Remote Symptom Practice Guides for Individuals Undergoing Cancer Treatments

Of the Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Team

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Overview and Practice Guide Development

Management of cancer treatment-related symptoms is an important safety issue given that symptoms can become life-threatening and often occur when patients are at home. Our previous research revealed that 88% of cancer programs in Ontario provide telephone access for symptom management by nurses and 54% of cancer nurses in Canada provide remote support (telephone, email) [1,2]. Despite that higher quality telephone services require use of symptom practice guides to minimize risk, access to and the ways symptom practice guides are used was variable in our two studies. Published single symptom clinical practice guidelines are not formatted for use by telephone and existing remote symptom practice guides do not reference them. With funding from the Canadian Partnership Against Cancer, we established a pan-Canadian Steering Committee with representation from eight provinces to develop 13 symptom practice guides.

The practice guides were developed using a systematic process guided by the CAN-IMPLEMENT© methodology[3-5]:

1. We convened a pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Steering Committee representing several provinces and including researchers, an information systems researcher, library scientist, advanced practice nurses, and nurse leaders.
2. We conducted a systematic review for *each symptom* to identify clinical practice guideline(s) published since 2002. Two identified guidelines (fatigue, anxiety/depression) were developed by pan-Canadian panels using rigorous processes[6,7]. Guidelines are syntheses of the best available evidence and are designed to support decision making in practice and health policy[8]. However, identified clinical practice guidelines were not adequate for remote symptom support.
3. We developed 13 symptom practice guides based on the available clinical practice guidelines (median 3 guidelines per practice guide; range 1 to 7). In total, we identified > 40 practice guidelines and their quality was appraised using the AGREE instrument (range 8% to 87%)[9]. Higher rigour scores indicate higher confidence that potential biases in guideline development were addressed, and recommendations are valid (both internally and externally) and feasible for practice[10]. Principles for developing the symptom practice guides included:
   - Meeting the criteria on the AGREE rigour sub-scale items (e.g. explicit recommendations, linked to evidence, based on systematic review, reviewed by experts).
   - Adding relevant questions from the valid and reliable Edmonton Symptom Assessment System (ESAS); a widely used screening instrument for routinely identifying symptoms in cancer patients seen in Canadian programs[11,12].
   - Enhancing usability for remote support practice and with the potential to integrate into an electronic health record.
   - Using plain language to facilitate communication between nurses using the practice guides and patients/families (Flesch–Kincaid Grade Level 6.4).

   Each symptom practice guide has five recommendations for the nurse: a) assess symptom severity; b) triage patient for symptom management based on highest severity; c) review medications being used for the symptom; d) review self-management strategies (presented using motivational interviewing techniques[13]); and e) summarize and document the plan agreed upon with the patient.
4. We tested the practice guide usability with cancer nurses and revealed that they: are easy to read; provide just the right amount of information; use appropriate terms; are likely to fit with clinical work flow; and have excellent self-management strategies.
5. We circulated the 13 practice guides for review by cancer experts across Canada. They validated the content of the practice guides and identified the need for local adaptation to integrate the practice guides with their current approaches for handling remote symptom assessments.
6. In March 2013, practice guides were updated with evidence from a systematic review to identify guidelines published up until the end of December 2012. Doses for over the counter medications were added. We circulated the 13 updated practice guides for review by the COSTaRS committee members.

In summary, we have developed 13 user-friendly remote symptom practice guides based on a synthesis of the best available evidence, validated the practice guides with oncology nurses, and used plain language to facilitate use with patients. Now they are available to be used in routine remote support practices.

References:

(1) Stacey D, Bakker D, Green E, Zanchetta M, Conlon M. Ambulatory oncology nursing telephone services: A provincial survey. *Canadian Oncology Nursing Journal* 2007;17(4):1-5.
(2) Macartney G, Stacey D, Carley M, Harrison M. Priorities, Barriers and Facilitators for Remote Support of Cancer Symptoms: A Survey of Canadian Oncology Nurses. *Canadian Oncology Nursing Journal* 2012;22(4):235-240. Priorités, obstacles et facilitateurs concernant le traitement à distance des symptômes du cancer: enquête après des infirmières en oncologie du Canada. P 241-47.
(3) Harrison MB, Legare F, Graham ID, Fervers B. Adapting clinical practice guidelines to local context and assessing barriers to their use. *Canadian Medical Association Journal* 2010;182(2):E78-E84.
(4) Harrison MB, van den Hoek J, for the Canadian Guideline Adaptation Study Group. CAN-IMPLEMENT©: A Guideline Adaptation and Implementation Planning Resource. Kingston, Ontario: Queen's University School of Nursing and Canadian Partnership Against Cancer; 2012.
(5) Stacey D, Macartney G, Carley M, Harrison MB, Costars TP. Development and evaluation of evidence-informed clinical nursing protocols for remote assessment, triage and support of cancer treatment-induced symptoms. *Nurs Res Pract* 2013;2013:171872.
(6) Howell D, Currie S, Mayo S et al. A Pan-Canadian Clinical Practice Guideline: Assessment of Psychosocial Health Care Needs of the Adult Cancer Patient. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology; 2009.
(7) Howell D, Keller-Olaman S, Oliver TK et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Cancer-Related Fatigue in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology; 2011.
(8) Gagliardi AR, Brouwers MC, Palda VA, Lemieux-Charles L, Grimshaw JM. How can we improve guideline use? A conceptual framework of implementability. *Implementation Science* 2011;6(26):1-11.
(9) The AGREE Collaboration. Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument. www.agreecollaboration.org; 2001.
(10) Brouwers M, Kho ME, Browman GP et al. Development of the AGREE II, part 2: assessment of validity of items and tools to support application. *Canadian Medical Association Journal* 2010;182(10):E472-E478.
(11) Barbera L, Seow H, Howell D et al. Symptom burden and performance status in a population-based cohort of ambulatory cancer patients. *Cancer* 2010;116(24):5767-5776.
(12) Nekolaichuk C, Watanabe S, Beaumont C. The Edmonton Symptom Assessment System: a 15-year retrospective review of validation studies (1991-2006). *Palliative Medicine* 2008;22(2):111-122.
(13) Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change (2nd ed.)*. New York: Guilford Press; 2002.

Anxiety Practice Guide

Remote Assessment, Triage, and Management of Anxiety in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and Time

Anxiety: an emotional or physiologic response to known or unknown causes that ranges from a normal reaction to extreme dysfunction. It may impact on decision making, adherence to treatment, functioning, or quality of life [3]; nervousness; concern; worry; apprehension.

1. Assess severity of the anxiety (Supporting evidence: 2 guidelines) [2,3]

Tell me what number from 0 to 10 best describes how anxious you are feeling

Not anxious 0 1 2 3 4 5 6 7 8 9 10 Worst possible anxiety [1(ESAS)]

Do have any concerns that are making you feel more anxious (e.g. life events, new information about cancer/treatment, financial problems)? ☐Yes ☐No If Yes, describe: _____

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[1,2,3]	0 – 3	☐	4 - 6	☐	7 - 10	☐
Have you felt this anxious for 2 weeks or longer?[2]	No	☐	Yes, off/on	☐	Yes, continuous	☐
Are you re-living or facing events in ways that make you feel more anxious (e.g. dreams, flashbacks)?[2,3] Describe.	No	☐	Yes, some	☐	Yes, often	☐
Are you having panic attacks; periods/spells of sudden fear, discomfort, intense worry, uneasiness?[2,3] Describe.	No	☐	Yes, some	☐	Yes, often	☐
How much does your anxiety affect your daily activities at home and/or at work?[2] Describe.	Not at all	☐	Yes, some	☐	Yes, significantly	☐
How much does your anxiety affect your sleep?[2]	Not at all	☐	Yes, some	☐	Yes, significantly	☐
Do any of these apply to you? ☐ Waiting for test results, ☐ Financial problems, ☐ History of anxiety or depression, ☐ Younger age (< 30), ☐ Withdrawal from alcohol/ substance use, ☐ Living alone, ☐ Recurrent/advanced disease, ☐ Not exercising?[2,3]	No	☐	Some	☐	Several	☐
Are you feeling (symptom-related risk factors for anxiety): ☐ Fatigue, ☐ Short of breath, ☐ Pain, ☐ Other If yes, see appropriate symptom practice guide.	None	☐	Some	☐	Several, with 1 or more symptoms assessed as severe	☐

	1 Mild	2 Moderate	3 Severe
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)[2]	☐ Review self-care. ☐ Verify medication use, if appropriate.	☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[2,3] ☐ If yes, refer for further evaluation immediately. ☐ If no, refer for non-urgent medical attention. ☐ Review self-care. ☐ Verify medication use, if appropriate.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for anxiety, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 2 guidelines)**[2,3]

Current use	Examples of Medications for anxiety	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[2,3]		Single RCT & Consensus
☐	Antipsychotics - haloperidol (Haldol®)[2,3]		Single RCT & Consensus
☐	Antihistamines - hydroxyzine (Atarax®)[2,3]		Single RCT & Consensus
☐	SSRIs - fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), escitalopram (Lexapro®)[2,3]		Systematic review

*****Use of antidepressant depends on side effect profiles of medications and the potential for interaction with other current medications.

4. Review self-care strategies **(Supporting evidence: 2 guidelines)**[2,3]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you feel anxious? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources.
3. ☐	☐	☐	Would more information about your symptoms help to ease your worries? If yes, provide appropriate information or suggest resources.
4. ☐	☐	☐	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)?[2]
5. ☐	☐	☐	Do you participate in any support groups[2,3] and/or have family/friends you can rely on for support?
6. ☐	☐	☐	Have you tried relaxation therapy, breathing techniques, guided imagery? [2,3](systematic review with meta-analysis)
7. ☐	☐	☐	Have you tried massage therapy?[3]
8. ☐	☐	☐	Have you tried a program such as cognitive-behavioural therapy or received personal counseling that provides more in-depth guidance on managing anxiety?[2,3]

5. Summarize and document plan agreed upon with caller including ongoing monitoring

(check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, August 2010. (AGREE Rigour score 85.4%)
3. Sheldon LK, et al. Putting evidence into practice: evidence-based interventions for anxiety. Clin J Oncol Nurs 2008 Oct;12(5):789-97. (AGREE Rigour score 37.5%)

Bleeding Practice Guide

Remote Assessment, Triage, and Management of Bleeding in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name
Date of Birth
Sex
Hospital card number

Date and Time

Bleeding: Loss of blood, bruising or petechiae that may be the result of a reduction in the quantity or functional quality of platelets, an alteration of clotting factors, a paraneoplastic syndrome, or a combination of these [1]; hemorrhage.

1. Assess severity of the bleeding (Supporting evidence: 1 guideline)[1]

Where are you bleeding from? _____ How much blood loss? _____

How worried are you about your bleeding?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

How much are you bleeding?[1]	Minor	☐	Some	☐	Gross	☐
Patient rating of worry about bleeding (see above)	0-5	☐	6-10	☐		
Do you have any bruises?[1]	No	☐	Few	☐	Generalized	☐
Have you had any problems with your blood clotting? ☐Unsure	No	☐			Yes	☐
Do you have a fever > 38º C?[1] ☐Unsure	No	☐			Yes	☐
Do you have any blood: ☐ In your stool or is it black?[1] ☐ In your urine ☐ In your vomit or does it look like coffee grounds?[1] ☐ In your phlegm/sputum when you cough[1]	No	☐			Yes	☐
Women only: Has there been an increase bleeding with your menstrual periods?[1]	No	☐	Yes, some	☐	Yes, significantly	☐
Do you know what your last platelet count was? [1] Date: ☐Unsure	≥ 100	☐	20-99	☐	< 20	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**[1]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional comments:

Patient Name_____

3. Review medications patient is using that may affect bleeding, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 1 guideline)**[1]

Current use	Examples of Medications that increase bleeding	Notes (e.g. dose)	Type of Evidence
☐	acetylsalicylic acid (Aspirin®)		Expert Consensus
☐	warfarin (Coumadin®)		Expert Consensus
☐	Injectable blood thinner - heparin, dalteparin (Fragmin®), tinzaparin (Innohep®), enoxaparin (Lovenox®)		Expert Consensus

4. Review self-care strategies **(Supporting evidence: 1 guideline)** [1]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	Are you trying to apply direct pressure for 10-15 minutes when the bleeding occurs?[1]
2. ☐	☐	☐	Are you trying to use ice packs?[1]
3. ☐	☐	☐	If you have a dressing, is there bleeding when it is changed? If yes, do you try to minimize how often the dressing is done, and use saline to help remove the dressing so it does not stick to the tissue?[1]
4. ☐	☐	☐	Are you using any special dressings to control bleeding of a wound (e.g. non-stick gauze, medicated dressing, packing)?[1]
5. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.[1]
6. ☐	☐	☐	Have you spoken with a pharmacist or doctor about medications you are taking that may affect bleeding?

5. Summarize and document plan agreed upon with caller **(check all that apply)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Damron BH, et al. Putting evidence into practice: prevention and management of bleeding in patients with cancer. Clin J Oncol Nurs 2009 Oct;13(5):573-83. (AGREE Rigour score 87%)

Breathlessness/Dyspnea Practice Guide

Remote Assessment, Triage, and Management of Breathlessness/Dyspnea in Adults Undergoing Cancer Treatment

Breathlessness/Dyspnea: A subjective experience described as breathing discomfort of varying intensities.[1-4] Includes descriptors such as hard to breathe, feeling smothered, tightness in chest, unable to catch breath, panting, gasping.

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of the breathlessness (Supporting evidence: 2 guidelines)[2,3]

Tell me what number from 0 to 10 best describes your shortness of breath?

No shortness of breath 0 1 2 3 4 5 6 7 8 9 10 Worst possible shortness of breath [5 (ESAS)]

How worried are you about your shortness of breath?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[3,5]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about shortness of breath (see above)[2]	0-5	☐	6-10	☐		
With what level of activity do you experience this shortness of breath?	Moderate activity	☐	Mild activity	☐	At rest	☐
Do you pause while talking every 5-15 seconds?[3]	No	☐			Yes	☐
Do you have pain in your chest when you breathe?[3]	No	☐			Yes	☐
Is your breathing noisy, rattly or congested?[3]	No	☐			Yes	☐
Did you wake suddenly with shortness of breath?[3]	No	☐			Yes	☐
Do you have a fever > 38º C?[3] ☐Unsure	No	☐			Yes, with breathlessness	☐
Does your shortness of breath interfere with your daily activities at home and/or at work? Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)[3]**	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional comments:

Patient Name_____

3. Review medications patient is using for shortness of breath, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)[1,2,3]

Current use	Examples of Medications for shortness of breath	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	Oxygen[1,2]		Expert Opinion
☐	Bronchodilators- salbutamol (Ventolin®)[1]		Expert Opinion
☐	Immediate-release oral or parenteral opioids - morphine (Statex®), hydromorphone (Dilaudid®), fentanyl[1,2,3]		Systematic Review

4. Review self-care strategies (Supporting evidence: 3 guidelines)[1,3,4]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you are short of breath? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Have you tried to use a fan or open window to increase air circulation directed at your face?[1]
3. ☐	☐	☐	Have you tried to turn down the temperature in your house?[1,3]
4. ☐	☐	☐	Are you trying to rest in upright positions that can help you breath?[1,3]
5. ☐	☐	☐	Are you trying different relaxation and breathing exercises (e.g. diaphragmatic breathing, pursed lip breathing)?[1,3,4] (systematic review)
6. ☐	☐	☐	If you have a wheelchair, portable oxygen or walking aids, are you trying to use them to help with activities that cause your shortness of breath?[1,4] (systematic review)
7. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. [3]
8. ☐	☐	☐	Have you tried a program such as cognitive behavioural therapy (relaxation therapy, guided imagery) to help manage your shortness of breath?[1,3](Can decrease anticipatory worry associated with exertional dyspnea)

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. DiSalvo WM, et al. Putting evidence into practice: evidence-based interventions for cancer-related dyspnea. Clin J Oncol Nurs 2008 Apr;12(2):341-52. (AGREE Rigour score 87%)
2. Dy SM, et al. Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. J Clin Oncol 2008 Aug 10;26(23):3886-95. (AGREE Rigour score 51%)
3. Cancer Care Ontario. Symptom Management Guide-to-Practice: Dyspnea. Toronto, Ontario, Canada: Cancer Care Ontario; 2010. (AGREE Rigour score 62.5%)
4. Bausewein C, et al. Non-pharmacological interventions for breathlessness in advanced stages of malignant and non-malignant diseases. Cochrane Database Syst Rev 2008;(2):CD005623.
5. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Constipation Practice Guide

Remote Assessment, Triage, and Management of Constipation in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and Time

Constipation: A decrease in the passage of formed stool characterized by stools that are hard and difficult to pass.[1,2]

1. Assess severity of the constipation (Supporting evidence: 2 guidelines)[1,2]

Tell me what number from 0 to 10 best describes your constipation

No constipation 0 1 2 3 4 5 6 7 8 9 10 Worst possible constipation [3(ESAS)]

How worried are you about your constipation?[2]

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[3]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about constipation (see above)[2]	0-5	☐	6-10	☐		
How many days has it been since you had a bowel movement (compared to your normal pattern)?[1,2]	≤ 2 days	☐	3 days or more	☐	3 days or more on meds	☐
How would you describe your stools (colour, hardness, odour, amount, blood, straining)?[2]					Bleeding (gross)	☐
Do you have any pain in your abdomen?[2] Describe.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Does your abdomen feel bloated?[2] ☐Unsure	No	☐	Yes, some	☐	Yes, a lot	☐
Do you have lots of gas?[2]	No	☐	Yes	☐		
Do you feel like your rectum is not emptying after a bowel movement or do you have hemorrhoids?[2]	No	☐	Yes	☐		
Are you taking any medications that cause constipation?[2]	No	☐	Yes	☐		
Have you recently had abdominal surgery?[1]	No	☐			Yes	☐
Do you have any other symptoms? ☐ Nausea/vomiting[1,2] ☐ Loss of appetite[1,2] ☐ Urinary symptoms such as leaking urine, or feeling like you cannot empty your bladder[2]	No	☐	Yes, some	☐	Yes, often	☐
Does your constipation interfere with your daily activities at home and/or at work?[2] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: expert opinion)**	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional comments:

Patient Name_____

3. Review medications patient is using for constipation, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)[1,2]

Current use	Examples of Medications for constipation*	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	First line[2]: oral sennosides or bisacodyl (Senokot®; Dulcolax®)[1,2] (5-15mg qhs to15 mg tid) and/or lactulose[1,2] (15 ml/day to 60 ml tid)		Expert Opinion
☐	Second line[2]: suppositories** (Dulcolax®/bisacodyl, glycerin)[1,2] or Enema[2]		Expert Opinion
☐	Third line[2]: Picosulfate sodium-magnesium oxide-citric acid[2] (1 sachet in water 1-2 times/day)		Expert Opinion
☐	polyethylene glycol (PEG; RestoaLAX®, Lax-a-day®) [1,2]		Systematic review
☐	docusate sodium (Colace®)[1,2]		Expert Opinion
☐	magnesium hydroxide (Milk of magnesia®)[1,2]		Expert Opinion

***Opioid-induced constipation must be considered. Inadequate/limited evidence for cancer-treatment related constipation.**
**** Verify blood count before using suppositories.**

4. Review self-care strategies (Supporting evidence: 2 guidelines)[1,2]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you are constipated? Reinforce as appropriate.[2] Specify:
2. ☐	☐	☐	What is your normal bowel routine? Reinforce as appropriate.[1,2] Specify:
3. ☐	☐	☐	Are you trying to drink fluids, 6-8 glasses per day, especially warm or hot fluids?[1,2]
4. ☐	☐	☐	Have you increased the fiber in your diet to 25g/day?(Only appropriate if adequate fluid intake (1500ml/24 hrs.) and physical activity)[1,2]
5. ☐	☐	☐	Do you eat fruit that are laxatives? (pitted dates, prune nectar, figs, pitted prunes)[2]
6. ☐	☐	☐	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week)[2]
7. ☐	☐	☐	Do you have easy access to a private toilet or bedside commode[1,2], with necessary assistive devices (raised toilet seat)? If possible, it is best to avoid a bedpan.[1]
8. ☐	☐	☐	Are you avoiding non-sterilized corn syrup and castor oil?[1] (Corn syrup can be a source of infection; castor oil can cause severe cramping)
9. ☐	☐	☐	If you have a low neutrophil count are you trying to avoid rectal exams, suppositories, enemas?[1]
10. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
11. ☐	☐	☐	Have you spoken with a doctor or pharmacist or dietitian about the constipation?[1,2]

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Woolery M, et al. Putting evidence into practice: evidence-based interventions for the prevention and management of constipation in patients with cancer. Clin J Oncol Nurs 2008 Apr;12(2):317-37. (AGREE Rigour score 80%)
2. Cancer Care Ontario. Symptom Management Guide-to-Practice: Bowel Care. Toronto, Ontario, Canada: Cancer Care Ontario; 2012. (AGREE Rigour score pending)
3. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
4. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.

Depression Practice Guide
Remote Assessment, Triage, and Management of Depression in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and Time

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect including clinical depression using criteria for a psychiatric disorder[3]; feelings of despair, hopelessness

1. Assess severity of the depression **(Supporting evidence: 2 guidelines)**[2,3]

Tell me what number from 0 to 10 best describes how depressed you are feeling

Not depressed 0 1 2 3 4 5 6 7 8 9 10 Worst possible depression [1(ESAS)]

How worried are you about feeling depressed?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Do you have any concerns that are making you feel more depressed (e.g. life events, new information about cancer/treatment, financial problems) ☐Yes ☐No Specify: _____

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[1,2,3]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about depression (see above)	0-5	☐	6-10	☐		
Have you felt depressed or had a loss of pleasure for 2 weeks or longer?[2,3]	No	☐	Yes, off/on	☐	Yes, continuous	☐
Have you experienced any of the following for ≥ 2 weeks: ☐ feeling worthless, ☐ sleeping too little or too much, ☐ feeling guilty, ☐ weight gain or weight loss?[2,3]	No	☐	1-3 present	☐	4 present	☐
Does feeling depressed interfere with your daily activities at home and/or at work?[2] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Have you felt tired or fatigued?[2,3] Describe.	No	☐	Yes, moderate	☐	Yes, often	☐
Have you felt agitated (which may include twitching or pacing) or slowing down of your thoughts?[2,3]	No	☐	Yes, some	☐	Yes, often	☐
Do any of these apply to you? ☐ bothersome symptoms, ☐ a lack of social support, ☐ history of depression ☐withdrawal from alcohol/substance abuse, ☐ living alone, ☐ recurrent/advanced disease, ☐ younger age (< 30)?[2]	None	☐	Yes, some	☐	Yes, several	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**[2]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[2,3] ☐ If yes, refer for further evaluation immediately. ☐ If no, refer for non-urgent medical attention. ☐ Review self-care. ☐ Verify medication use, if appropriate.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for depression, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)[2,3]

Current use	Examples of Medications for depression*	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	SSRIs - fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), escitalopram (Lexapro®)[3]		Systematic review
☐	Tricyclic antidepressants - amitriptyline (Elavil®), imipramine (Tofranil®), desipramine (Norpramin®), nortriptyline (Pamelor®), doxepin (Sinequan®)[3]		Systematic review

*Use of antidepressant depends on side effect profiles of medications and the potential for interaction with other current medications.

4. Review self-management strategies (Supporting evidence: 2 guidelines)[2,3]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you feel depressed? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources.
3. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.[2]
4. ☐	☐	☐	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)?[2]
5. ☐	☐	☐	Do you participate in any support groups[2,3] and/or have family/friends you can rely on for support?
6. ☐	☐	☐	Have you tried relaxation therapy or guided imagery?[2,3](systematic review with meta-analysis)
7. ☐	☐	☐	Have you tried a program such as cognitive-behavioural therapy or received personal counseling that provides more in-depth guidance on managing depression?[2,3]

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, August 2010. (AGREE Rigour score 85.4%)
3. Fulcher CD, et al. Putting evidence into practice: interventions for depression. Clin J Oncol Nurs 2008 Feb;12(1):131-40. (AGREE rigour score 43.8%)

Diarrhea Practice Guide

Remote Assessment, Triage, and Management of Diarrhea in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name
Date of Birth
Sex
Hospital card number

Date and Time

Diarrhea: An abnormal increase in stool liquidity and frequency over baseline (> 4-6 stools/day) which may be accompanied by abdominal cramping.[4,6,7]

1. Assess severity of the diarrhea (Supporting evidence: 7 guidelines)[1-7]

Tell me what number from 0 to 10 best describes your diarrhea

No diarrhea 0 1 2 3 4 5 6 7 8 9 10 Worst possible diarrhea [9(ESAS)]

How worried are you about your diarrhea?[7]

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Have you been tested for c-difficile? If yes, do you know the results?

☐Yes ☐No ☐Unsure Results_____

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[9]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about diarrhea (see above)[7]	0-5	☐	6-10	☐		
Think about your normal bowel pattern. How many extra bowel movements are you having per day (including at night), above what is normal for you?[1-7]	< 4 stools	☐	4-6 stools	☐	≥ 7 stools	☐
How would you describe your stools (colour, hardness, odour, amount, oily, blood, straining)? [3,6,7]					Bleeding (gross)	☐
Ostomy: How much extra output are you having, above what is normal for you?[3-6] ☐ N/A	None	☐	Some	☐	Severe	☐
Do you have a fever > 38º C?[3,4,6,7] ☐Unsure	No	☐			Yes, with diarrhea	☐
Do you have pain in your abdomen or rectum with or without cramping or bloating?[3,6,7]	No	☐	Yes, some	☐	Yes, often	☐
Does your diarrhea interfere with your daily activities at home and/or at work?[3,6,7] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Do you have any other symptoms? ☐ Nausea/vomiting[3,4,6,7] ☐ Loss of appetite[7]	No	☐	Yes, some	☐	Yes, often	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[3,4,6,7]	No	☐	Yes, some	☐	Yes, significantly	☐
Have you been able to drink fluids?[6]	Yes	☐			No	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 7 guidelines)**[1-7]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for diarrhea, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 6 guidelines)[1-6]

Current use	Examples of Medications for diarrhea	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	Loperamide (Imodium®)[1-6] 2mg post each loose bowel movement (max 16mg/day)		Systematic Review
☐	Atropine-diphenoxylate (Lomotil®)[4,5,6]		Systematic Review
☐	Octreotide (Sandostatin®)[1-6]		Systematic Review
☐	Psyllium fiber (Metamucil®)[4] 1-2 tsp. per day		Randomized control trial

4. Review self-care strategies (Supporting evidence: 5 guidelines)[3-7]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you have diarrhea? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Are you trying to drink 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth, diluted fruit juice)?[3-7]
3. ☐	☐	☐	Do you know what kinds of foods you should be trying to eat? Suggest: applesauce, oatmeal, bananas, barley, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned turkey or chicken, mashed potatoes, cooked or canned fruit without skin[3-7] (high in soluble fiber and low in insoluble fiber)
4. ☐	☐	☐	Are you trying to replace electrolytes (e.g. potassium and sodium or salt) that your body may be losing with the diarrhea by eating foods such as bananas and potatoes, drinking sports drinks or peach/apricot nectar, or oral rehydration drink (1/2 tsp. salt, 6 tsp. sugar, 4 cups water)?[4,7]
5. ☐	☐	☐	Are you trying to eat 5-6 small meals?[3,5,6,7]
6. ☐	☐	☐	Are you trying to avoid lactose-containing products (milk, yoghurt, cheese)[3,4,6,7]
7. ☐	☐	☐	Are you trying to avoid alcohol and minimize caffeine (<2-3 servings) (coffee, chocolate)[3-7]
8. ☐	☐	☐	Are you trying to avoid greasy/fried and spicy foods?[4,6,7]
9. ☐	☐	☐	Are you trying to avoid large amounts fruit juices or sweetened fruit drinks?[3,4,7]
10. ☐	☐	☐	Are you trying to avoid raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes?[4,6,7] (Insoluble fiber)
11. ☐	☐	☐	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown?[6,7]
12. ☐	☐	☐	Have you been keeping track of the number of stools you are having and are you aware of other problems you should be watching for with your diarrhea? (e.g. fever, dizziness)[3,6] (review criteria listed above in assessment)
13. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
14. ☐	☐	☐	Have you spoken with a doctor or pharmacist about medications you may be taking that can cause or worsen your diarrhea?[6]

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

1. Major P, et al. The Role of Octreotide in the Management of Patients with Cancer: Practice Guideline Report #12-7. Cancer Care Ontario, Program in Evidence Based Care; 2004. (AGREE Rigour score 86%)
2. Keefe DM, et al. Updated clinical practice guidelines for the prevention and treatment of mucositis. Cancer 2007 Mar 1;109(5):820-31. (AGREE Rigour score 82%)
3. Benson AB, III, et al. Recommended guidelines for the treatment of cancer treatment-induced diarrhea. J Clin Oncol 2004 Jul 15;22(14):2918-26. (AGREE Rigor score 73%)
4. Muehlbauer P, et al. Putting evidence into practice: What interventions are effective in preventing and treating diarrhea in adults with cancer receiving chemotherapy or radiation therapy? Oncology Nursing Society; 2008. (AGREE Rigour score 48%)
5. BC Cancer Agency. BCCA Guidelines for Management of Chemotherapy-Induced Diarrhea. 2004. (AGREE Rigour score 17%)
6. Buduhan V, et al. Professional Practice Nursing Standards - Symptom Management Guidelines: Cancer-Related Diarrhea. BC Cancer Agency; 2010. (AGREE Rigour score 17%)
7. Cancer Care Ontario. Symptom Management Guide-to-Practice: Bowel Care. Toronto, Ontario, Canada: Cancer Care Ontario; 2012. (AGREE Rigour score pending)
8. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.
9. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Fatigue/Tiredness Practice Guide

Remote Assessment, Triage, and Management of Fatigue/Tiredness in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and Time

Fatigue: a subjective feeling of tiredness or exhaustion prompted by cancer or cancer treatment that is disproportionate to the level of recent exertion, is not relieved by rest and interferes with usual daily activities.[1]

1. Assess severity of the fatigue/tiredness **(Supporting evidence: 3 guidelines)**[1]

Tell me what number from 0 to 10 best describes how tired you are feeling

Not tired 0 1 2 3 4 5 6 7 8 9 10 Worst possible tiredness [2(ESAS)]

How worried are you about your fatigue/tiredness?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[1,2]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about fatigue (see above)	0-5	☐	6-10	☐		
Do you have the following: shortness of breath at rest, sudden onset of severe fatigue, excessive need to sit or rest, rapid heart rate, rapid blood loss, or pain in your chest? [1]	No	☐			Yes	☐
How would you describe the pattern of fatigue?[1]	Intermittent	☐	Constant/ Less than two weeks	☐	Constant/ Daily for two weeks	☐
Does your fatigue interfere with your daily activities at home and/or at work?[1] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Are there times when you feel exhausted? Describe.	No	☐	Yes, intermittently	☐	Yes, constantly for two weeks	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 2 guidelines)**	☐ Review self-care.		☐ Review self-care. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If severe fatigue is stabilized, review self-care strategies ☐ If severe fatigue is new, refer for non-urgent medical attention.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for fatigue, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 3 guidelines)**

Current use	Examples of Medications for fatigue	Notes	Type of Evidence
☐			

*Use of pharmacological agents for cancer-related fatigue is experimental and NOT recommended (e.g. psycho-stimulants, sleep medications, low dose corticosteroids) unless for select patients at end of life with severe fatigue

4. Review self-care strategies **(Supporting evidence: 3 guidelines)**

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you feel fatigued/tired? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Do you understand what cancer-related fatigue is? Provide education about how it differs from normal fatigue, that it is expected with cancer treatment
3. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
4. ☐	☐	☐	Are you monitoring your fatigue levels?
5. ☐	☐	☐	Are you trying to save energy for things that are important to you?
6. ☐	☐	☐	What are you doing for physical activity? Moderate level of physical activity during and after cancer treatment is encouraged (e.g. 30 min of moderate intensity activity most days of the week: fast walk, cycle, swim, resistance exercise) *Use with caution in patients with some conditions (i.e. bone metastases)
7. ☐	☐	☐	Do you think you are eating/drinking enough to meet your body's energy needs?
8. ☐	☐	☐	Have you tried activities such as reading, games, music, gardening, experiences in nature?
9. ☐	☐	☐	Do you participate in any support groups and/or have family/friends you can rely on for support?
10. ☐	☐	☐	Have you tried activities to make you more relaxed? Such as relaxation therapy, deep breathing, yoga, guided imagery, or massage therapy? (3 RCT's sessions lowered fatigue scores)
11. ☐	☐	☐	Have you done any of the following to improve the quality of your sleep? Avoid long or late afternoon naps; limit time in bed to actual sleep; go to bed when sleepy; use bed for sleep and sexual activity only; have consistent schedule for bedtime and getting up; avoid caffeine and stimulating activity in the evening; relax for 1 hour before going to bed; establish a bedtime routine
12. ☐	☐	☐	Have you spoken with or would you like to speak with a health care professional to help guide you in managing your fatigue? (physiotherapist, occupational therapist, dietitian)
13. ☐	☐	☐	Have you tried a program such as cognitive behavioural therapy to manage your fatigue?

5. Summarize and document plan agreed upon with caller **(check all that apply)**

☐	No change, continue with self-care strategies
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Howell D, et al. A pan-Canadian practice guideline and algorithm: screening, assessment, and supportive care of adults with cancer-related fatigue. Curr Oncol 2013 Jun;20(3):e233-e246. (AGREE rigour score 86.5). Other guidelines referenced within this guideline are:
   a. Mitchell SA, et al. Putting Evidence into Practice (PEP) Topics - Fatigue. Oncology Nursing Society; 2009. (AGREE rigour score 55.2%)
   b. National Comprehensive Cancer Network. Clinical Practice Guidelines in Oncology - Cancer-Related Fatigue, V.2. 2009. (AGREE rigour score 28.5%)
2. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Febrile Neutropenia Practice Guide

Remote Assessment, Triage, and Management of Febrile Neutropenia in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name
Date of Birth
Sex
Hospital card number

Date and Time

Fever: A single oral temperature of ≥38.3º C (101 ºF) or a temperature of ≥38.0º C (100.4 ºF) for ≥1 hour. [1,2,6,7]
Neutropenia: A neutrophil count of < 500 cells/mm^3 or a count of < 1000 cells/mm^3 with a predicted decrease to < 500 cells/mm^3. [1,2,4,6,7]
Febrile neutropenia: A neutrophil count of < 1000 cells/ mm^3 and a single oral temperature of ≥38.3º C (101 ºF) or a temperature of ≥38.0º C (100.4 ºF) for ≥1 hour.

1. Assess severity of the fever and neutropenia (Supporting evidence: 8 guidelines)[1-8]

How worried are you about your fever?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

What is your temperature in the last 24 hours? Current: _____ Previous temperatures: _____

Have you taken any acetaminophen (Tylenol®) or ibuprofen (Advil®), if yes, how much and when? _____

Ask patient to indicate which of the following are present or absent

Temperature of ≥38.0º C (100.4 ºF)?[1-8]	No	☐	Yes	☐
Last known neutrophil count[1-8] _____ Date: ☐Unsure	>1000 cells/mm^3	☐	Fever plus <500 cells/mm^3 or 1000 cells/mm^3 with expected drop	☐
	1 **Mild**		3 **Severe**	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 8 guidelines)[1-8]	☐ Review self-care.		☐ Refer for medical attention immediately. Febrile Neutropenia treatment with antibiotics should be initiated within 2 hours of presentation. Collection of clinical and laboratory data to locate potential site or cause of infection is critical prior to starting antibiotics.[1]	

Note: Although guidelines indicate the need to take action when a temperature is ≥38.3º C (101 ºF) at any time or a temperature is ≥38.0º C (100.4 ºF) for ≥1 hour, for consistency across symptom practice guides a temperature of 38.0º C is used.

Additional Comments:

Patient Name_____

3. Review medications patient is using for fever, including prescribed, over the counter, and/or herbal supplements

Current use	Examples of Medications	Notes	Type of Evidence
☐			

*Use of medications to lower fever in cancer patients is controversial and should not be used to mask a fever of unknown origin.

4. Review self-care strategies to minimize risk of infection **(Supporting evidence: 2 guidelines)**[1,4]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	If temperature not ≥38.0º C, are you checking your body temperature with a thermometer? [4]
2. ☐	☐	☐	Are you washing your hands frequently?[1]
3. ☐	☐	☐	Are you eating well cooked foods and/or well cleaned uncooked raw fruits and vegetables?[1] (Randomized Control Trial)
4. ☐	☐	☐	Are you brushing your teeth with a soft toothbrush at least twice a day (dental flossing can be done if it does not cause bleeding)? [1]
5. ☐	☐	☐	Are you taking daily showers or baths? [1]
6. ☐	☐	☐	Are you trying to avoid enemas, suppositories, tampons and invasive procedures? [1]
7. ☐	☐	☐	Are you checking your skin for potential sites of infection (e.g. access devices, rectal area) and keeping these areas clean and dry? [1]
8. ☐	☐	☐	Are you trying to avoid crowds and people who might be sick? [1]
9. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller **(check all that apply)**

☐	No change, continue with self-care strategies
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Freifeld AG, et al. Clinical practice guideline for the use of antimicrobial agents in neutropenic patients with cancer: 2010 update by the infectious diseases society of america. Clin Infect Dis 2011 Feb 15;52(4):e56-e93. (AGREE Rigour score 62%)
2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: Prevention and treatment of cancer-related infections. Version 1. 2012. (AGREE Rigour score pending)
3. Mendes AV, et al. New guidelines for the clinical management of febrile neutropenia and sepsis in pediatric oncology patients. J Pediatr (Rio J) 2007 May;83(2 Suppl):S54-S63. (AGREE Rigour score 33%)
4. de Naurois J, et al. Management of febrile neutropenia: ESMO Clinical Practice Guidelines. Ann Oncol 2010 May;21 Suppl 5:v252-v256. (AGREE Rigour score 19%)
5. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.
6. Tam CS, et al. Use of empiric antimicrobial therapy in neutropenic fever. Australian Consensus Guidelines 2011 Steering Committee. Intern Med J 2011 Jan;41(1b):90-101. (AGREE Rigour score pending)
7. Alberta Health Services. Management of Febrile Neutropenia in Adult Cancer Patients. Alberta, Canada; 2012. (AGREE Rigor score 53%)
8. National Institute for Health and Clinical Excellence. Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients. Manchester, England; 2012. (AGREE Rigour score pending)

Loss of Appetite Practice Guide

Remote Assessment, Triage, and Management of Loss of Appetite in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and Time

Anorexia: An involuntary loss of appetite[1,3]; being without appetite.

1. Assess severity of the anorexia (Supporting evidence: 2 guidelines)[2,3]

Tell me what number from 0 to 10 best describes your appetite

Best appetite 0 1 2 3 4 5 6 7 8 9 10 Worst possible appetite [4(ESAS)]

How worried are you about your poor appetite? [3]

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[2,3,4]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about poor appetite (see above)[3]	0-5	☐	6-10	☐		
How much have you had to eat and drink in past 24 hours (e.g. at each meal)?[3] (compared to your normal food intake)	Some	☐	Minimal	☐	None	☐
Is there anything causing your lack of appetite[3]: ☐ Recent surgery or treatment ☐ New medication ☐ Other symptoms, describe.	No	☐	Yes, some	☐	Yes, several	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[3]	No	☐	Yes, some	☐	Yes, significantly	☐
Does your poor appetite interfere with your daily activities at home and/or at work?[3] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Have you lost weight in the last 1-2 weeks without trying? [3]Amount: ☐Unsure	No	☐	Yes	☐		
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If severe loss of appetite is stabilized, review self-care strategies ☐ If severe loss of appetite is new refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional comments:

Patient Name_____

3. Review medications patient is using for anorexia, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)[1,2]

Current use	Examples of Medications for appetite	Notes (e.g. dose, suggest taking as prescribed)	Type of Evidence
☐	megestrol (Megace®)[1,2]		Systematic review
☐	Corticosteroids* - dexamethasone (Decadron®), prednisone[1]		Systematic review

* Corticosteroids offer short-lived benefit. Long-term use is associated with significant toxicities.

4. Review self-care strategies (Supporting evidence: 3 guidelines)[1,2,3]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you feel like you are not hungry? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Are you trying to eat 5-6 small meals?[3]
3. ☐	☐	☐	Are you trying to eat more when you feel most hungry?[3]
4. ☐	☐	☐	Are you trying to eat foods that are higher in protein and calories such as cheese, yogurt, eggs, or milk shakes?[3]
5. ☐	☐	☐	Are you able to obtain groceries and help prepare your meals (access to food, financial resources)? If preparing meals is a problem ask friends family to help or buy convenience foods.[3]
6. ☐	☐	☐	Are you drinking any higher energy and protein drinks (Ensure, Glucerna, Boost®)?[1,3] (systematic review)
7. ☐	☐	☐	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week) [2]
8. ☐	☐	☐	Have you spoken with a dietitian?[1,2,3] (systematic review)
9. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Adams LA, et al. Putting evidence into practice: evidence-based interventions to prevent and manage anorexia. Clin J Oncol Nurs 2009 Feb;13(1):95-102. (AGREE Rigour score 83%)
2. Dy SM, et al. Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. J Clin Oncol 2008 Aug 10;26(23):3886-95. (AGREE Rigour score 51%)
3. Cancer Care Ontario. Symptom Management Guide-to-Practice: Loss of Appetite. Toronto, Ontario; 2012. (AGREE Rigour score pending)
4. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Mouth Sores/Stomatitis Practice Guide

Remote Assessment, Triage, and Management of Mouth Sores/Stomatitis in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name
Date of Birth
Sex
Hospital card number

Date and Time

Mouth sores/Stomatitis/Oral Mucositis: An inflammatory and potentially ulcerative process of the mucous membranes, resulting in severe discomfort that can impair patients' ability to eat, swallow, and talk, and is accompanied by a risk for life-threatening bacteremia and sepsis.[2,5]

1. Assess severity of the mouth sores (Supporting evidence: 5 guidelines)[1-5]

Tell me what number from 0 to 10 best describes your mouth sores?

No mouth sores 0 1 2 3 4 5 6 7 8 9 10 Worst possible mouth sores[6(ESAS)]

How worried are you about your mouth sores?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see above)[4,6]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about mouth sores (see above)[4]	0-5	☐	6-10	☐		
How many sores/ulcers/blisters do you have?[1-4]	0-4	☐	>4	☐	Coalescing/ Merging/Joining	☐
Do the sores in your mouth bleed?[2-4]	No	☐	Yes, with eating or oral hygiene	☐	Yes, spontaneously	☐
Are the sores painful?[1-5]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you see any redness or white patchy areas (isolated or clustered) in your mouth?[1,2,4,5]	No	☐	Yes, some	☐	Yes, often	☐
Do you have a dry mouth?[4]	No	☐	Yes	☐		
Are you able to eat and drink?[2-5] If no, can you open and close your mouth?[4]	Yes	☐			No	☐
Have you lost weight in the last 1-2 weeks without trying?[4] Amount: ☐Unsure	No	☐	Yes	☐		
Are you having trouble breathing?[4]	No	☐	Yes, some	☐	Yes, significantly	☐
Does your mouth sore(s) interfere with your daily activities at home and/or at work?[4] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 4 guidelines)** [1,2,4,5]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for mouth sores, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines) [2,4,5]

Current use	Examples of Medications for mouth sores	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	benzydamine hydrogen chloride (Tantum mouth rinse)[2]		1 Randomized trial
☐	Oral medications for pain[4,5]		Expert opinion

*Many other medications have been tested however their effectiveness has not been established.

4. Review self-care strategies (Supporting evidence: 4 guidelines)[1,2,4,5]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you have mouth sores? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Are you trying to rinse your mouth 4 times a day[5] with a bland rinse? For 1 cup warm water, add 2.5 ml (1/2 tsp.) table salt, baking soda or both. Swish 15 ml (1 tablespoon) in your mouth for at least 30 seconds and spit out.[1,2,4] Prepare daily and keep at room temperature.
3. ☐	☐	☐	Are you trying to brush your teeth at least twice a day using a soft toothbrush and flossing once daily or as tolerated?[1,2,4,5]
4. ☐	☐	☐	If you wear dentures and your mouth is sensitive, do you try to use your dentures only at mealtimes?[4,5]
5. ☐	☐	☐	Are you using water-based moisturizers to protect your lips? [1,2,4,5]
6. ☐	☐	☐	Do you rinse your toothbrush in hot water before using and allow it to air dry before storing?[2,4,5]
7. ☐	☐	☐	Are you sucking on xylitol lozenges or chewing on xylitol gum (max. 6 grams per day)[4]
8. ☐	☐	☐	Are you trying to avoid tobacco and alcohol, including alcohol-based mouthwashes?[2,4,5]
9. ☐	☐	☐	Are you trying to drink 8-10 glasses of fluids per day?[2,4,5]
10. ☐	☐	☐	Are you trying to eat a soft diet? Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes[2,5]
11. ☐	☐	☐	Are you trying to avoid foods and drinks that are acidic, salty, spicy, or very hot or very cold (temperature)?[2,5]
12. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Keefe DM, et al. Updated clinical practice guidelines for the prevention and treatment of mucositis. Cancer 2007 Mar 1;109(5):820-31. (AGREE Rigour score 82%)
2. Harris DJ, et al. Putting evidence into practice: evidence-based interventions for the management of oral mucositis. Clin J Oncol Nurs 2008 Feb;12(1):141-52. (AGREE Rigour score 79%)
3. Quinn B, et al. Guidelines for the assessment of oral mucositis in adult chemotherapy, radiotherapy and haematopoietic stem cell transplant patients. Eur J Cancer 2008 Jan;44(1):61-72. (AGREE Rigour score 73%)
4. Cancer Care Ontario. Symptom Management Guide-to-Practice: Oral Care. Toronto, Ontario; 2012. (AGREE Rigour score pending)
5. Broadfield L, et al. Best Practice Guidelines for the Management of Oral Complications from Cancer Therapy. Supportive Care Cancer Site Team, Cancer Care Nova Scotia; 2006. (AGREE Rigour score 89%)
6. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Nausea & Vomiting Practice Guide

Remote Assessment, Triage, and Management of Nausea & Vomiting in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Nausea: A subjective perception that emesis may occur. Feeling of queasiness.
Vomiting: A forceful expulsion of stomach contents through the mouth and may include retching (gastric and esophageal movement without vomiting – dry heaves.)[6,10]

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of nausea/vomiting (Supporting evidence: 4 guidelines)[1,6,7,10]

Tell me what number from 0 to 10 best describes your nausea
No nausea 0 1 2 3 4 5 6 7 8 9 10 Worst possible nausea [8(ESAS)]
Tell me what number from 0 to 10 best describes your vomiting?
No vomiting 0 1 2 3 4 5 6 7 8 9 10 Worst possible vomiting [8(ESAS)]
How worried are you about your nausea/vomiting?
Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating for nausea (see ESAS above)[1,6,8]	0-3	☐	4-10	☐		
Patient rating for vomiting (see ESAS above) [1,6,8]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about nausea/vomiting (see above)[6]	0-5	☐	6-10	☐		
How many times per day are you vomiting or retching?[1,6,7,10] ☐No vomiting	≤1	☐	2-5	☐	≥6	☐
Have you been able to eat within last 24 hours?[6,7,10]	Yes	☐	No	☐		
Have you been able to tolerate drinking fluids? [6,7,10]	Yes	☐			No	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[6,10]	No	☐	Yes, some	☐	Yes, significantly	☐
Do you have any blood in your vomit or does it look like coffee grounds?[6] ☐No vomiting	No	☐			Yes	☐
Do you have any abdominal pain or headache?[6]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Does your nausea/vomiting interfere with your daily activities at home and/or at work[6]? Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)[6,7]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 7 guidelines)**[1-5,9,10]

Current use	Examples of Medications for nausea/vomiting	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®)[1-5,9,10]		Systematic review
☐	dexamethasone (Decadron®)[1,2,3,5,9,10]		(Large RCT and/or systematic review)
☐	fosaprepitant, aprepitant (Emend®)[1-5]		Systematic review
☐	metoclopramide (Maxeran®)[1-5,9,10]		Systematic review
☐	prochlorperazine (Stemetil®)[1,2,5,9,10]		Systematic review
☐	Other: lorazepam (Ativan®)[1-3,5,9,10], nabilone, dronabinol[2,5]; haloperidol (Haldol®)[2,5]		(Large RCT and/or systematic review)

4. Review self-care strategies **(Supporting evidence: 6 guidelines)** [2-5,6,10]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you have nausea/vomiting? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Are you trying to drink clear fluids (e.g. water, sports drinks, broth, gingerale, chamomile tea)?[6,10]
3. ☐	☐	☐	Have you tried relaxation techniques that may include guided imagery, music therapy, progressive muscle relaxation?[2,3,5,6,10]
4. ☐	☐	☐	Are you taking anti-emetic medications before meals so they are effective during/after meals?[5,6]
5. ☐	☐	☐	If vomiting, are you limiting food and drink until vomiting stops? After 30-60 minutes without vomiting, sip clear fluids. When clear fluids stay down, add dry starchy foods (e.g. crackers, dry toast, dry cereal, pretzels). If starchy food stay down, add protein rich foods (e.g. eggs, chicken).[6]
6. ☐	☐	☐	Are you trying to: - eat 5-6 small meals or snacks? [2,5,6] - eat foods that minimize your nausea and are your "comfort foods"? [2,5] - avoid greasy/fried, highly salty, and spicy foods? [2,5,6] - eat foods that are cold, avoiding extreme temperatures and strong odors? [2,5,6,10]
7. ☐	☐	☐	Are you sitting upright or reclining with head raised for 30-60 minutes after meals? [6]
8. ☐	☐	☐	Are you wearing loose clothing?[6]
9. ☐	☐	☐	Are you rinsing your mouth before eating and keeping your mouth clean (brushing, rinsing)?[6]
10. ☐	☐	☐	Have you tried acupuncture or acupressure to help with your nausea/vomiting?[4,5,6]
11. ☐	☐	☐	Have you spoken with a dietitian? [10]
12. ☐	☐	☐	Would more information about your symptoms help you to manage them better? [6] If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller **(check all that apply)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

1. Basch E, et al. Antiemetics: ASCO clinical practice guideline update. J Clin Oncol 2011 Nov 1;29(31):4189-98. (AGREE Rigor score 72%)
2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: antiemesis. Version 1. 2013. (AGREE Rigor score pending)
3. Gralla RJ, et al. MASCC/ESMO Antiemetic Guideline. 2011. (AGREE Rigor score pending)
4. Naeim A, et al. Evidence-based recommendations for cancer nausea and vomiting. J Clin Oncol 2008 Aug 10;26(23):3903-10. (AGREE Rigor score 68%)
5. Tipton JM, et al. Putting evidence into practice: evidence-based interventions to prevent, manage, and treat chemotherapy-induced nausea and vomiting. Clin J Oncol Nurs 2007 Feb;11(1):69-78. (AGREE Rigor score 57%)
6. Cancer Care Ontario. Symptom Management Guide-to-Practice: Nausea and Vomiting. Toronto, Ontario; 2010. (AGREE Rigour score 71%)
7. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.
8. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
9. Feyer PC, et al. Radiotherapy-induced nausea and vomiting: MASCC/ESMO guideline for antiemetics in radiotherapy: update 2009. Support Care Cancer 2011 Mar;19 Suppl 1:S5-14.
10. Cancer Care Nova Scotia. Guidelines for the Management of Nausea/Vomiting in Cancer Patients. Halifax, Nova Scotia; 2004.

Peripheral Neuropathy Practice Guide

Remote Assessment, Triage, and Management of Peripheral Neuropathy in Adults Undergoing Cancer Treatment

Neuropathy: Described as numbness, tingling, burning, pins and needles, tremor, balance disturbances, pain. The end result of peripheral, motor, sensory, and autonomic neuron damage caused by neurotoxic chemotherapy agents that inactivate the components required to maintain the metabolic needs of the axon.[1,2,3]

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of the neuropathy (Supporting evidence: 3 guidelines)[1,2,3]

Tell me what number from 0 to 10 best describes your neuropathy/numbness/tingling?
No neuropathy 0 1 2 3 4 5 6 7 8 9 10 Worst possible neuropathy [5(ESAS)]

How worried are you about your neuropathy/numbness/tingling?
Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[5]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about neuropathy (see above)	0-5	☐	6-10	☐		
Do you have pain in your _____ (neuropathy location)?[1,2,3] Describe on a scale of 0 to 10.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you have new weakness in your arms or legs?[1,2]	No	☐	Yes, some	☐	Yes, often	☐
Have you noticed problems with your balance or how you walk or climb stairs? If yes, how much?[1,2]	No/Mild	☐	Yes, some	☐	Yes, often	☐
Are you constipated or have difficulty emptying your bladder of urine?[1,2]	No/Mild	☐	Yes, some	☐	Yes, often	☐
Does your neuropathy/numbness/tingling interfere with your daily activities at home and/or at work (e.g. buttoning clothing, writing, holding coffee cup)?[1,2] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)[3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for neuropathy, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines) [2,3,4]

Current use	Examples of Medications for neuropathy	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	Anti-convulsants – gabapentin, pregabalin (Lyrica®)[2,4]		Systematic review
☐	Tricyclic anti-depressants – amitriptyline, nortriptyline, duloxetine (Cymbalta®), venlafaxine (Effexor®), bupropion (Wellbutrin®, Zyban®)[2,3,4]		Systematic review
☐	Opioids – fentanyl, morphine (Statex®), hydromorphone (Dilaudid®), codeine, oxycodone[2,3]		Expert Opinion
☐	Topical – lidocaine patch 5%, NSAID-, diclofenac[2,3]		Expert Opinion

Note: opioids often combined with anticonvulsants or anti-depressants but increase CNS adverse events requiring careful titration

4. Review self-care strategies (Supporting evidence: 3 guidelines) [1,2,3]

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps with managing your neuropathy? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Do you look at your hands and feet every day for sores/blisters that you may not feel?[1,2]
3. ☐	☐	☐	**If neuropathy in feet:** Do you have footwear that fits you properly?[1,2]
4. ☐	☐	☐	In your home: - are the walkways clear of clutter?[1,2] - do you have a skid-free shower or are you using bath mats in your tub?[1,2] - have you removed throw rugs that may be a tripping hazard?[1,2]
5. ☐	☐	☐	When you are walking on uneven ground, do you try to look at the ground to help make up for the loss of sensation in your legs or feet?[1,2]
6. ☐	☐	☐	**If any neuropathy:** To avoid burns due to decreased sensation: -Have you lowered the water temperature in your hot water heater?[1] -Do you use a bath thermometer to ensure water in shower or tub is < 120ºF/49ºC?[1]
7. ☐	☐	☐	Do you try to dangle your legs before you stand up to avoid feeling dizzy?[1,2]
8. ☐	☐	☐	Do you try eat a high-fiber diet and drink adequate fluids to avoid becoming constipated?[1,2]
9. ☐	☐	☐	Have you tried acupuncture?[2]
10. ☐	☐	☐	Have you spoken with a physiotherapist about: - a walker, cane, or a splint to help with your balance and improve walking?[1,2] - a physical training plan or TENS (transcutaneous electrical nerve stimulation)?[2,3]
11. ☐	☐	☐	Have you spoken with an occupational therapist for suggestions such as: -switching to loafer-style shoes or using Velcro shoe laces -adaptive equipment such as enlarged handles on eating utensils, button hooks, Velcro on computer keys to stimulate sensation?
12. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller monitoring (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Visovsky C, et al. Putting evidence into practice: evidence-based interventions for chemotherapy-induced peripheral neuropathy. Clin J Oncol Nurs 2007 Dec;11(6):901-13. (AGREE Rigour score 84%)
2. Stubblefield MD, et al. NCCN task force report: management of neuropathy in cancer. J Natl Compr Canc Netw 2009 Sep;7 Suppl 5:S1-S26. (AGREE Rigour score 78%)
3. National Comprehensive Cancer Network. NCCN Clinical practice guidelines in oncology: Adult cancer pain. Version 1. 2009. (AGREE Rigour score 78%)
4. Caraceni A, et al. Use of opioid analgesics in the treatment of cancer pain: evidence-based recommendations from the EAPC. Lancet Oncol 2012 Feb;13(2):e58-e68.
5. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Skin Reaction Practice Guide

Remote Assessment, Triage, and Management of Skin Reactions in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name
Date of Birth
Sex
Hospital card number

Date and Time

Skin reaction/alteration: A change in the colour, texture or integrity of the skin.[4]

1. Assess severity of the skin reaction (Supporting evidence: 3 guidelines)[1,2,4]

Tell me what number from 0 to 10 best describes your skin reaction

No skin reaction 0 1 2 3 4 5 6 7 8 9 10 Worst possible skin reaction [3(ESAS)]

How worried are you about your skin reaction?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Site of skin reaction(s) _____

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above)[3]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about skin reaction (see above)	0-5	☐	6-10	☐		
Is your skin red?[1,2,4]	None	☐	Faint/dull	☐	Tender/bright	☐
Is your skin peeling?[1,2,4]	No/Dry	☐	Patchy, moist	☐	Generalized, moist	☐
Do you have any swelling around the skin reaction area?[1,2]	No	☐	Yes, some	☐	Yes, pitting edema	☐
Do you have pain at the skin reaction area?[2,4]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you have any open, draining wounds?[2,4]	No	☐			Yes	☐
Do you have any bleeding[1,2,4]	No	☐	Yes, some	☐	Yes, gross	☐
Do you have any necrotic skin?[1,4]	No	☐			Yes	☐
Do you have a fever > 38° C?[2] ☐Unsure	No	☐			Yes, with skin reaction	☐
Have you started a new medication? [2,4]	No	☐			Yes	☐
Does your skin reaction interfere with your daily activities at home and/or at work?[2,4] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 2 guidelines)**[1,2]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

Additional Comments:

Patient Name_____

3. Review medications patient is using for skin reaction, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)[1,2,4]

Current use	Examples of Medications for skin reaction to radiation therapy*	Notes (e.g. dose, suggest to use as prescribed)	Type of Evidence
☐	Calendula ointment[1,4]		1 randomized trial
☐	Hyaluronic acid cream[4]		1 randomized trial
☐	Low-dose corticosteroid cream[1,2,4*]		Expert opinion

* There is insufficient evidence to support or refute other specific topical agents (i.e., corticosteroids, sucralfate cream, Biafine®, ascorbic acid, aloe vera, chamomile cream, almond ointment, polymer adhesive skin sealant) for the prevention of acute skin reaction.

4. Review self-management strategies (Supporting evidence: 3 guidelines)[1,2,4]

What strategies are already being used?	Strategy suggested/education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you have a skin reaction? Reinforce as appropriate. Specify:
2. ☐	☐	☐	Are you trying to take warm showers or immersion in warm baths (not soaking in the tub) using mild soap, and patting dry (no rubbing)?[1,2,4(Randomized control trial evidence)]
3. ☐	☐	☐	Are you trying to use plain, non-scented, lanolin-free, water-based creams on intact skin only?[1,2,4]
4. ☐	☐	☐	Are you trying to avoid using perfumed products? [2]
5. ☐	☐	☐	Are you using deodorant if skin is intact? [2,4(Randomized control trial evidence)]
6. ☐	☐	☐	Are you trying to use an electric razor OR avoid shaving the area that is irritated?[2,4]
7. ☐	☐	☐	Are you avoiding waxing or other hair removal creams?[2]
8. ☐	☐	☐	Are you avoiding skin creams or gels in the treatment area before each treatment?[4]
9. ☐	☐	☐	Are you trying to avoid chlorinated pools and Jacuzzis?[2,4]
10. ☐	☐	☐	Are you trying to avoid temperature extremes in the treatment area (e.g. ice pack or heating pad) to the reaction area?[2,4]
11. ☐	☐	☐	Are you trying to protect the treatment area from the sun and the cold? [2,4]
12. ☐	☐	☐	Are you trying to avoid tape or Band-aids in the treatment area?[2,4]
13. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with caller (check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Bolderston A, et al. The prevention and management of acute skin reactions related to radiation therapy: a systematic review and practice guideline. Support Care Cancer 2006 Aug;14(8):802-17. (AGREE Rigour score 85.4%)
2. BC Cancer Agency. Care of Radiation Skin Reactions. British Columbia, Canada; 2012. (AGREE Rigour score pending)
3. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
4. Feight D, et al. Putting evidence into practice: Evidence-based interventions for radiation dermatitis. Clin J Oncol Nurs 2011 Oct;15(5):481-92.

General Assessment

Practice Guides for the Remote Assessment, Triage, and Management of Symptoms in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex
Hospital card number

Date and time of encounter _____ Caller _____

Type of Cancer _____ Primary Oncologist _____

Other practitioners (most responsible) _____

1. **Tell me about your symptom(s)** (Supporting Evidence: Expert Consensus)
   (PQRST- Provoking factors, Quality, Radiating, Relieving factors, Severity, Other symptoms, Timing, Triggers, Location)

2. **Conduct general symptom assessment** (Supporting Evidence: Expert Consensus)
   Receiving cancer treatment:
   - ☐Radiation: Site of radiation _____
   - ☐Chemotherapy: Name of Chemotherapy _____
     Date of last treatment(s) _____

   Length of time since symptom started? _____

   New symptom? ☐Yes ☐No ☐Unsure

   Told symptom could occur? ☐Yes ☐No ☐Unsure

   Other symptoms? ☐Yes ☐No If Yes, specify:

☐Anorexia	☐Depression	☐Fatigue	☐Peripheral Neuropathy
☐Anxiety	☐Diarrhea	☐Febrile Neutropenia	☐Skin Reactions
☐Bleeding	☐Dyspnea	☐Nausea/Vomiting	☐Stomatitis
☐Constipation	☐Other _____		

   Recent exposure to known virus/flu? ☐Yes ☐No ☐Unsure If Yes, specify _____

3. **Assess current use of medications, herbs, natural health products (name, dose, current use)**

Medication	Dose Prescribed	Taking as prescribed/Last dose if PRN
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /

   Are any medications new or are there recent changes? ☐Yes ☐No If Yes, specify:

4. See appropriate symptom practice guide(s) for further assessment, triage and management.