Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Project

Remote Symptom Protocols for Individuals Undergoing Cancer Treatments

March 2012

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If you translate any of this material into languages other than English or French, we would appreciate that you notify Dawn Stacey RN, PhD, University of Ottawa.

Disclaimer

These COSTaRS Remote Symptom Protocols for Individuals Undergoing Cancer Treatments are intended for use by trained Registered Nurses (RNs). They provide general guidance on appropriate practice and their use is subject to the registered nurses' judgment in each individual case. The COSTaRS Remote Symptom Protocols for Individuals Undergoing Cancer Treatments are designed to provide information to assist decision-making and are not meant to be prescriptive. Individuals who use these protocols are required to make their own determination regarding specific safe and appropriate clinical practices. While care has been taken to ensure that these protocols reflect the state of general knowledge and expert consensus about practice in the field at the date of publication, neither the COSTaRS Steering Committee nor the Canadian Partnership Against Cancer who funded this project make any warranty or guarantee in respect to any of the contents or information contained in these protocols. Neither group accept responsibility or liability whatsoever for any errors or omissions in these protocols, regardless of whether those errors or omissions were made negligently or otherwise.

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Overview and Protocol 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). Despite that higher quality telephone services require use of symptom protocols to minimize risk, access to and the ways symptom protocols 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 protocols 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 protocols.

The protocols were developed using a systematic process guided by the CAN-IMPLEMENT© methodology:[3;4]

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.[5;6] Guidelines are syntheses of the best available evidence and are designed to support decision making in practice and health policy.[7] However, identified clinical practice guidelines were not adequate for remote symptom support.
3. We developed 13 symptom protocols based on the available clinical practice guidelines (median 3 guidelines per protocol; range 1 to 7). In total, we identified > 40 practice guidelines and their quality was appraised using the AGREE instrument (range 11% to 87%).[8] 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.[9] Principles for developing the symptom protocols 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.[10;11]
   - 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 protocols and patients/families.

   Each symptom protocol 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[12]); and e) summarize and document the plan agreed upon with the patient.
4. We tested the protocol 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 protocols for review by cancer experts across Canada. They validated the content of the protocols and identified the need for local adaptation to integrate the protocols with their current approaches for handling remote symptom assessments.

In summary, we have developed 13 user-friendly remote symptom protocols based on a synthesis of the best available evidence,[2] validated the protocols 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) 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.
(2) Harrison MB, van den Hoek J, for the Canadian Guideline Adaptation Study Group. CAN-IMPLEMENT©: A Guideline Adaptation and Implementation Planning Resource. 2010. Kingston, Ontario, Queen's University School of Nursing and Canadian Partnership Against Cancer.
(3) 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. Canadian Partnership Against Cancer: The National Advisory Working Group on behalf of the Cancer Journey Portfolio. In press 2012.
(4) Howell D, Currie S, Mayo S, Jones G, Boyle M, 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.
(5) 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.
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(7) Brouwers M, Kho ME, Browman GP, Burgers JS, Cluzeau F, Feder G 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.
(8) 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.
(9) Barbera L, Seow H, Howell D, Sutradhar R, Earle C, Liu Y et al. Symptom burden and performance status in a population-based cohort of ambulatory cancer patients. Cancer 2010; 116(24):5767-5776.
(10) Miller WR, Rollnick S. Motivational interviewing: Preparing people for change (2nd ed.). New York: Guilford Press; 2002.
(11) Brouwers M, Stacey D, O'Connor A. Knowledge creation: synthesis, tools and product. Canadian Medical Association Journal 2010; 182(2):E68-E72.

Anxiety Protocol

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

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.

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of the anxiety (Supporting evidence: 2/2 guidelines)

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 ESAS

Do have any concerns that are making you feel more anxious (e.g. life events, new information about cancer/treatment, making a decision)? ☐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.	None/ Mild	☐	Moderate	☐	Severe	☐
Are you having panic attacks; periods/spells of sudden fear, discomfort, intense worry, uneasiness?[2,3] Describe.	None/ Mild	☐	Moderate	☐	Severe	☐
How much does your anxiety affect your daily activities at home and/or at work?[2] Describe.	None	☐	Some	☐	Yes, significant	☐
How much does your anxiety affect your sleep?[2]	None	☐	Some	☐	Yes, significant	☐
Are any of the following relevant to you? (circle risk factors): waiting for test results, financial problems, history of anxiety or depression, recurrent/advanced disease, withdrawal from alcohol/ substance use, living alone, younger age (< 30), not exercising?[2,3]	None	☐	Some	☐	Several	☐
Are you feeling (symptom-related risk factors for anxiety): Fatigue ☐Yes ☐No Short of breath ☐Yes ☐No Pain ☐Yes ☐No Other ☐Yes ☐No If yes, see appropriate symptom protocol.	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: 1/2 guidelines)	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If 1 or more symptoms present with any anxiety, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 2/2 guidelines)**

Current use	Medications for anxiety	Notes (eg. 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-management strategies **(Supporting evidence: 2/2 guidelines)**

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:
☐	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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, Currie S, Mayo, S, Jones G, Boyle M, et al. (2009) 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. . (AGREE Rigour score 85.4%)
3. Sheldon LK, Swanson S, Dolce A, Marsh K, Summers J. (2008). Putting Evidence into Practice: Evidence-based interventions for anxiety. Clinical Journal of Oncology Nursing, 12(5), 789-797. (AGREE Rigour score 37.5%)

Bleeding Protocol

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: 1/1 guideline)

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	☐	Evident	☐	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 > 38° C? ☐Unsure	No	☐		☐	Yes	☐
Do you have any blood in your stool or is it black?[1] ☐Unsure	No	☐		☐	Yes	☐
Do you have any blood in your vomit or does it look like coffee grounds?[1] ☐No vomiting	No	☐		☐	Yes	☐
Do you know what your last platelet count was? Date: ☐Unsure	≥ 100	☐	20-99	☐	< 20	☐

	1 Mild	2 Moderate	3 Severe
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1/1 guideline)**	☐ Review self-care. Verify medication use, if appropriate.	☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	☐ If 1 or more symptoms present with any bleeding, seek medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: Expert Consensus)

Current use	Medications	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-management strategies (Supporting evidence: 1/1 guideline)

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? [1]
5. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Damron, B.H., Brant, J.M., Belansky, H.B., Friend, P.J., Samsonow, S., & Schaal, A. (2009). Putting evidence into practice: Prevention and management of bleeding in patients with cancer. *Clinical Journal of Oncology Nursing 13*(5),573-583. (AGREE Rigour score 87%)
2. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. J. Palliat Care 1991; 7(2):6-9.

Breathlessness/Dyspnea Protocol

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] 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: 1/3 guidelines)**

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 [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)[3,4]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about shortness of breath (see above)	0-5	☐	6-10	☐		
With what level of activity do you experience this shortness of breath?	Moderate activity	☐	Mild activity	☐	At rest	☐
Do you have pain in your chest when you breathe?[3]	No	☐			Yes	☐
Is your breathing noisy, rattly or congested?[3]	No	☐			Yes	☐
Do you have a new cough with phlegm/sputum?	No	☐			Yes	☐
Do you have a fever > 38° C?[3] ☐Unsure	No	☐			Yes	☐
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: 1/3 guidelines)**	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any shortness of breath, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 3/3 guidelines)**

Current use	Medications for shortness of breath	Notes (eg. 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-management strategies **(Supporting evidence: 2/3 guidelines)**

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. ☐	☐	☐	Are you trying to rest in upright positions that can help you breath?[1,3]
4. ☐	☐	☐	Are you trying different breathing exercises (eg. diaphragmatic breathing, pursed lip breathing)?[1,3]
5. ☐	☐	☐	Are you trying to avoid cold air, humidity, & tobacco smoke?[3]
6. ☐	☐	☐	Are you trying to save energy for things that are important to you?[3]
7. ☐	☐	☐	Have you tried to turn down the temperature in your house?[1,3]
8. ☐	☐	☐	If you have a wheelchair, portable oxygen or other assistive device, are you trying to use them to help with activities that cause your shortness of breath?[1]
9. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
10. ☐	☐	☐	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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. DiSalvo, W. M., Joyce, M. M., Tyson, L. B., Culkin, A. E., & Mackay, K. (2008). Putting evidence into practice: Evidence-based interventions for cancer-related dyspnea. *Clinical Journal of Oncology Nursing, 12*(2), 341-352. (AGREE Rigour score 87%;)
2. Dy, S. M., Lorenz, K. A., Naeim, A., Sanati, H., Walling, A. and Asch, S. M. (2008). Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. *Journal of Clinical Oncology, 26*(23), 3886-3895. (AGREE Rigour score 51%)
3. Cancer Care Ontario. (2010). Cancer Care Ontario's Symptom management guide-to-practice: Dyspnea. Retrieved from: https://www.cancercare.on.ca/toolbox/symptools/. (AGREE Rigour score 62.5%)
4. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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 Protocol

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]

1. Assess severity of the constipation (Supporting evidence: 1/2 guidelines)

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 ESAS

How worried are you about your constipation?

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)	0-5	☐	6-10	☐		
How many days has it been since you had a bowel movement?[2]	≤ 2 days	☐	3 days or more	☐	3 days or more on meds	☐
Are you currently taking medication to help relieve your constipation?	No	☐	Yes, intermittently	☐	Yes, regularly	☐
Do you have any abdominal pain?[2] Describe.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Is your abdomen bigger than normal?[2] Does it feel harder than normal? ☐Unsure	None	☐	Increasing	☐	Severe, rigid	☐
Have you had any nausea/lack of appetite or have you vomited?[1,2]	No	☐	Nausea/lack of appetite	☐	Vomiting	☐
If you vomited, did it smell like stool?[2] ☐Unsure	No	☐			Yes	☐
Have you recently had abdominal surgery?[2]	No	☐			Yes	☐
Have you noticed any change in your sense of touch (numbness, tingling, burning)?	No	☐	Yes	☐		
Do you have new weakness in your arms or legs?[2]	No	☐			Yes	☐
Have you noticed a change in your urination pattern (voiding you can't control or feeling like you can't empty your bladder)?	No	☐			Yes	☐
Does your constipation 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: 1/2 guidelines)**	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any constipation, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 1/2 guidelines)**

Current use	Medications for constipation*	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
☐	senna (Senokot®)[1]		Expert Opinion
☐	docusate sodium (Colace®)[1]		Expert Opinion
☐	Suppositories** (Dulcolax®/bisacodyl, glycerin)[1]		Expert Opinion
☐	Golytely®[1]		Expert opinion + Low level evidence
☐	Lactulose[1]		Expert Opinion
☐	magnesium hydroxide (Milk of magnesia®)[1]		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-management strategies **(Supporting evidence: 1/2 guidelines)**

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. Specify:
2. ☐	☐	☐	What is your normal bowel routine? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to drink fluids, 8 glasses per day, especially warm or hot fluids?[1]
4. ☐	☐	☐	Have you increased the fiber in your diet?(Only appropriate if adequate fluid intake and physical activity)[1]
5. ☐	☐	☐	Do you have a comfortable, quiet, private environment for going to the bathroom?[1]
6. ☐	☐	☐	Do you have easy access to a toilet or bedside commode, and any necessary assistive devices (raised toilet seat)? If possible, try to avoid the use of a bedpan.[1]
7. ☐	☐	☐	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)
8. ☐	☐	☐	If you have a low neutrophil count are you trying to avoid rectal exams, suppositories, enemas?[1]
9. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
10. ☐	☐	☐	Have you spoken with a doctor or pharmacist about medications you may be taking that can be constipating?[1]
11. ☐	☐	☐	Have you spoken with a dietitian?[1]

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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Woolery, M., Bisanz, A., Lyons, H. F., Gaido, L., Yenulevich, M., et al. (2008). Putting evidence into practice: Evidence-based interventions for the prevention and management of constipation in patients with cancer. *Clinical Journal of Oncology Nursing, 12*(2), 317-337. (AGREE Rigour score 80%)
2. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigour score 11%)
3. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. J. Palliat Care 1991; 7(2):6-9.
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Depression Protocol

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

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

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of the depression (Supporting evidence: 2/2 guidelines)

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 ESAS

How worried are you about feeling depressed?

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

Are there any concerns contributing to your feelings of depression (e.g. life events, sleep deprivation, 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 at least 2 weeks almost all day, every day?[2,3]	No	☐			Yes	☐
Have you experienced any of the following for 2 weeks or longer (circle): feeling worthless, feeling guilty, sleeping too little or too much, weight gain or weight loss?[2,3]	None	☐	2 present	☐	4 present	☐
Does feeling depressed interfere with your daily activities at home and/or at work?[2] Describe.	No	☐	Yes, some	☐	Yes, significant	☐
Have you felt tired or fatigued?[2,3] Describe.	No/Mild	☐	Moderate	☐	Severe	☐
Have you felt agitated (which may include twitching or pacing) or slowing down of your thoughts?[2,3]	No	☐	Yes, some	☐	Yes, severe	☐
Do you have any other risk factors such as (circle): bothersome symptoms, a lack of social support, a history of depression or 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: 1/2 guidelines)	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised 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?[2,3] If yes, immediate referral for further evaluation.	
					☐ If no, and 1 or more symptoms present with any depression, seek 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 protocols? 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: 2/2 guidelines)**

Current use	Medications for depression*	Notes (eg. 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: 2/2 guidelines)**

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 symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.[2]
3. ☐	☐	☐	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)?[2]
4. ☐	☐	☐	Do you participate in any support groups[2,3] and/or have family/friends you can rely on for support?
5. ☐	☐	☐	Have you tried relaxation therapy or guided imagery?[2,3](systematic review with meta-analysis)
6. ☐	☐	☐	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):
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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, Currie S, Mayo, S, Jones G, Boyle M, et al. (2009) 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. Retrieved from: http://www.capo.ca/about-capo/professional-student-info/. (AGREE rigour score 85.4%)
3. Fulcher CD, Badger T, Gunter AK, Marrs JA, Reese JM. (2008, Feb). Putting Evidence Into Practice: Interventions for Depression. Clinical Journal of Oncology Nursing, 12(1), 131-140. (AGREE rigour score 43.8%)

Diarrhea Protocol

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.[3,5]

1. Assess severity of the diarrhea (Supporting evidence: 6/6 guidelines)

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 [ESAS]

How worried are you about your diarrhea?

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)[8]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about diarrhea (see above)	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?[2,3,5,6]	< 4 stools	☐	4-6 stools	☐	≥ 7 stools	☐
Ostomy: How much extra output are you having, above what is normal for you?[2,3,5,6]	Mild	☐	Moderate	☐	Severe	☐
Do you have a fever > 38° C?[2,3,5,6] ☐Unsure	No	☐			Yes	☐
Do you have pain in your abdomen or rectum with or without cramping or bloating?[2,5,6]	No	☐			Yes	☐
Do you have any blood in your stool or is it black?[2,5,6] ☐Unsure	No	☐			Yes	☐
Does your diarrhea interfere with your daily activities at home and/or at work?[2,5] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Have you vomited and/or had moderate nausea?[2,3,5,6]	No	☐			Yes	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[2,3,5,6]	No	☐			Yes	☐
Have you been able to drink fluids?[5,6]	Yes	☐			No	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: ½ guidelines)**	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any diarrhea, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 5/6 guidelines)**

Current use	Medications for diarrhea	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
☐	Loperamide (Imodium®)[2,3,4,5]		Systematic Review
☐	Atropine-diphenoxylate (Lomotil®)[3,4,5]		Systematic Review
☐	Octreotide (Sandostatin®)[1,2,3,4,5]		Systematic Review
☐	Psyllium fiber (Metamucil®)[3]		Randomized control trial

4. Review self-management strategies **(Supporting evidence: 5/6 guidelines)**

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)?[2,3,4,5,6]
3. ☐	☐	☐	Do you know what kinds of foods you should be trying to eat? Suggest: applesauce, oatmeal, bananas, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned turkey or chicken, mashed potatoes, cooked or canned fruit without skin[2,3,4,5,6] (Foods high in soluble fiber and low in insoluble fiber)
4. ☐	☐	☐	Are you trying to replace electrolytes (eg. potassium and sodium or salt) that your body may be losing with the diarrhea by eating foods such as bananas and potatoes and drinking sports drinks or peach/apricot nectar?[3]
5. ☐	☐	☐	Are you trying to eat 5-6 small meals?[2,3,5,6]
6. ☐	☐	☐	Are you trying to avoid lactose-containing products (milk, yoghurt, cheese)[2,3,5,6]
7. ☐	☐	☐	Are you trying to avoid alcohol and minimize caffeine (<2-3 servings) (coffee, chocolate)[2,3,4,5,6]
8. ☐	☐	☐	Are you trying to avoid greasy/fried and spicy foods?[3,5,6]
9. ☐	☐	☐	Are you trying to avoid large amounts fruit juices or sweetened fruit drinks?[2,3]
10. ☐	☐	☐	Are you trying to avoid raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes?[3,5,6] (Insoluble fiber)
11. ☐	☐	☐	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown?[5]
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)[2,5] (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?[5]

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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Major, P., Figueredo, A., Tandan, V., Bramwell, V., Charette, M., Oliver, T., et al. (2004). The role of octreotide in the management of patients with cancer. Practice guideline report #12-7. Cancer Care Ontario. Retrieved from: https://www.cancercare.on.ca/toolbox/qualityguidelines/clin-program/systemic-ebs/. (AGREE Rigour score 86%)
2. Benson, A.B., III, Ajani, J.A., Catalano, R.B., Engelking, C., Kornblau, S.M., Martenson, J.A., Jr., et al. (2004). Recommended guidelines for the treatment of cancer treatment-induced diarrhea. *Journal of Clinical Oncology, 22*(14), 2918–2926. (AGREE Rigor score 73%)
3. Oncology Nursing Society. (2008). Diarrhea: What interventions are effective in preventing and treating diarrhea in adults with cancer receiving chemotherapy or radiation therapy? ONS PEP. Retrieved from: http://www.ons.org/Research/PEP/Diarrhea. (AGREE Rigour score 48%)
4. British Columbia Cancer Agency. (2004). BCCA Guidelines for management of chemotherapy-induced diarrhea. Retrieved from: http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/SupportiveCare/Chemotherapy-Induced+Diarrhea.htm. (AGREE Rigour score 17%)
5. British Columbia Cancer Agency. (2008). Professional practice nursing standards - Symptom management guidelines: Cancer-related diarrhea. Retrieved from: http://www.bccancer.bc.ca/NR/rdonlyres/5D986439-3614-4F17-9E50-7FECC73C45D1/50139/Diarrhea.pdf. (AGREE Rigour score 17%)
6. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigour score 11%)
7. National Institutes of Health: National Cancer Institute. (2010). Common terminology criteria for adverse events (CTCAE) v4.03. Retrieved from: http://evs.nci.nih.gov/ftp1/CTCAE/About.html.
8. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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 Protocol

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: 3/3 guidelines)

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 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?	No	☐			Yes	☐
How would you describe the pattern of fatigue?	Intermittent	☐		☐	Constant/ Daily for two weeks	☐
Does your fatigue interfere with your daily activities at home and/or at work? 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: 1/2 guidelines)**	☐ Review self-care.		☐ Review self-care. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If 1 or more symptoms present with any fatigue/tiredness, seek medical attention immediately. *If severe fatigue is stabilized, review self-management strategies.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 3/3 guidelines)**

Current use	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-management strategies **(Supporting evidence: 3/3 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 (ie. 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:
☐	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Howell D, Keller-Olaman S, Oliver TK, et al., (2012, in press) A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Cancer-Related Fatigue in Adults with Cancer. Canadian Partnership Against Cancer: The National Advisory Working Group on behalf o the Cancer Journey Portfolio.
   Other guidelines referenced within this guideline are:
   a. Oncology Nursing Society (ONS). Putting Evidence into Practice (PEP) Topics – Fatigue. Accessed December 2009. Retrieved from: http://www.ons.org/Research/PEP/Fatigue. (AGREE rigour score 55.2%)
   b. Clinical Practice Guidelines in Oncology – Cancer-Related Fatigue, V.2.2009 (June 2009). National Comprehensive Cancer Network (NCCN). Retrieved from: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. (AGREE rigour score 28.5%)
2. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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 Protocol

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.
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.
Febile 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: 4/4guidelines)

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)?[1,2,3,4,5]	No	☐	Yes	☐
Last known neutrophil count[1,2,3,5] _____ Date: ☐Unsure	>1000 cells/mm^3	☐	<500 cells/mm^3 or 1000 cells/mm^3 with expected drop	☐
Have you received either chemotherapy or radiation treatment within the past 1-4 weeks?[4]	No	☐	Yes	☐
	1 **Mild**		3 **Severe**	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/4 guidelines)	☐ Review self-care.		☐ If fever with known or suspected neutropenia, in addition to any other symptoms, seek medical attention immediately.	

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 protocols 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	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-management strategies to minimize risk of infection **(Supporting evidence: 1/4 guidelines)**

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	Are you washing your hands frequently?[4]
2. ☐	☐	☐	Are you trying to increase your fluid intake to 8-12 glasses per day?[4]
3. ☐	☐	☐	Are you brushing your teeth with a soft toothbrush?[4]
4. ☐	☐	☐	Are you trying to avoid enemas, suppositories, tampons and invasive procedures?[4]
5. ☐	☐	☐	Are you trying to keep any wounds clean and dry?[4]
6. ☐	☐	☐	Are you trying to avoid crowds and people who might be sick?[4]
7. ☐	☐	☐	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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Hughes, W. T., Armstrong, D., Bodey, G. P., Bow, E. J., Brown, A. E., et al. (2002). 2002 Guidelines for the use of antimicrobial agents in neutropenic patients with cancer. *Clinical Infectious Diseases, 34*, 730-751. (AGREE Rigour score 62%)
2. National Comprehensive Cancer Network. (2008). NCCN Clinical practice guidelines in oncology: Prevention and treatment of cancer-related infections. Version 1. Retrieved from: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. (AGREE Rigour score 48%)
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4. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigor score 11%)
5. National Institutes of Health: National Cancer Institute. (2010). Common terminology criteria for adverse events (CTCAE) v4.03. Retrieved from: http://evs.nci.nih.gov/ftp1/CTCAE/About.html.

Loss of Appetite Protocol

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]; being without appetite.

1. Assess severity of the anorexia (Supporting evidence: 1/3 guideline)

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 [ESAS]

How worried are you about your poor appetite?

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)[4]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about poor appetite (see above)	0-5	☐	6-10	☐		
How much have you had to eat and drink in past 24 hours (eg. at each meal)?[3]	Some	☐	Minimal	☐	None	☐
Does your poor appetite interfere with your daily activities at home and/or at work?[3] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
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	☐
Have you lost weight in the last 1-2 weeks? Amount: ☐Unsure	No	☐	Yes	☐		
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1/3 guidelines)**	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If 1 or more symptoms present with any anorexia, seek medical attention immediately. *If severe loss of appetite is stabilized, review self-management strategies.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 1/3 guideline)**

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

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

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1. ☐	☐	☐	What helps when you feel 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 using any food supplements (Ensure, Glucerna, Boost®)?[1]
6. ☐	☐	☐	Are you trying to limit drinking ½ hour before a meal to avoid feeling too full?[3]
7. ☐	☐	☐	Did you know that cold foods are sometimes better tolerated? [3]
8. ☐	☐	☐	Are you trying to sit up after each meal for 30-60 minutes to help digest your food?[3]
9. ☐	☐	☐	Have you spoken with a dietitian?[1,2]
10. ☐	☐	☐	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:
☐	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Adams, L. A., Shepard, N., Caruso, R., Norling, M. J., Belansky, H., & Cunningham, R. S. (2009). Putting evidence into practice: Evidence-based interventions to prevent and manage anorexia. *Clinical Journal of Oncology Nursing, 13*(1), 95-102. (AGREE Rigour score 83%)
2. Dy, S. M., Lorenz, K. A., Naeim, A., Sanati, H., Walling, A. and Asch, S. M. (2008). Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. *Journal of Clinical Oncology, 26*(23), 3886-3895. (AGREE Rigour score 51%;)
3. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigour score 11%)
4. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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 Protocol

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]

1. Assess severity of the mouth sores **(Supporting evidence: 4/4 guidelines)**

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[5]

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)	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about mouth sores (see above)	0-5	☐	6-10	☐		
How many sores/ulcers/blisters do you have?[2,3,4]	0-4	☐	>4	☐	Coalescing/ Merging/Joining	☐
Do the sores in your mouth bleed?[2,3,4]	No	☐	Yes, with eating or oral hygiene	☐	Yes, spontaneously	☐
Are the sores painful?[1,2,3,4]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Are you able to eat and drink?[2,3,4]	Yes	☐			No	☐
Are you having trouble breathing?[4]	No	☐			Yes	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1/4 guidelines)**	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any mouth sores, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 1/4 guidelines)**

Current use	Medications for mouth sores	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
☐	benzydamine hydrogen chloride (Tantum mouth rinse)[2]		1 Randomized trial

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

4. Review self-management strategies **(Supporting evidence: 4/4 guidelines)**

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 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.[2,4] Store extra solution in the fridge or 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]
4. ☐	☐	☐	If you wear dentures and your mouth is sensitive, do you try to use your dentures only at mealtimes?[4]
5. ☐	☐	☐	Are you using water-based moisturizers to protect your lips?[2,4]
6. ☐	☐	☐	Do you allow your toothbrush to air dry before storing?[2,4]
7. ☐	☐	☐	Are you trying to avoid tobacco and alcohol, including alcohol-based mouthwashes?[2,4]
8. ☐	☐	☐	Are you trying to drink 8-10 glasses of fluids per day?[2,4]
9. ☐	☐	☐	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[2,4]
10. ☐	☐	☐	Are you trying to avoid foods and drinks that are acidic, salty, spicy, or very hot (temperature)?[2,4]
11. ☐	☐	☐	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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Keefe, D. M. et al. (2007). Updated clinical practice guidelines for the prevention and treatment of mucositis. *Cancer,* 109(5): 820-31. (AGREE Rigour score 82%)
2. Harris, D. J., Eilers, J., Harriman, A., Cashavelly, B. J., & Maxwell, C. (2008). Putting evidence into practice: evidence-based interventions for the management of oral mucositis. *Clinical Journal of Oncology Nursing, 12*(1): 141-52. (AGREE Rigour score 79%)
3. Quinn, B. et al. (2008). Guidelines for the assessment of oral mucositis in adult chemotherapy, radiotherapy and haematopoietic stem cell transplant patients. *European Journal of Cancer, 44*: 61-72. (AGREE Rigour score 73%)
4. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigour score 11%)
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Nausea & Vomiting Protocol

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.)[7]

Name
Date of Birth
Sex
Hospital card number

Date and Time

1. Assess severity of nausea/vomiting (Supporting evidence: 3/7 guidelines)

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 [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 [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)[9]	0-3	☐	4-6	☐	7-10	☐
Patient rating for vomiting (see ESAS above)[9]	0-3	☐	4-6	☐	7-10	☐
Patient rating of worry about nausea/vomiting (see above)	0-5	☐	6-10	☐		
How many times per day are you vomiting or retching?[8] ☐No vomiting	≤1	☐	2-5	☐	>5	☐
Have you been able to eat within last 24 hours?[7,8]	Yes	☐	Yes, reduced	☐	No	☐
Have you been able to tolerate drinking fluids?[8]	Yes	☐			No	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[3,7]	No	☐			Yes	☐
Do you have any blood in your vomit or does it look like coffee grounds?[7] ☐No vomiting	No	☐			Yes	☐
Do you have any abdominal pain?[7]	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? Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 3/7 guidelines)	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any vomiting or severe nausea, seek medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 6/7 guidelines)**

Current use	Medications for nausea/vomiting	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
☐	ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®)[1,2,3,4,5,6]		Systematic review
☐	metoclopramide (Maxeran®)[1,2,3,5,6]		Systematic review
☐	prochlorperazine (Stemetil®)[1,2,3,4,6]		Systematic review
☐	aprepitant (Emend®)[2,3,4,5,6]		Systematic review

4. Review self-management strategies **(Supporting evidence: 4/7 guidelines)**

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 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth)?[7]
3. ☐	☐	☐	Have you tried relaxation techniques that may include guided imagery, music therapy, progressive muscle relaxation?[3,6]
4. ☐	☐	☐	Are you taking anti-emetic medications prior to your meals so that they are effective during and after meals?[6,7]
5. ☐	☐	☐	Are you trying to: - eat 5-6 small meals?[7] - eat foods that minimize your nausea and are your "comfort foods"?[6] - avoid greasy/fried, highly salty, and spicy foods?[6,7] - eat foods that are cold, avoiding extreme temperatures?[6,7] - reduce food aromas and avoid other strong odors?[6,7]
6. ☐	☐	☐	Have you tried acupuncture or acupressure to help with your nausea/vomiting?[3,5,6] (supporting evidence: systematic review)
7. ☐	☐	☐	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:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Gralla, R., Osoba, D., Kris, M., Kirkbride, P., Hesketh, P., et al. (1999). ASCO Special article: Recommendations for the use of anti-emetics: evidence-based clinical practical guidelines. *Journal of Clinical Oncology, 17*(9), 2971-2994. (AGREE Rigor score 85%)
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3. National Comprehensive Cancer Network. (2009). NCCN Clinical practice guidelines in oncology: antiemesis. Version 3. Retrieved from: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. (AGREE Rigor core 83%)
4. Antiemetic Subcommittee of the Multinational Association of Supportive Care in Cancer (MASCC). (2006). Prevention of chemotherapy- and radiotherapy-induced emesis: results of the 2004 Perugia International Antiemetic Consensus Conference. *Annals of Oncology, 17*(1), 20-28. (AGREE Rigor score 75%)
5. Naiem, A., Dy, S., Lorenz, K., Sanati, H., Walling, A., & Asch, S. (2008). Evidence-based recommendations for cancer nausea and vomiting. *Journal of Clinical Oncology, 26*(23), 3903-3910. (AGREE Rigor score 68%)
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7. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigor score 11%)
8. National Institutes of Health: National Cancer Institute. (2010). Common terminology criteria for adverse events (CTCAE) v4.03. Retrieved from: http://evs.nci.nih.gov/ftp1/CTCAE/About.html.
9. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. J. Palliat Care 1991; 7(2):6-9.

Peripheral Neuropathy Protocol

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

Name
Date of Birth
Sex
Hospital card number

Date and Time

Neuropathy: Described as numbness, tingling, 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]

1. Assess severity of the neuropathy (Supporting evidence: 3/3 guidelines)

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 [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)[4]	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.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you have new weakness in your arms or legs?[1,2]	No	☐			Yes	☐
Have you noticed problems with your balance or how you walk, if yes, how much?[1,2]	No/Mild	☐	Moderate	☐	Severe	☐
Are you constipated?[1,2]	No/Mild	☐	Moderate	☐	Severe	☐
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: 1/3 guidelines)	☐ Review self-care. Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ If 1 or more symptoms present with any neuropathy, seek medical attention.	

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 2/3 guidelines)**

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

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

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):
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References

1. Visovsky, C., Collins, M., Abbott, L., Aschenbrenner, J., & Hart, C. (2007). Putting evidence into practice: Evidence-based interventions for chemotherapy-induced peripheral neuropathy. *Clinical Journal of Oncology Nursing, 11*(6), 901-913. (AGREE Rigour score 84%)
2. Stubblefield, M., Burstein, H., Burton, A., Custodio, C., Deng, G., et al. (2009). NCCN Task force report: Management of neuropathy in cancer. *Journal of the National Comprehensive Cancer Network, 7*(Supp 5), 1-26. (AGREE Rigour score 78%)
3. National Comprehensive Cancer Network. (2009). NCCN Clinical practice guidelines in oncology: Adult cancer pain. Version 1. Retrieved from: http://www.nccn.org/professionals/physician_gls/f_guidelines.asp. (AGREE Rigour score 78%)
4. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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 Protocol

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.[2]

1. Assess severity of the skin reaction (Supporting evidence: 3/3 guidelines)

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 [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/Mild	☐	Moderate	☐	Pitting	☐
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 ulcers?[1,4]	No	☐			Yes	☐
Do you have any bleeding[1,4]	No	☐			Yes	☐
Do you have any areas of black skin or dead tissue?[1,4]	No	☐			Yes	☐
Do you have any open, draining wounds?[2,4]	No	☐			Yes	☐
Do you have a new rash?	No	☐			Yes	☐
Do you have a fever > 38° C?[2] ☐Unsure	No	☐			Yes	☐
Have you started a new medication?[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	☐
If you have a Port-o-cath, a PICC or another kind of access device that goes directly into your blood stream, are there any signs of infection that you notice, such as redness, tenderness, discharge, or swelling at the site?[2]	No	☐			Yes	☐
	1 **Mild**		2 **Moderate**		3 **Severe**	

2. Triage patient for symptom management based on highest severity

(Supporting evidence: 1/3 guidelines)

1 Mild	2 Moderate	3 Severe
☐ Review self-care. Verify medication use, if appropriate.	☐ Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	☐ If 1 or more symptoms present with any skin reaction, seek medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? 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: 2/3 guidelines)

Current use	Medications for skin reaction to radiation therapy*	Notes (eg. 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[1,4*]		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: 3/3 guidelines)

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 using deodorant if skin is intact?[4(Randomized control trial evidence)]
5. ☐	☐	☐	Are you trying to drink 8-12 glasses of fluids per day to maintain hydration?[2]
6. ☐	☐	☐	Are you trying to use an electric razor OR avoid shaving the area that is irritated?[2,4]
7. ☐	☐	☐	Are you avoiding skin creams or gels in the treatment area before each treatment?[4]
8. ☐	☐	☐	Are you trying to avoid chlorinated pools and Jacuzzis?[2,4]
9. ☐	☐	☐	Are you trying to avoid temperature extremes in the treatment area (eg. ice pack or heating pad) to the reaction area?[2,4]
10. ☐	☐	☐	Are you trying to protect the treatment area from the sun and the cold?[4]
11. ☐	☐	☐	Are you trying to avoid tape or Band-aids in the treatment area?[2,4]
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:
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References
1. Bolderston, A., Lloyd, N. S., Wong, R. K. S., Holden, L., Robb-Blenderman, L., et al. (2005). The prevention and management of acute skin reactions related to radiation therapy: A clinical practice guideline. Retrieved from: http://www.cancercare.on.ca/pdf/pebc13-7s.pdf. (AGREE Rigour score 85.4%)
2. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf. (AGREE Rigour score 11%)
3. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. 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, Baney T, Bruce S, McQuestion M. (2011). Putting evidence into practice: Evidence-based interventions for radiation dermatitis. Clinical Journal of Oncology Nursing, 15(5), 481-492.

General Assessment

Protocols 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 protocol(s) for further assessment, triage and management.