 29 (72.5%) cases, and psychosocial referral or action plans were documented in 27 (67.5%) cases, although these findings were not statistically significant (p=0.729). Complete documentation was achieved in 33 (82.5%) patient records, reflecting marked improvement in compliance with the audit standards following implementation of the intervention.

Table 4. Comparison of documentation practices before and after intervention (Baseline n=40, Post-intervention n=40)

Documentation parameter	Baseline n (%)	Post-intervention n (%)	Test value	95% CI for difference	p-value
Any psychosocial distress documented	13 (32.5%)	34 (85.0%)	Z=4.77	34.2–70.8%	<0.001*
Distress Thermometer score documented	9 (22.5%)	33 (82.5%)	Z=5.37	42.5–77.5%	<0.001*
Emotional concerns documented	11 (27.5%)	31 (77.5%)	Z=4.48	31.1–68.9%	<0.001*
Practical/social concerns documented	8 (20.0%)	30 (75.0%)	Z=4.93	36.7–73.3%	<0.001*
Family concerns documented	7 (17.5%)	29 (72.5%)	Z=4.94	36.8–73.2%	<0.001*
Spiritual concerns documented	6 (15.0%)	27 (67.5%)	Z=4.77	34.2–70.8%	<0.001*
Referral/action plan documented	4 (10.0%)	24 (60.0%)	Z=4.69	32.2–67.8%	<0.001*

*Significant at p<0.05.

Table 4 compares documentation practices before and after implementation of the audit-based quality improvement intervention. Documentation of any psychosocial distress improved significantly from 13 (32.5%) at baseline to 34 (85.0%) after intervention (Z=4.77, 95% CI: 34.2–70.8, p<0.001). Documentation of the Distress Thermometer score increased from 9 (22.5%) to 33 (82.5%) (Z=5.37, p<0.001).

Similarly, documentation of emotional concerns improved from 27.5% to 77.5% (Z=4.48, p<0.001), while documentation of practical or social concerns increased markedly from 20.0% to 75.0% (Z=4.93, p<0.001). Documentation of family concerns improved from 17.5% to 72.5% (Z=4.94, p<0.001), and spiritual concerns increased from 15.0% to 67.5% (Z=4.77, p<0.001). Furthermore, documentation of referral or action plans increased significantly from 10.0% to 60.0% (Z=4.69, p<0.001).

DISCUSSION

In the present audit cycle, the mean age was 54.7±12.9 years, with slight male predominance and a high proportion of advanced/metastatic disease (83.8%). Clinically significant distress was present in 78.8% of patients, showing that psychosocial distress is highly prevalent among advanced cancer patients. Similar findings were reported by Rohini et al. (2025)[1], who observed moderate-to-severe emotional distress in 94.1% of palliative care cancer patients. Graham-Wisener et al. (2021)[2] and Abu-Odah et al. (2023)[3] also supported the usefulness of the Distress Thermometer in advanced cancer and palliative care settings.

Baseline documentation was poor, with only 32.5% records documenting any psychosocial distress and only 22.5% documenting the Distress Thermometer score. This agrees with Deodhar et al. (2021)[4], who found gaps in documentation

of spiritual and psychosocial concerns among advanced cancer patients before audit intervention. Bhatnagar et al. (2023)[5] similarly reported that physical symptoms were better documented than psychosocial domains such as anxiety and depression. These findings highlight that psychosocial, family, spiritual, and referral-related documentation is often neglected in routine palliative care records.

After intervention, staff sensitization was completed in 92.5%, standardized DT forms were attached in 85.0%, and complete documentation increased to 82.5%. This improvement supports the findings of Zebrack et al. (2015)[6], who showed that structured distress screening programs improve adherence and responsiveness in cancer care. Buchan et al. (2018)[7] also demonstrated that systematic symptom assessment tools improved completion rates in inpatient palliative care.

Comparison before and after intervention showed statistically significant improvement in all documentation domains. Documentation of any psychosocial distress increased from 32.5% to 85.0%, DT score documentation from 22.5% to 82.5%, emotional concerns from 27.5% to 77.5%, and referral/action plans from 10.0% to 60.0% (all $p<0.001$). These findings are consistent with Deshields et al. (2021)[8], who emphasized that distress management requires screening, response, referral, and follow-up. Rivest et al. (2022)[9] and Rohan et al. (2023)[10] also noted that staff training, workflow integration, reminders, and feedback are essential for successful implementation of distress screening.

Overall, the present study demonstrates that an audit-based quality improvement cycle was effective in improving psychosocial distress documentation among palliative care patients. The findings are in line with Ownby (2019)[11], Fitch (2024)[12], and NCCN (2024)[13], who emphasized routine distress screening as a key component of patient-centred oncology and palliative care.

CONCLUSION

The present audit cycle demonstrated that psychosocial distress is highly prevalent among patients receiving palliative care, with the majority experiencing clinically significant distress requiring comprehensive assessment and multidisciplinary support. Despite the high burden of psychosocial concerns, baseline documentation of distress, emotional, family, practical, spiritual issues, and referral plans was found to be inadequate.

Implementation of a structured audit-based quality improvement intervention comprising staff sensitization, standardized Distress Thermometer documentation forms, regular audit-feedback sessions, and reinforcement of documentation practices resulted in substantial improvement in the completeness and quality of psychosocial distress documentation. Significant improvements were observed in documentation of Distress Thermometer scores, emotional concerns, practical and family issues, spiritual concerns, and referral or action plans following the intervention.

The findings indicate that a simple, structured audit cycle is an effective quality improvement strategy for enhancing routine psychosocial assessment and documentation in palliative care. Regular clinical audits, continued staff education, and integration of standardized psychosocial assessment tools into routine clinical practice can promote holistic, patient-centred care and facilitate timely multidisciplinary interventions for patients with advanced cancer.

LIMITATIONS OF THE STUDY

1) The study was conducted at a single tertiary cancer centre, limiting the generalizability of the findings to other healthcare settings.
2) The sample size was relatively small and included only 80 patients.
3) The audit evaluated documentation practices rather than the actual quality or effectiveness of psychosocial interventions delivered.
4) The post-intervention assessment was performed over a relatively short duration; therefore, long-term sustainability of improved documentation could not be evaluated.
5) Variations in documentation among different healthcare professionals may have introduced observer-related bias.
6) Patient-related outcomes such as quality of life, anxiety, depression, caregiver satisfaction, and symptom improvement were not assessed.
7) Some psychosocial concerns may have been discussed clinically but not documented in the medical records, resulting in underestimation of actual clinical practice.
8) The study did not evaluate barriers perceived by healthcare professionals regarding psychosocial distress documentation.

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