TELEPHONE NURSING PRACTICE and Symptom Management Guidelines

Nursing Professional Advisory Committee
Nursing Professional Advisory Committee
Telephone Practice Working Group
Telephone Nursing Practice Manual and Symptom Management Guidelines

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TELENURSING AND THE ONCOLOGY NURSE

Introduction

In November 2001, Cancer Care Ontario (CCO) held a workshop in Toronto on oncology nursing telephone practice. Dr. Margaret Fitch, Head Oncology Nursing and Supportive Care and Beverley Page, Education Specialist in Oncology Nursing, Toronto Sunnybrook Regional Cancer Centre co-facilitated. The purpose of this meeting was to look at ways of supporting oncology nurses in this emerging field of care. The outcome was a plan to develop, test and implement telephone practice guidelines, based on the current literature which could be used by Oncology Nurses throughout CCO.

Telephone practice is an issue for all nurses. The College of Nurses of Ontario (CNO) outlined clear expectations in their “Telephone Nursing Practice Standards” (1999) document. Telephone practice is within the registered nurse scope of practice and nurses in various settings can be expected to communicate effectively with patients and family members who need nursing guidance to manage their care.

In Oncology, there are many situations that require a nurse to assess the patient over the telephone, define the problem(s), and intervene accordingly. Oncology nurses are confronted daily with different situations where their knowledge and expertise is required to address symptom management and patient care. However, there were no consistent guidelines in place to support the nurses in their telephone practice. It was critical to take leadership and develop telephone practice guidelines that could be used effectively in a variety of settings.

In order to meet this challenge, CCO, through the Nursing Professional Advisory Committee, struck a working group. The Working Group Leader was Lorraine Montoya, a Nurse Educator from the Ottawa Regional Cancer Centre. Lorraine was instrumental in bringing nurses together not only to develop the guidelines, but also to create an educational program as well as this manual. Her leadership and search of excellence became the driving force for this project, and we acknowledge her work and dedication. A number of nurses throughout Ontario participated on the working group, and are noted on the front page of this manual. The knowledge and expertise that they represent lends strength and credibility to this project.

The Working Group developed three guidelines deemed to be priority areas by the group: fever, nausea and vomiting and pain. These guidelines created the opportunity to test the template and framework for all subsequent guidelines, and there was existing literature on which to base content. The workshop group delineated 9 other guideline areas as the second phase and has since surpassed that number and continues to work on additional guidelines.

Why are guidelines so important? Doesn’t every nurse “know” what to do when conversing with patients on the phone? Those are important questions to consider and the working group debated this at length. They came to understand that there were no standards that guided oncology nurses in telephone practice, acknowledging that the assessment and advice that a nurse gives to a potentially
ill patient is crucial. Fever in an immune-compromised patient is not a simple issue, nor is a nose-bleed in a patient with low platelets. Each situation must be managed appropriately, and advice given that is not only credible, but also based on the current literature. Safety of patients is an essential element of quality care, and we wanted to strive for and achieve safe, effective care for every patient.

Evaluation processes were undertaken at several points during the development. These were guided by two dominant factors: the utility of the guidelines in busy practice settings, and the ease of use for practicing nurses. Having acknowledged that element, the working group will continue to develop guidelines, update and modify the existing ones, and assess the use and effectiveness in practice.

Finally, it is our intent that the guidelines be available to all nurses who work with people with cancer. The telephone practice guidelines are available on the CCO Web site, and accessible to nurses in a variety of settings. The education program and entire manual are also available on request.

This work was not undertaken lightly. The Working Group spent many hours on researching the literature, adding and modifying content, revising the framework, evaluating the practice application and working in collaboration with their colleagues. This intensive work could not have been conducted in any other way, and it is to the credit of the members of the working group that the guidelines are excellent resources for all oncology nurses.

Esther Green,
Chief Nursing Officer, Cancer Care Ontario
COMPONENTS OF A GUIDELINE

Well-written guidelines provide standardization, decision support, legal protection to the nurse. They facilitate documentation in that notes can refer to interventions “as per guideline.”

☑ Guidelines follow a logical thought process.

☑ Guidelines should trigger assessment questions. Assessment questions should rule out emergent symptoms first and move from more serious to less serious symptoms.

☑ Spoken terminology should be at a Grade 5 level to ensure general understanding by the lay population.

☑ Acuity should be determined within a guideline by defining a time frame for receiving care, and where that care should be received.

☑ Guidelines should be consistent. Symptoms of dehydration should be the same in the 'diarrhea' guideline as in the 'vomiting' guideline.

☑ High-risk patients need to be included in the guideline. The neutropenic patient with a fever is flagged at higher risk than the non-neutropenic patient with fever.

☑ Guidelines should have appropriate and accurate information and education for patients. When possible, the information is evidence-based and referenced.

☑ Guidelines should describe criteria to help patients evaluate their symptoms. The criteria are well defined and measurable. Instead of using descriptors like 'small' or 'moderate', use actual measurements such as 'soaking one pad in four hours'.

☑ Guidelines prompt the nurse to use disclaimers such as "If your symptoms persist or become worse, please call back."

☑ Guidelines prompt the nurse when patient follow-up is needed.

When a patient calls with multiple symptom complaints, the nurse must rule out emergent symptoms and then use the guideline for the most serious symptom. More than one guideline may be utilized for one call.
In this document, we discuss the conditions of Anorexia and Cachexia, as well as common terms associated with these conditions. The text includes a general assessment section and a symptom assessment section, along with a guide on how to manage symptoms and improve nutrition. Additionally, there is a table that categorizes symptoms into emergent, urgent, and non-urgent categories, along with patient teaching and follow-up/evaluation/documentation guidelines. The text is organized in a clear, logical manner, making it easy to understand and reference.
ANOREXIA GUIDELINE

Addenda

Potential Complications

- Dehydration: ↑ thirst, dry mouth, ↓ urine output, ↓ skin turgor, postural hypotension, weakness, dizziness, confusion
- Blood work abnormalities: ↓ albumin, ↑ creatinine, ↑ urea, phosphorus, cholesterol, magnesium, etc.
- Weight loss, fatigue, depression, anxiety, decreased quality of life.
- Decreased functional status and ability to carry out activities of daily living.
- Delay or cessation of treatment due to severity of weight loss, potential for toxicity.

Risk Factors/Possible Causes

- Advanced disease (stage 3 – 4) with metastases
- Patients with lung, gastric, esophageal, pancreatic and liver cancers, however any cancer patient is at risk.
- Disease related: bowel obstruction, extensive bowel surgery, pain.
- Treatment related: radiation enteritis or other radiation therapy side effects, chemotherapy or other medication side effects, narcotic use.
- Other: depression/anxiety
- Presence of one or more nutrition impact symptoms: nausea, vomiting, mucositis, diarrhea, dysphagia, taste alterations, food intolerances.

Figure 1: Time Course of Significant Weight Loss

<table>
<thead>
<tr>
<th>Time</th>
<th>Significant Loss</th>
<th>Severe Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 week</td>
<td>1 – 2%</td>
<td>&gt;2%</td>
</tr>
<tr>
<td>1 month</td>
<td>5%</td>
<td>&gt;5%</td>
</tr>
<tr>
<td>3 months</td>
<td>7.5%</td>
<td>&gt;7.5%</td>
</tr>
<tr>
<td>6 months</td>
<td>10%</td>
<td>&gt;10%</td>
</tr>
</tbody>
</table>

References


**BREATHLESSNESS GUIDELINE**

**Breathlessness:** Is a subjective experience, described as an unpleasant or uncomfortable awareness of breathing, or of the need to breathe.  
**Dyspnea,** or shortness of breath is the medical diagnosis given to breathlessness.  
**Common Subjective Description:** Hard to breath, feeling smothered, tightness in the chest, hard to move air, needing more air, “I just feel short of breath”, “I can’t get my breath”.  

**General Assessment**  
- Name, DOB, Clinic identification number, Physician  
- Diagnosis, Treatment: Type, Date of last treatment  
- Current medications, Allergies  
- Pharmacy name and number

**Symptom Assessment**  
- When did your breathlessness start? Any chronic breathing problems? i.e. asthma, emphysema, etc.  
- Right now, how is your breathing on a scale of 0-10? At its worst _____? At its best _____?  
- Can you describe your breathlessness? What does it feel like?  
- How long does your breathlessness last? Is it constant? Does it come and go?  
- What makes it worse? (When you speak, walking on the level ground, at rest, with exertion, talking, climbing stairs, lying down vs. standing up, weather – humidity.  
- What makes it better? (Medications, puffers, oxygen, fresh air, fan, rest, breathing exercise, or when you relax)  
- It there anything else that is occurring with your breathlessness? (Fever, pain, chest pain, cough [colour of sputum], wheezing, stridor, mental confusion)

<table>
<thead>
<tr>
<th>Emergent</th>
<th>Urgent</th>
<th>Non-Urgent</th>
</tr>
</thead>
</table>
| • Acute episodes or exacerbation of breathlessness, i.e. air, hunger, unable to speak or unable to lie flat  
• New, acute onset chest pain  
• Fever greater than 38°  | • New onset or change to patient’s regular (usual) breathing pattern, i.e. increased shortness of breath, labored breathing while awake and asleep, pauses when talking  | • Unchanged from usual chronic symptoms, i.e. symptoms of COPD, emphysema, asthma |

- Requires immediate medical attention  
- Requires medical attention within next 24 hours  
- Support, teaching and follow-up as required

**Patient Teaching**  
- Comfort measures – Positioning, relaxation, distraction, breathing retraining techniques, (See Addenda - Figure 1) take medications & Oxygen.  
- Review preventative measures – breathing exercises, avoid symptom triggers, pace and prioritize activities.  
- Record episodes of breathlessness and self-interventions – at rest, medications, keep track of number of episodes and intensity (Scale 0-10).  
- Document adverse effects of treatment as needed  
- Avoid things that make breathing worse, i.e. cold air, humidity, tobacco smoke

**Follow-up/Evaluation/Documentation**  
- Record date and time of telephone encounter  
- Record assessment, interventions, and any follow-up plans  
- Refer to CCAC or other appropriate colleagues as indicated  
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate  
- Reinforce with patient when to seek immediate medical attention
**Potential Complications**

- Reduced ability to cough – greater risk for infection
- Altered fluid and electrolyte balance – i.e., risk for hypokalemia, hyponatremia, hypercalcemia.
- Constipation, diarrhea (overflow due to impacted feces), fatigue, delayed wound healing, depression.
- ↓ Quality of Life

**Risk Factors/Possible Causes**

- Oncologic Emergency: Superior Vena Cava Syndrome
  - **Direct** Tumor Effects (i.e., Primary Lung cancer or metastatic effects such as airway obstruction, atelectasis)
  - **Indirect** Tumor Effects (i.e., Pneumonia, pulmonary embolism, anemia, pleural effusion, hepatomegaly, congestive heart failure, pre-existing pulmonary disease, COPD, asthma).
- **Treatment** Side Effects (i.e., Pneumonitis or fibrosis from chemotherapy or radiotherapy).

**Figure 1: Breathing Retraining Techniques**

<table>
<thead>
<tr>
<th>Diaphragmatic breathing</th>
<th>Pursed lip breathing</th>
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<tr>
<td>Patients are taught to consciously expand their abdominal wall during inspiratory diaphragm descent – success can be checked by placing one hand on the abdomen and the other on the chest.</td>
<td>Patients are taught to consciously breathe in through their nose, then to breathe out through partially pursed lips. Expiration, therefore, takes twice as long.</td>
</tr>
<tr>
<td>Patients are advised to carry out this exercise, in the supine position, over 10-20 minutes for three times a day. After six to eight weeks improvements can be seen in the breathing patterns, blood gases and expiratory muscle strength.</td>
<td>Pursed lip breathing is especially useful during periods of increased ventilation.</td>
</tr>
<tr>
<td>Pursed lip breathing can lead to improvements in the breathing pattern and respiratory muscle function, but the impact on the symptom of breathlessness is variable.</td>
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**References**

**Constipation** is defined as infrequent, excessively hard and dry bowel movements resulting from a decrease in rectal filling or emptying.

**Common terms:** “bloated”, “bowel problems”.

### General Assessment
- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number

### Symptom Assessment
- Number of stools/day or date of last bowel movement
- Associated symptoms: motor weakness, sensory loss, pain, nausea, vomiting, abdominal distention/rigidity, passing of flatus, urinary retention
- If vomiting, describe colour, odor, consistency, amount
- Normal elimination patterns: frequency, consistency, colour
- Review of present food and fluid intake
- Concomitant disease - diabetes, hypothyroidism or other
- What are you currently using to treat your constipation? Is it working?

### Emergent
- Severe abdominal pain ± nausea or vomiting.
- Fecal smelling vomit.
- Severe and rigid abdominal distention
- History of recent abdominal surgery
- Sensory loss +/- motor weakness

### Urgent
- Increased nausea, vomiting
- Increasing abdominal pain, distension
- No bowel movements for greater than 3 days

### Non-Urgent
- Dry or hard stool ± abdominal pain
- History of immobility
- Increased anorexia
- Decreased fluid intake
- Bowel regime not followed as prescribed
- No bowel movement for 2 days

### Patient Teaching
#### Diet
- Increase fibre: whole grain products, bran, fresh fruit, raw vegetables
- Increase fluid intake: 8-12 glasses per day
- Limit use of gas-producing foods: cabbage, beans, green peppers

#### Bowel Regime
- Review stool softeners and laxatives prescribed
- Ensure proper use of daily bowel regime
- Emphasize importance of daily bowel program, particularly if on constipating therapeutic agents (opioids, Ondansetron, Vincristine, etc.)

#### Activity
- Increase activity level as able

### Follow-up/Evaluation/Documentation
- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
### CONSTITUTION GUIDELINE

#### Addenda

##### Potential Complications
- Mechanical obstruction
- Inadequate absorption or oral drugs
- Metabolic disturbance
- Fecal impaction
- Rectal tearing, fissure, hemorrhage
- Bowel obstruction

##### Risk Factors/Possible Causes
- **Oncologic Emergency:** Consider Spinal Cord Compression
  Consider Hypercalcemia
- **Pharmacologic Agents:** Analgesic opiates, chemotherapeutic agents (Vincristine, Vinblastine), some antiemetics (Ondansetron), anticonvulsants, some psychotropic medications.
- **Pathologic process:** bowel obstruction or non-mechanical obstruction e.g.: paralytic ileus
- **Extrinsic factors:** diet, dehydration, lack of privacy

##### References
**DIARRHEA GUIDELINE**

Diarrhea is an abnormal increase in quantity, frequency and fluid content of stool and often associated with urgency, perianal discomfort and incontinence.

**Common Terms:** loose stools, loose BM's, “runs,” “problem with my bowels.”

### General Assessment

- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number

### Symptom Assessment

- Onset, duration, volume of diarrhea
- Number, consistency and colour of stools in last 24 hrs
- Any mucous or blood? How much?
- Normal bowel patterns, any ostomy?
- Any associated cramps, gas, abdominal pain, distension or tenesmus (ineffectual straining)
- Have you tried treating the diarrhea?
- With what? Has it been effective?
- Any recent antibiotic use or any recent hospitalization
- If on chemo, what and when last given
- If on rads, what area and how many treatments
- Are you receiving chemo and rads together
- Any other symptoms: i.e. nausea, vomiting, - thirst, dry mouth or skin, dizziness, fever, skin irritation around anus or stoma, weight changes
- Any recent changes in normal eating pattern (i.e. eating out)
- How is the skin around your anus or ostomy?
- Are you able to drink and keep fluids down? How much? What kinds of fluids?
- Amount and character of urine

### Emergent

- Abdominal or rectal pain, N & V
- > 10 stools per day
- Grossly bloody stools
- Dehydration, dizziness
- Fever = or > 38°

### Urgent

- 6 – 10 stools per day and severe cramping
- Presence of blood or mucus in stools
- Not able to tolerate adequate fluids
- Skin breakdown

### Non-Urgent

- 4 - 6 stools per day
- Some cramping
- Some nocturnal BM’s
- Able to tolerate adequate amounts of fluids

### Patient Teaching

- Adjust diet by ↓ fibre (fresh fruit, veg, bran, nuts, seeds), eliminate milk and milk products, caffeine and alcohol
- Avoid greasy, spicy or sugary foods.
- ↑ fluid intake as tolerated to 8 – 12 8 oz cups/day and eat frequent small meals of cooked fruits/vegetables, rice, lean meats, fish or chicken, bananas, applesauce, toast
- Take antidiarrheal medications as prescribed by MD or according to package instructions
- Encourage “sport” drinks like Gatorade or Powerade
- Comfort measures: sitz baths, tucks, hemorrhoid barrier creams as needed

### Follow-up/Evaluation/Documentation

- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention

Requires immediate medical attention

Requires medical attention within next 24 hours

Support, teaching and follow-up as required
DIARRHEA GUIDELINE

Addenda

Potential Complications

- Malnutrition, dehydration
- Renal insufficiency, electrolyte imbalance
- Cardiovascular compromise
- Reduced absorption of oral medications
- Perianal inflammation, irritation, bleeding
- Anxiety, sleep disturbances, fatigue
- Abdominal pain
- Decreased quality of life
- Disrupted skin integrity

Risk Factors/Possible Causes

- Abdominal or pelvic radiation
- Use of alternative therapies (dietary supplements, herbal remedies, coffee enemas)
- Antibiotics, laxatives, antacids, NSAIDS
- Surgery (gastrectomy, vagotomy, intestinal resection)
- Diet, enteral tube feedings
- Lactose intolerance
- Graft vs Host Disease
- Chemotherapy: 5FU, capecitabine, cisplatin, cyclophosphamide, cytosine arabinoside, daunorubicin, docetaxel, doxorubicin, interferon, irinotecan, leucovorin, methotrexate, oxaliplatin, topotecan
- Other medical conditions include irritable bowel syndrome, infection (viral, bacterial, protozean, parasitic, fungal), surgery, fecal impaction

References

**DYSURIA/NOCTURIA/HEMATURERIA GUIDELINE**

Altered Urinary Elimination

<table>
<thead>
<tr>
<th>General Assessment</th>
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<tbody>
<tr>
<td>Name, DOB, Clinic identification number, Physician</td>
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<tr>
<td>Diagnosis, Treatment: Type, Date of last treatment</td>
</tr>
<tr>
<td>Current medications, Allergies</td>
</tr>
<tr>
<td>Pharmacy name and number</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptom Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset, duration, current voiding pattern (frequency, urgency, hesitation)</td>
</tr>
<tr>
<td>Time of last voiding</td>
</tr>
<tr>
<td>Appearance of urine: colour, clarity, presence of blood or mucus</td>
</tr>
<tr>
<td>Volume of urine</td>
</tr>
<tr>
<td>Usual voiding pattern</td>
</tr>
<tr>
<td>Presence of pain: location, description, duration</td>
</tr>
<tr>
<td>Recent procedures: catherizations, TURP, high-dose radiation, biopsy</td>
</tr>
<tr>
<td>Any accompanying symptoms: fever, fatigue, dizziness, SOB</td>
</tr>
<tr>
<td>Sexual activity</td>
</tr>
<tr>
<td>How much fluid intake in 24 hours</td>
</tr>
<tr>
<td>History of urinary tract infections</td>
</tr>
<tr>
<td>Date of latest blood work and urinalysis</td>
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<table>
<thead>
<tr>
<th>Emergent</th>
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</thead>
<tbody>
<tr>
<td>Acute pain</td>
</tr>
<tr>
<td>Unable to void &gt; 10 hours with normal fluid intake</td>
</tr>
<tr>
<td>Frank bleeding</td>
</tr>
<tr>
<td>Fever &gt; 38 °C</td>
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<table>
<thead>
<tr>
<th>Urgent</th>
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<tbody>
<tr>
<td>Significant changes in voiding pattern causing discomfort/distress</td>
</tr>
<tr>
<td>Change in character of urine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Urgent</th>
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</thead>
<tbody>
<tr>
<td>Minor changes in normal voiding pattern</td>
</tr>
</tbody>
</table>

Requires immediate medical attention

Requires medical attention within next 24 hours

Support, teaching and follow-up as required

**Patient Teaching**

- Encourage fluid intake of 8-12 8 oz glasses per day
- Reduce fluid intake after supper
- Avoid foods and fluids that irritate the bladder, i.e. spices, coffee, alcohol
- Encourage lubrication during intercourse, and post coital voiding for women
- Avoid soaking in the bath, Jacuzzi or hot tub
- Avoid powdered or perfumed personal hygiene products
- May take an over-the-counter antinflammatory (e.g.: ibuprofen) before bedtime – reduces inflammation, edema etc.

**Follow-up/Evaluation/Documentation**

- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
# DYSURIA/NOCTURIA/HEMATURIA GUIDELINE

**Addenda**

## Potential Complications
- Acute renal failure
- Bladder distension
- Disruption of quality of life, sleep disturbances, fatigue

## Risk Factors/Possible Causes
- **Oncologic Emergency:** Spinal Cord Compression
- History of chronic UTI
- Diabetes
- Infection
- Benign Prostatic Hypertrophy
- Chemotherapy, i.e. cyclophosphamide
- Current Medications, i.e. opioids, diuretics, some antihypertensives e.g.: Flomax, Cardura (Flomax and Cardura can cause fainting, postural hypotension when used with antihypertensives or other alpha/beta blockers)
- Disease Progression
- Invasive Pelvic procedures, e.g. TURPS, cystoscopy, hysterectomy, prostatectomy
- Pelvic Radiation in men or women via external beam or brachytherapy
- Treatment-induced inflammation
- Obstruction

## References

Boehringer Ingelheim Pharmaceuticals, Inc. (1997). Flomax drug insert, Ridgefield, CT.
# Fatigue Guideline

**Fatigue** is defined as an unusual, persistent, subjective sense of tiredness related to cancer or cancer treatment that interferes with usual functioning.

**Common Terms:** tired, weak, worn out, wasted, exhausted, no energy, can’t concentrate on anything

## General Assessment

- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number
- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number

## Symptom Assessment

- Onset and duration
- Any other symptoms: signs of bleeding, skin/membrane pallor, feeling cold, feeling faint, dizziness, shortness of breath (at rest or with activity), rapid heart beat, chest pain, leg heaviness
- Do you feel rested after a night’s sleep?
- Ability to carry out ADL’s? How has this changed?
- How much time in bed in last 24 hours? Has this changed?
- Does anything help to alleviate your fatigue? Specifically?
- Any difficulty concentrating? Maintaining attention to conversation?
- Do you feel sad, anxious, or stressed?
- Could you score your feeling of fatigue on a scale 0-10: 0 = no problems; 10 = total exhaustion; 1-4 = mild; 4-6 = moderate; 7-9 = severe
- Have you had a blood transfusion? When?
- Are you able to eat and drink normally?

### Emergent

- Sudden onset of severe fatigue
- Chest pain
- Tachycardia
- Shortness of breath at rest
- Hemorrhage/rapid blood loss

Seek immediate medical attention

### Urgent

- Severe fatigue (> 6 on scale)
- Functional deficits affecting QOL
- Exertional SOB

Requires medical attention within the next 24 hours

### Non-Urgent

- 1-6 on scale
- Ability to carry out ADL’s

Support, teaching and follow-up as required

## Patient Teaching

- Employ energy conservation strategies: set priorities, pace activities, delegate as needed
- Schedule rest periods throughout the day
- Explore restorative therapies i.e. games, music, reading
- Stress management options: relaxation techniques
- Increased physical activity has been shown to promote circulation, to increase energy levels, to impart a feeling of well-being and to promote better sleep patterns. Encourage to increase physical activity/exercise as able
- 75% of patients undergoing cancer treatment experience fatigue.
- Fatigue can exist independently of anemia.
- Fatigue can be episodic in nature but is often cumulative.
- Treatment-related fatigue is NOT an indicator of disease progression.
- Cancer related fatigue is not preventable but is often manageable.

## Follow-up/Evaluation/Documentation

- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
### Potential Complications
- Reduced Quality of Life
- Depression
- Cognitive Dysfunction

### Potential Complications of Anemia:
- Severe tissue hypoxia which may result in Myocardial Ischemia/Infarct
- Cognitive dysfunction
- Anorexia

### Risk Factors/Possible Causes
- Chemotherapy and/or Radiation
- Anemia
- Sleep Disturbances
- Fluid & Electrolyte Imbalances
- Infection
- Disease Process
- Medication side effects
- Depression
- Changes in Activity or Exercise Patterns
- Stress

### Potential Causes of Anemia Related to Malignancy:
- Anemia of chronic disease
- Bone marrow infiltration
- Myelosuppressive effects of chemotherapy
- Bleeding
- Hemolysis
- Infection
- Nutritional deficiencies

### Treatment of Anemia:
- Treat underlying cause, i.e. bleeding, iron deficiency
- Red Blood Cell transfusion
- Erythropoietin if appropriate

### References
**FEver Guideline**

**Fever** is defined as an oral temperature greater than or equal to 38°C (100.4°F)

**Common Terms:** Having a temperature, having “chills.”

### General Assessment
- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number
- Temperature, Onset, Duration, Pattern
- When and what was your last cancer treatment?
- Have you had recent blood work? When, where?
- Any recent hospitalizations? When, where?
- Any other symptoms: headache or difficulty concentrating, SOB, cough or sputum, open or draining mouth sores, other open or draining wounds, urinary burning or urgency, pain or problems with BM’s, new rashes
- Is there a Venous Access Device? Type, appearance of site (redness, swelling, warmth etc), when last accessed
- Any recent trips out of the country?

### Symptom Assessment
- Any recent hospitalizations? When, where?
- Any other symptoms: headache or difficulty concentrating, SOB, cough or sputum, open or draining mouth sores, other open or draining wounds, urinary burning or urgency, pain or problems with BM’s, new rashes
- Is there a Venous Access Device? Type, appearance of site (redness, swelling, warmth etc), when last accessed
- Any recent trips out of the country?

### Emergent
- Myelosuppressive Tx within last 1-3 weeks
- Confirmed neutropenia by blood result
- Severe headaches, SOB
- Changes of mental functions
- Severe stomatitis (severe ulceration - unable to swallow)
- Possible wound or other infection
- Still febrile after 48 hours of antibiotic Tx

### Urgent
- Persistent chills
- Fever longer than 24 hours
- Have a Venous Access Device
- Stomatitis (painful erythema, edema)

### Non-Urgent
- Known side effect of biologic agents (see addenda for list of biologic agents)

---

### Patient Teaching
- Monitor temperature q 2 - 4 h
- Encourage frequent hand washing and oral hygiene with a soft toothbrush
- Avoid enemas, suppositories, douches, tampons or invasive procedures
- Keep wounds clean and dry
- Avoid crowds and people with possible illness (eg flu, common cold)
- Notify MD if come into contact with flu, shingles, chicken pox, mumps or measles
- Take antibiotics/antipyretics as prescribed
- Call back if symptoms worsen
- Increase fluid intake to 8-12 glasses of fluid as able

### Follow-up/Evaluation/Documentation
- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
# FEVER GUIDELINE

## Addenda

### Potential Complications
- Increased metabolic demands
- Mental status changes, i.e. confusion
- Arrhythmias
- Increased anxiety
- If untreated, febrile neutropenia may lead to life threatening sepsis

### Risk Factors/Possible Causes
- **Oncologic Emergency: Febrile Neutropenia**
  - Myelosuppressive chemo within the last 2-3 weeks (Nadir is 7-14 days post chemo)
  - Infection: Venous Access Device, stomatitis, wound, UTI
  - Haematological malignancy
  - Age extremes (young and old)
  - Tumour
  - Allergic or hypersensitive reaction to drugs
  - Allergic or hypersensitive reaction to blood component therapies
  - Graft versus Host Disease
  - Recent flu vaccination
  - Drug side effects: i.e. biologic/immunologic therapies (please see below)

### Biologic/Immunologic Therapies

**Side effects are:**
Fever, chills, rigor, muscle aches and pains. Fever can occur within hours of receiving therapy. Examples of biological therapies are Interferon, Interlukin, Granulocyte Macrophage-Colony stimulating factor (GM-CSF), Herceptin, Rituxan, Filgrastim (Neupogen-G-CSF)

### References


Macartney, G. (2003, April). *The nurse’s role in identifying and addressing oncologic emergencies.* Workshop presented for oncology nurses, Ottawa, Canada


NAUSEA AND VOMITING GUIDELINE

**Nausea** is an unpleasant sensation ranging from anorexia and indigestion to an inclination to vomit. **Vomiting** is an forceful expulsion of stomach contents through the mouth and may include retching (gastric and esophageal movement without vomiting - dry heaves). **Common Terms:** "sick to my stomach, pressure in stomach, no appetite, feels like flu, retching, gagging, indigestion"

<table>
<thead>
<tr>
<th>General Assessment</th>
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<tr>
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<td>Pharmacy name and number</td>
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<thead>
<tr>
<th>Symptom Assessment</th>
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<tbody>
<tr>
<td>If on chemo, what and when last given?</td>
</tr>
<tr>
<td>If on radiation, what area and how many treatments have you received?</td>
</tr>
<tr>
<td>Nausea: onset, frequency, intensity, alleviating/ aggravating factors</td>
</tr>
<tr>
<td>Vomiting: character, colour, force, quantity, frequency</td>
</tr>
<tr>
<td>Current use of antiemetics, past remedies</td>
</tr>
<tr>
<td>Any non-pharmacologic interventions? If so, what and are they effective.</td>
</tr>
<tr>
<td>Other: How much food/fluid intake over the last 24 hours?</td>
</tr>
<tr>
<td>Any abdominal distention</td>
</tr>
<tr>
<td>Presence of flatus, time of last BM?</td>
</tr>
<tr>
<td>Any signs of dehydration: decreased urine output, fever, thirst, dry mucus membranes, weakness dizziness, confusion</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Emergent</th>
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<tbody>
<tr>
<td>Blood or coffee ground emesis</td>
</tr>
<tr>
<td>Severe abdominal pain or headache</td>
</tr>
<tr>
<td>Weak, dizzy, incoherent or unresponsive</td>
</tr>
<tr>
<td>Seek immediate medical attention</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent</th>
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</thead>
<tbody>
<tr>
<td>Evidence of dehydration (see addenda)</td>
</tr>
<tr>
<td>Unable to eat or drink for 24 hours</td>
</tr>
<tr>
<td>Treatment change not effective within 6 hours</td>
</tr>
<tr>
<td>Seek medical attention within the next 24 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Urgent</th>
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</thead>
<tbody>
<tr>
<td>Acute, delayed or anticipatory</td>
</tr>
<tr>
<td>Chemotherapy-related nausea and vomiting</td>
</tr>
<tr>
<td>No evidence of dehydration</td>
</tr>
<tr>
<td>Support, teaching and follow-up as required</td>
</tr>
</tbody>
</table>

**Patient Teaching**

- Review prescribed antiemetic therapy, dose schedule, route
- Consider changing antiemetic or route
- Take prescribed antiemetics regularly for three days following each chemo treatment, before meals, and before treatment
- Encourage sips of clear fluids as tolerated
- Small, frequent meals, cold foods, bland, non-spicy food, no extreme temperatures, no strong odors
- Teach to monitor for signs of dehydration
- Notify MD if unable to maintain fluid intake for 24 hours
- Distraction strategies: (to be used in addition to anti-emetic therapy) music, moderate exercise, relaxation, breathing exercises
- Instruct to re-contact if condition does not improve

**Follow-up/Evaluation/Documentation**

- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
NAUSEA AND VOMITING GUIDELINE

Addenda

Potential Complications

- Dehydration/Electrolyte imbalance
  - Signs of dehydration: increased thirst, loss of skin turgor, dry mouth, decreased urine output, postural hypotension, weakness, dizziness, confusion
  - Metabolic alkalosis in severe vomiting
- Decreased mental/physical status
- Potential for aspiration pneumonia
- Decreased nutrition, esophageal tears
- Decreased self care ability

Risk Factors/Possible Causes

- Age extremes (young and old)
- Gender: More common in women
- Advanced stage disease
- High level of anxiety
- Moderate to high emetogenic chemotherapy agents e.g.: cisplatin, cytarabine, cyclophosphamide, etoposide
- Susceptibility to GI distress
- Opioid narcotics, severe pain
- Bowel obstruction, constipation, ascites
- Hypercalcemia, electrolyte disturbances
- CNS lesions, increased ICP
- Gastric or CNS radiation
- Non-Oncological: flu, food poisoning, etc

References

**Stomatitis** is an acute inflammation or ulceration of the oral or oropharyngeal mucosal membrane. It is often referred to as oral mucositis. Common terms are sore mouth, mouth sores.

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<tr>
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<table>
<thead>
<tr>
<th><strong>Symptom Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have pain in your mouth?</td>
</tr>
<tr>
<td>Is there any bleeding in your mouth? If so, for how long?</td>
</tr>
<tr>
<td>Do you have a temperature?</td>
</tr>
<tr>
<td>Do you have any blisters, ulcers or white patchy areas on your tongue, lips or in your mouth? If so, how many do you have and how long have you experienced this problem?</td>
</tr>
<tr>
<td>Do you have any saliva? If so, is it thicker than usual?</td>
</tr>
<tr>
<td>Are you able to drink or eat? If so, please specify the quantity.</td>
</tr>
<tr>
<td>Have you lost any weight? Please specify the amount.</td>
</tr>
<tr>
<td>Do you have dentures? If so, are you able to wear them, or do they aggravate the pain?</td>
</tr>
<tr>
<td>Does eating or swallowing make the pain worse?</td>
</tr>
<tr>
<td>Are you using any mouthwashes? If so, what type?</td>
</tr>
<tr>
<td>Are you using any analgesic? Please specify.</td>
</tr>
<tr>
<td>Are you using any other types of treatment? i.e. holistic or herbal.</td>
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<table>
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<tr>
<th><strong>Emergent</strong></th>
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<tbody>
<tr>
<td>Temperature $\geq 38$ C</td>
</tr>
<tr>
<td>Unable to drink fluids</td>
</tr>
<tr>
<td>Respiratory distress</td>
</tr>
<tr>
<td>Bleeding from oral ulcers</td>
</tr>
<tr>
<td>Pain not controlled by current analgesic</td>
</tr>
<tr>
<td>Blistered or cracked tongue</td>
</tr>
</tbody>
</table>

**Seek immediate medical attention**

<table>
<thead>
<tr>
<th><strong>Urgent</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of dehydration (see addenda)</td>
</tr>
<tr>
<td>Unable to eat or drink for 24 hours</td>
</tr>
<tr>
<td>Treatment change not effective within 6 hours</td>
</tr>
<tr>
<td>Whitish covering of oral mucosa</td>
</tr>
</tbody>
</table>

**Seek medical attention within the next 24 hours**

<table>
<thead>
<tr>
<th><strong>Non-Urgent</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Painless ulcers, erythema</td>
</tr>
<tr>
<td>Mild soreness in absence of lesions</td>
</tr>
</tbody>
</table>

**Support, teaching and follow-up as required**

**Patient Teaching**

- Perform mouth care at least four times a day
- Use an extra-soft toothbrush, rinse toothbrush after use
- Brush tongue
- Keep lips lubricated with a water or aloe-based balm
- Do not use alcohol-based mouthwashes. Instead, use a mouthwash of 1 tsp. salt per cup of warm water or a prescription from your physician
- Drink 8-12 cups (250 mls) of fluid per day, avoid acidic or carbonated drinks
- Avoid alcohol and smoking
- Eat a soft diet. Avoid foods that are acidic, salty, spicy or dry
- If mouth is sensitive, use dentures only at mealtime
- Suck on sugarless candy or gum to keep mouth moist
- Monitor temperature q4h
- Avoid very hot foods (temperature)
- Use systemic and/or local analgesia for pain
- Medicated mouth rinse as prescribed by physician

**Follow-up/Evaluation/Documentation**

- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
## Potential Complications

- Systemic infection
- Quality of life
- Malnutrition
- Airway obstruction
- Dehydration
- Constipation

## Risk Factors/Possible Causes

- **Chemotherapeutic Agents**: (high risk are: cytarabine, 5FU, methotrexate, bleomycin, doxorubicin, etoposide, mitomycin c, mitoxantrone, docetaxel, paclitaxel, vinblastine, vincristine), anticholinergics and antihistamines, phenytoin and steroids.
- **Radiation Therapy**: inflammatory response to treatment in head and neck region
- **Oral Tumours**: disrupt the integrity of the oral mucosa, which may cause inflammation/infection
- Bone marrow transplantation
- Age extremes
- Exposure to alcohol, tobacco, hot acidic or spicy foods
- Poor nutritional status, dehydration
- Poor oral hygiene
- Pre-existing chronic dental infection: gum disease, tooth decay

## References


# Pain Guideline

**Pain**: Acute or chronic discomfort of any duration and intensity. “Pain is what the patient says it is.”

**Common Terms**: Aches, discomfort, soreness

## General Assessment
- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number

## Symptom Assessment
- **Location**: note whether external or internal, note whether stationary or radiating. Is it a new site of pain?
- **Intensity** (0 to 10): Include present rating of pain, rating of pain at it’s worst; rating of pain at it’s least, rating of acceptable pain.
- **Description**: Use patient’s words, i.e. dull, ache, stabbing, sharp, unbearable, cramping, burning, exhausting, pins and needles, throbbing.
- **Associated symptoms**: nausea, vomiting, constipation, anxiety, dyspnea, numbness/tingling, urinary retention, anorexia, motor weakness, pain related distress, effects on ability to carry on with daily life
- **Duration**: How long does pain usually last? i.e. seconds, minutes, hours, constant
- **Aggravating/Alleviating Factors**: walking, moving, eating, time of day (when), heat, cold, distraction, massage lying still, relaxation, changing position, medication, other.
- How are current pain medications being used?
- What does the pain interfere with? i.e. coping, social activities, sleep/rest, talking/emotions, appetite
- What has been prescribed for any medication side effects?
- What are the patient’s expectations regarding pain control?

### Emergent
- Patient in acute distress/discomfort
- Pain onset is sudden and acute
- Acute exacerbation of previous levels
- Has developed a new site for pain
- Associated motor weakness
- Analgesics interfering with ADL’s

### Urgent
- Moderate pain
- Pain or analgesics interfering with function but not interfering with ADL’s
- Patient states he/she cannot manage pain with present treatment regime

### Non-Urgent
- Patient not using analgesia effectively
- Mild pain not interfering with ADL’s
- Requires prescription and/or referral

### Patient Teaching
- Take analgesic regularly. Use breakthrough doses as needed. Use a diary to track pain and keep record of effectiveness and side effects of analgesia. Assess and review bowel routine.
- If waking up at night, plan to take a breakthrough dose before going to bed
- Anticipate possible painful events eg: bathing, and premedicate with analgesic an hour beforehand
- Review non-pharmacologic measures to be used in concert with analgesics: imagery/distraction techniques can be used while waiting for analgesic to take effect, massage promotes muscle relaxation, heat or cold may diminish pain sensation, social activities may distract from pain, music and relaxation exercises facilitates concentration and attention on sensations other than pain

### Follow-up/Evaluation/Documentation
- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention
PAIN GUIDELINE

Addenda

Potential Complications
- Disruption of ADL
- Psychosocial distress, i.e. anxiety/depression
- Decreased quality of life
- Inadequate pain management leads to increased pain related distress which can increase interference with daily life activities

Risk Factors/Possible Causes
- Oncologic Emergency: Spinal Cord Compression, Superior Vena Cava Syndrome
- Risk factor for inadequate pain management: Knowledge Deficit
- Tumor involvement
- Tumor metastasis
- Mucositis
- Diagnostic or treatment procedure
- Radiation Therapy
- Chemotherapy
- Post Surgical
- Not cancer related

References
**SKIN ALTERATION GUIDELINE**

Skin Reaction or Condition: A change in the colour, texture or integrity of the skin.  
Common Terms: rash, blisters, lesions, dermatitis, cracking, peeling, a burn, pimples, inflammation, redness

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<table>
<thead>
<tr>
<th><strong>Symptom Assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Concurrent therapy, i.e. Chemo and radiation therapy</td>
</tr>
<tr>
<td>Is there a history of bone marrow/stem cell transplant (Have you been told that you have Graft vs. Host Disease?)</td>
</tr>
<tr>
<td>Onset, pattern, duration</td>
</tr>
<tr>
<td>Any accompanying symptoms? fever, malaise, nausea, diarrhea, headache?</td>
</tr>
<tr>
<td>Colour, odor, any swelling</td>
</tr>
<tr>
<td>Bumpy or smooth</td>
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<tr>
<td>Wet or dry</td>
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<tr>
<td>Itchy or not</td>
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<tr>
<td>Warm or cool</td>
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<tr>
<td>Pain or tenderness, does it interfere with ADL</td>
</tr>
<tr>
<td>Attempted remedies? Do they help?</td>
</tr>
<tr>
<td>Incontinence</td>
</tr>
<tr>
<td>Wound history, any signs of would infection (redness, tenderness, discharge, describe)</td>
</tr>
<tr>
<td>Presence of VAD?</td>
</tr>
<tr>
<td>Any co-morbidities e.g.: diabetes</td>
</tr>
<tr>
<td>Any recent bloodwork</td>
</tr>
<tr>
<td>Any new or different food or drinks? Any new or different hygiene/cleaning products?</td>
</tr>
<tr>
<td>Exposure to someone with infectious illness?</td>
</tr>
<tr>
<td>Previous radiation treatment?</td>
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<tr>
<td>Exposure to sun?</td>
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<tr>
<th><strong>Emergent</strong></th>
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<tbody>
<tr>
<td>Fever of 38 C or greater</td>
</tr>
<tr>
<td>Potential VAD infection</td>
</tr>
<tr>
<td>Potential wound infection</td>
</tr>
<tr>
<td>History of Graft vs. Host Disease</td>
</tr>
<tr>
<td>Discomfort affecting ADL</td>
</tr>
<tr>
<td>Exposure to infectious individual</td>
</tr>
<tr>
<td>Rapid progression of symptoms</td>
</tr>
<tr>
<td>Open, draining lesion(s)</td>
</tr>
<tr>
<td>Suspected zoster infection</td>
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</tbody>
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<tr>
<th><strong>Urgent</strong></th>
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<tbody>
<tr>
<td>Expected changes</td>
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<tr>
<td>Improvement with home remedy</td>
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<tr>
<th><strong>Non-Urgent</strong></th>
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<tbody>
<tr>
<td>Expected changes</td>
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<tr>
<td>Improvement with home remedy</td>
</tr>
</tbody>
</table>

**Patient Teaching**

| Cool or lukewarm baths, mild soap, pat dry (no rubbing) |
| Avoid direct application of cold to area (ice pack) |
| Use moisturizing water-based emollients, (Keri, Neutrogena, Lubriderm, etc.) on intact skin only. |
| Avoid chlorinated pools, Jacuzzis |
| Avoid tight clothing and harsh fabrics to reduce skin trauma; cotton recommended |
| Don't shave site of irritation |
| If allergic reactions suspected - antihistamines, calamine lotion, Aveeno bath |
| Sitz baths for perianal irritation |
| Avoid perfumed products for laundry, and personal hygiene |
| Cornstarch to dry, intact skin to soothe itching and help with friction – do not use in skin folds or on open areas. |
| Sun protection; sunscreen with SPF of 15 or greater to avoid sun damage |
| Skin open to air if possible |
| Vit B6 (Pyridoxine) may decrease severity of hand foot syndrome (Alley, 2002) |
| Drink 8-12, 8-oz glasses of fluid per day (maintain hydration) |
| Avoid tape or Band-Aids to irritated skin |
| Wash hands frequently and avoid scratching or breaking of lesions |

**Follow-up/Evaluation/Documentation**

| Record date and time of telephone encounter |
| Record assessment, interventions, and any follow-up plans |
| Refer to CCAC or other appropriate colleagues as indicated |
| Reinforce with patient to call back if symptoms do not improve or begin to deteriorate |
| Reinforce with patient when to seek immediate medical attention |
**Potential Complications**

- Infection localized or systemic (herpes zoster)
- Anxiety, sleep disturbance, fatigue
- Compromised QOL
- Loss of function in affected area
- Significant pain in affected area

**Risk Factors/Possible Causes**

- Graft vs. Host Disease
- Hypersensitivity reactions: urticaria, angioedema, rash
- Radiation sensitivity and recall: skin reactions in previously irradiated tissue or increased skin sensitivity to RT
  - Associated chemo drugs: Bleomycin, Docetaxel, Doxorubicin, 5FU, Gemcitabine, Vinblastine, Daunorubicin
- Allergic reaction/contact dermatitis: maculo papular rashes
- Infectious agents, i.e. Herpes zoster (shingles, chicken pox)
- Chemotherapy side effect, i.e. Palmar-plantar erythrodysesthesia from Caelyx or 5FU, Xeloda, Bleomycin, Docetaxel, Capecitabine, Cytarabine, Thiopeta
- Vescicant extravasation, vascular discoloration
- Insect bite, or contact with a parasite
- Skin integrity alteration related to cancer of the skin, or liver involvement
- Sun exposure causing blistering

**Definition of Common Descriptive Types**

- Palmer-plantar erythrodysesthesia begins as erythema and edema of palms and/or soles, sensitivity, paresthesia and can progress to desquamation and significant pain.
- **Macule** - a flat mark, circumscribed area of colour change
- **Papule** - elevated 'spot', palpable, firm, generally < 5mm (insect bite)
- **Nodule** - elevated, firm, circumscribed, palpable and can involve all layers of the skin; > 5mm
- **Plaque** - elevated, flat topped, firm, rough, superficial papule, > 2cm in diameter. Papules can coalesce to form plaques. (psoriasis)
- **Wheal** - elevated, irregular-shaped area of cutaneous edema, solid, transient, variable diameter, red, pale pink, or white in colour. (urticaria)
- **Vesicle** - elevated, circumscribed, superficial fluid filled blister, < 5mm in diameter.
- **Bulla** - a vesicle > 5mm in diameter
- **Pustule** - elevated, superficial pus filled vesicle (impetigo)
- **Scale** - heaped up keratinized cells, flakey exfoliation, thick or thin, dry or oily variable size (psoriasis)
- **Crust** - dried serum, blood or exudates, slightly elevated.
- **Excoriation** - loss of epidermis.

**Note**: Lesions, that appear red or brown on white skin, would appear black or purple on pigmented skin and mild degrees of erythema may be masked completely.

**References**


## Radiation Skin Reactions

Radiation Skin Reactions are due to injury to normal cells in the radiation treatment area. Severity is related to the dose of radiation, other concurrent treatments and individual facts.

### Common Terms:
- Radiation burns, raw skin

### General Assessment
- Name, DOB, Clinic identification number, Physician
- Diagnosis, Treatment: Type, Date of last treatment
- Current medications, Allergies
- Pharmacy name and number

### Symptom Assessment

#### Radiation Therapy:
- When did it start?
- When was treatment complete?
- What part(s) of the body were treated?
- Have you had previous radiation treatments?

#### Chemotherapy:
- Are you receiving oral or IV chemotherapy?
- Which chemo medications did you receive and when?
- Are you receiving chemotherapy and radiation therapy together?

Are you experiencing the following?
- Dryness and/or itchiness (pruritus)
- Redness, tenderness, heat, edema (erythema)
- Peeling (dry desquamation)
- Weeping, moist, wet, painful, edema, drainage, crusting (moist desquamation)

**Are you having difficulty swallowing, eating or drinking?**
**Are there signs of infection?**
- Abnormal drainage and/or odour
- Fever
- Pain and swelling

**Are you having difficulty moving or walking?**
**Is the skin reaction causing excessive pain, associated nausea or fatigue?**
**What remedies are you using to ease your skin reaction discomfort? Have they been effective?**
**What medications are you taking for your reaction?**

### Emergent
- Fever of 38 C or greater
- Other signs of infection
- Uncontrolled pain

### Urgent
- Discomfort affecting ability to perform ADL
- Current treatment not working
- Worsening of symptoms, i.e. new, onset of moist desquamation

### Non-Urgent
- Improvement with self-care strategies

### Patient Teaching
- Avoid friction, i.e. skin surfaces rubbing together, clothing rubbing against skin
- Avoid temperature extremes, i.e. heating pads, ice packs
- Avoid irritants, i.e. deodorants, strong soaps, perfumes, lotions (other than those recommended by the physician or nurse)
- Avoid exposure to the sun and to cold winds
- Wash skin gently with a mild soap and lukewarm water. Pat dry.
- Do not use cornstarch if skin is not intact or in skin-fold/crease areas, i.e. axilla, groin gluteal folds
- Avoid using adhesive tape over the treated area
- Use pain medications/anti-inflammatories regularly
- Use moisturizing water-based emollients on intact skin, i.e. Glaxal Base, Lubriderm
- Report signs and symptoms of infection, i.e. fever, drainage, odour
- Maintain good nutritional and fluid intake to promote tissue repair.

### Follow-up/Evaluation/Documentation
- Record date and time of telephone encounter
- Record assessment, interventions, and any follow-up plans
- Refer to CCAC or other appropriate colleagues as indicated
- Reinforce with patient to call back if symptoms do not improve or begin to deteriorate
- Reinforce with patient when to seek immediate medical attention

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**Requires immediate medical attention**

**Requires medical attention within next 24 hours**

**Support, teaching and follow-up as required**
### Potential Complications
- Local infections
- Anxiety, sleep disturbance
- Compromised QOL

### Risk Factors/Possible Causes
- Body areas with increased moisture and friction, i.e. axilla, perineum, inframammary fold, behind the ears
- Other body areas, i.e. chest wall, supraclavicular area, head and neck, face
- Pre-existing conditions, (i.e. diabetes, skin grafts, vascular disease
- Age (advancing age may contribute to degenerative changes and compromised blood flow)
- Chronic sun exposure (thins epidermis and increases skin radio sensitivity)
- Smoking (increases tissue hypoxia and retards healing)
- Concurrent chemotherapy, i.e. doxorubicin, methotrexate, 5-FU, hydrouea, bleomycin

### References


PRINCIPLES AND GUIDELINES FOR TELEPHONE PRACTICE

When providing advice and interventions via the telephone, the expectation of the nurse remains the same: to use the nursing process to determine the needs of the patient and provide appropriate care. All telephone communication involving a patient involves a nurse-patient relationship. CNO’s Standard for the Therapeutic Nurse-Client Relationship (1999) states:

"The nurse-client relationship is established and maintained by the nurse through the use of professional nursing knowledge and skill, and caring attitudes and behaviors. The relationship is therapeutic; it is based on trust, respect and intimacy with the client, and requires the appropriate use of power."

The nurse in any care delivery setting must exhibit core interpersonal and intellectual competencies as evidenced by critical thinking skills, effective verbal communication, a systemic approach to history taking and assessment, and thorough documentation of the entire encounter.

Telephone Advice

Canadian Association of Nurses in Oncology (CANO)
Within the context of oncology nursing in Canada, telephone advice falls under the following CANO standards of care for oncology nurses.

Standard 6: Supportive, Therapeutic Relationship
Individuals with cancer and their family are entitled to a supportive, knowledgeable, caring and therapeutic relationship with care providers throughout their cancer experience.

Standard 7: Evidence-based Care
Individuals with cancer and their families are entitled to care that is based on theory, science (physiologic and psychosocial sciences), and incorporates principles of evidence-based practice, best practice or available evidence.

Role of the Registered Nurse

Components of care include application of knowledge and experience, assessment, communication, mutual decision-making, allocation of resources, evaluation and outcomes. (Larson-Dahn, 2001)

The care provided in telephone nursing practice is interactive and is expected to encompass client assessment, planning and provision of information as well as support, evaluation and documentation (CNO Telephone Nursing Practice Standards). More specifically, the telephone consultation role focuses on providing health education and advice, and sharing information regarding health services. Nurses who provide telephone nursing care use the nursing process to identify client needs, to provide and evaluate care. On the basis of the preliminary assessment data, the nurse applies critical thinking skills as well as her/his clinical judgment in choosing and following a protocol appropriate for the
caller’s circumstances. The implementation phase of the nursing process might be the provision of health advice, information and/or counseling, referring the client to emergency services or encouraging the client to visit the physician. The nurse evaluates the client’s understanding of the advice/information provided: usually assessed by having the client repeat back the information.

Nurses providing care via the telephone possess a current and in-depth knowledge base in the clinical area(s) relevant to the role, as well as expert communication skills. After completion of the telephone call, nurses document the telephone interaction.

**Goals of Telephone Nursing Practice:**
- Enhance access to health care
- Provide patients with information about their healthcare needs
- Support the patient’s decision-making about the most effective and cost-efficient health care resources to meet their needs
- Support patients coping at home with acute or chronic illness

**Activities that Establish and Maintain Therapeutic Nurse-Client Relationship:**
- Identify the goals and wishes of the patient and make them the focus of the plan of care;
- Give the patient the time needed to explain him/herself and ask questions;
- Explore unusual comments, attitudes or behaviors to discover underlying meaning;
- Show a genuine interest in the patient by being warm and friendly
- Provide information to promote patient choice and enable the making of informed decisions

**Scope of Practice**

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function. (College of Nurses of Ontario, 2003)

All nurses are accountable for their own decisions and actions, for the quality of their practice and for maintaining competence throughout their careers.
Documentation

Documentation is a legal and professional **requirement** for nurses (Canadian Nurses Protective Society, 1997). Nurses who provide telephone care are required to document the telephone interaction (CNO, Nursing Documentation Standards, 2002).

Documentation must be complete and concise and time efficient (Anastasia, 2001, p.52). Anastasia (1997) identifies documentation as a key element to assist the nurse to recall the facts should the situation, or aspects related to the situation, be challenged or questioned in a court of law.

Documentation is **fundamental** in maintaining the patient’s written health record across the continuum and must be complete, objective, accurate, timely, legible and concise. A nurse must maintain documentation that is relevant, chronological, non-erasable, permanent, retrievable, confidential and client focused.

The **minimum requirements** to be included in documenting telephone interactions with patients are:

- The date and time of the call
- The name, telephone number and address of the caller
- The client’s date of birth or age
- The reason for the call
- Detailed signs and symptoms described:
  - **Examples**:
    1. Severe vaginal bleeding
      *versus*
      Bright red vaginal bleeding soaking through 1pad/hour x 8 hours (Wheeler, 1997, p. 40).
    2. Highly fatigued
      *versus*
      Patient lying in bed for 20/24 hours. Walking to bathroom only or unable to tolerate sitting up for meals.
- The specific protocol used to manage the call
- Advice or information given
- Referrals made
  - **Example**: Referral to Dietician (Judy Foodguide) for nutritional counseling.
- Required follow-up
- The nurse’s signature and designation

(College of Nurses, 1999, p.9)
In addition to the College of Nurses, further literature supports documenting:

- Verbalized understanding of the information provided to the caller.
  **Example:** Mrs. Smith repeated back the plan for her constipation management, she states she understands the need for increased fluid intake to 8-10 cups a day and she will call back in 48 hours to report progress.

- Recommended time frame for caller to seek care
  **Example:** Mrs. Smith advised to attend the emergency department if symptoms do not improve or worsen in the next eight hours. Patient states she understands.

- If the caller is not the patient
  - The caller’s relationship to the patient
  - The location of the caller in relation to the patient
  - If at all possible, request to speak to the patient directly

Example: Call received from patient’s husband, Joe Smith, the patient’s primary caregiver at home. Patient’s husband reports that patient is resting on bed beside him.

**Documentation** demonstrates professional nursing practice and accountability. It is a vital means of communication among health care providers.

Documentation contributes to consistency and continuity within the patient’s plan of care. Adherence to documentation standards of practice promotes safe and effective quality care to patients.
CUSTOMER SERVICE

In a health care organization, quality customer service principles apply. A major principle is that the customer’s expectation and perception of the experience with staff is most important. The nurse has the ability and opportunity to develop a positive and trusting relationship with the ‘customer’ and this applies to telephone nursing as well as face-to-face nursing.

Common Complaints:
1. *Holding for long periods of time:* Courtesy statements go a long way in building a satisfactory relationship with the patient. Thank them for their patience while they wait, give them the option of being called back within a specified time period and always ask their permission to be put on hold before doing so. The patient may have a valid reason for not wanting to wait (they are calling from a pay phone, their cell phone battery is fading, they have a truly emergent situation, etc.)

2. *Not being called back within a timely fashion:* Give the caller a time parameter for calling back and ensure that this is met.

3. *Being transferred from person to person:* Many calls are personal in nature and repeating private information to multiple persons is upsetting. There is always the risk of accidental disconnection; therefore good customer service includes relaying the extension number of the intended recipient of the transfer.

4. *Broken commitments:* Creditability is lost when a commitment made by the nurse is not kept. If a patient is told that he/she will receive a call within one hour, the nurse should make that call whether she has all the information required or not. The nurse can then renegotiate with the patient for further time at that point. This will let the patient know that the nurse has not forgotten about them and that their concerns are being dealt with.

5. *Being treated rudely or without compassion:* All callers should be treated in a manner that is respectful, therapeutic, professional and caring.
COMMUNICATION PRINCIPLES AND TECHNIQUES

The nurse's ability to provide care is supported by communication skills, both verbal and listening. With effective communication, the nurse can be more confident in the ability to obtain a complete history and assessment, thereby assisting the patient to receive the most appropriate care.

Telephone Personality:

- The first 10-20 seconds of a telephone interaction significantly impacts the patient's perception of the nurse's ability and desire to meet the patient's needs. The simple technique of pausing and focusing before each encounter will help maintain the freshness of the nurse's voice.

- The patient's perception of the nurse's attitude often serves to define the potential for a trusting, positive relationship. A caring attitude is the focus of positive communication and cannot be stressed enough.

   *If patients don't know how much you care, they won't care how much you know…*

Ways to portray a caring attitude may include the following:

- Avoid assumptions or stereotypes
- Empathize with the patient
- Use reflective speech or verbal responses that project interest and active listening
- Address the patient by name throughout the encounter. Initially, and until given permission, use more formal titles such as "Mrs."
- Do not use terms of endearment such as 'honey', as these are demeaning.

- Treat each call as if it were the first call of the day. Consistency, combined with control, empathy and clear focus are needed when dealing with difficult calls.

- Self-confidence and organization will impact the nurse's communication efforts. Having basic supplies, such as pens, paper, and a telephone directory, will allow the nurse to focus on the caller instead of scrambling for the required equipment.

Voice Quality:

*Tone:* Use a tone of voice that has vitality, is pleasant and natural. Smile when you speak, as this will naturally raise the pitch of your voice. How the nurse is feeling is reflected in facial expression and then translated through the tone of voice. In turn, the patient's emotions are reflected in their tone of voice and should be part of the nurse's assessment.
**Volume:** Nurses need to remain aware of the volume of their voice. Variations in volume can add emphasis and impact to phone encounters. Remaining calm and consistent may diffuse a tense situation. A nurse may have a naturally quiet voice volume and need reminders to speak up. If a patient cannot hear the nurse, valuable information may be lost in the phone encounter and the patient may be uncomfortable in asking the nurse to repeat him/herself.

**Clarity and Speed:** Careful enunciation and a moderate pace are positive communication techniques. Variation in the rate of speed can reflect mood changes and emphasize points. The nurse must listen to the patient for direction, based on the patient's ability to respond to questions. A patient, who has a hearing impediment, or speech/language barrier, will require slower paced communication. Clarity can be achieved by *avoiding* medical or technical terms.

**Barriers to Effective Communication:**

- Sounding busy or abrupt
- Using inappropriate language or slang
- Arguing with the patient
- Placing blame on the patient or other health care providers
- Lecturing the patient
- Minimizing the patient's concerns
- Rushing the call
- Losing professional perspectives
- Chewing while speaking
- Speaking too loudly or too softly
- Carrying on more than one conversation at a time
- Conducting the call in a noisy, non-private area
- Being unprepared to respond to the patient's need
- Knowledge gaps
- Bias

**Listening Skills**

Listening is more than just hearing. Listening involves paying attention and understanding that there is meaning beyond the words the patient uses.

**Concentrate:** It is very easy to be distracted both - mentally and physically. Make a conscious effort to listen carefully.

**Review:** Repeat/review what the patient has said to make sure it is understood.

**Don’t jump to conclusions:** A barrier may be erected if the nurse prematurely anticipates the patient's needs.

**Listen for auditory cues:** The noises, or sounds, that can accompany speech provide vital cues of emotion that can convey information. Should the nonverbal cues not match what is being said, then, the nurse should suspect that something is wrong.
Interview Strategies

The nurse needs to be a skilled interviewer to perform successful patient assessment.

Open-ended questions: Eliminate 'yes/no' responses and thus illicit greater amounts of information.

Summarizing statements: will help establish a basis for further conversation. For example: "These seem to be your concerns..."

Reflective statements: convey the nurse's observations and attention to more than just the verbal exchange. "You seem to be out of breath..." or "You seem very upset".

Encouraging statements: Phrases that encourage the patient to continue to share information. "Please go on..." or "Please tell me more about...". The nurse may need to be more focused with a patient who tends to ramble.

Using Clarification: The nurse needs to obtain further detailed information about a certain subject, or a clearer understanding, of a patient's response. "You vomited how many times?"

Restating: Can demonstrate the nurse's understanding of what the patient is saying. "So, you would say that you feel better today?" The nurse may ask the patient to repeat what they understood the nurse to say.

Validation statements: The nurse acknowledges the abilities and actions of the patient. "You did the right thing by calling."

Constructive statements: The nurse will motivate cooperation by using constructive statements that appeal to the patient's sense of autonomy. Utilizing tact and 'I' statements will be more graciously accepted by the patient. Try "I need you to..." or "It would be helpful if you..." instead of "You have to..." or You should..."

Definitive statements: The patient and nurse both need to be clear about what is being said. "I will..." instead of "I'll try to...", or when arranging a follow-up call, be specific about times. "I will call back in two hours" instead of "I will call back as soon as possible".

Positive focus: The nurse has options, even in situations where she/he may not have the answers. The focus should be on what can be done instead of on what barriers may exist. Therefore, a statement such as: "I don't know, but I can find out" is better than "I don't know." If a patient has unreasonable demands, try "This is what I can do" instead of "This is what I can do" instead of, "That is impossible."
Call Closure

- The nurse should use the skill of summarization to review progress and pull important facts together.

- The nurse should review whether the patient has the resources/ability to carry out any instructions given.

- The nurse should review instruction so that the patient clearly understands his/her responsibilities. Use of "I will/you will" statements cement the instruction. "You will take the prescribed anti-nausea medication as soon as you get it, and again four hours after that. If it is ineffective, you will call me back. I will fax the prescription to your pharmacy for you to pick it up."

- The nurse should tell the patient to call back if symptoms persist, worsen, or change. Confirm compliance with agreed upon actions.

- Last impressions of a call have a great impact on the patient, and the nurse needs to continue to pay close attention to the tone of voice and rate of speech of the patient. Allow time for any last-minute questions, and allow the patient disconnect the call first.
Common Pitfalls in Telephone Communication

The following are situations to avoid in telephone communication and are common errors made by telephone triage nurses;

1) **Leading Questions:**
Avoid leading the caller towards a specific answer or diagnosis. Allow time for the caller to express his concerns in his own way using open-ended questions.

Sheila Wheeler (1993) states “Rather than seeking to determine a specific cause of symptoms, the telephone triage nurse aims to identify symptoms and classify them by acuity” (p. 34).

2) **Medical Jargon:**
Communicate using words that the patient will understand.

3) **Collecting Inadequate Data:**
Collect enough information to provide a clear picture of what the problem is.

4) **Not Talking Long Enough:**
Provide enough time to get the information you need (5 -10 min).

5) **Jumping To Conclusions:**
Never assume that you know the reason for the caller’ s concern.

6) **Stereotyping Callers:**
Never prejudge, or assume information about a person. Remain open to new or discrepant information.

7) **Accepting Self-Diagnosis:**
The caller may be incorrect in what they feel is causing the problems. Delve further if there is ambiguous or conflicting information given.

8) **Second-Guessing the Caller:**
Ask questions in different ways. Allow the caller to complete their whole train of thought. Wheeler (1993) describes this as, “You’re not sick until I say you are syndrome” (p. 77).

9) **Language Barrier:**
Request to speak to a trusted person you can communicate with or have a colleague who understands the language, speak to the caller. The nurse should not try to assume what the caller is saying in a suboptimal communication situation.
Beware of Red Flags

Red flags are broad categories of high risk. Consider the acronym “SAVED” when assessing for Red Flags:

S ➔ Severe symptoms
  i.e. Pain, bleeding, shock, cardiac arrest.

A ➔ Age of caller and age-related considerations.

V ➔ Veracity ➔ The caller is able reproduce the events of the situation accurately
  i.e. Ask the same question in different ways.

E ➔ Emotional distress or stress of the caller.
  i.e. There is a direct correlation between the caller’s stress and the acuity of the situation.

D ➔ Debilitation/ Distance
  i.e. Consider whether this patient is able to perform ADL. Is he bedridden/mobile?. Does the patient have access/transportation to the centre?

More about Red flags in Symptoms

1. Severe symptoms – Prioritize your call by assessing the most severe symptoms first.

2. Strange symptoms -Note symptoms which are atypical “worst”, “new”, sudden, unexpected, recurrent.

3. Suspicious symptoms – “Big Six” which are often misdiagnosed are:
   1. Head
   2. Respiratory
   3. Chest
   4. Dizziness
   5. Flu
   6. Ectopic Pregnancy

Note: The patient may give distracting information (i.e. the caller misinterprets symptoms or symptom acuity). The caller may deny symptoms (i.e. with a myocardial infarction or abuse) and the caller may have hidden agendas.

4. Get a feel for the caller’s state (panic? anger? calm?)

5. Find out and ask what is most important.
Legal Considerations

"Telephone triage is a new developing and controversial field of care." (Coleman, 1997). Hearing is the main form of assessment in telephone triage. The nurse has the challenges of no visual, no olfactory, and no tactile contact with the caller, as well as ‘red flags’. All of these factors make telephone triage nursing a risky business. Guidelines can help reduce the nurses’ legal risk by helping to maintain a consistent high standard of nursing care. However, as professionals, nurses have autonomy. This means that the telephone triage nurse must use independent judgment in applying the guidelines with the best patient outcome in mind for each caller. Meticulous documentation along with adherence to the organization’s protocols and principles of practice will protect the nurse from any legal allegations.

Negligence

Malpractice is negligence committed by a professional in the performance of professional duties. Negligence in nursing is the failure to take the care that a reasonable nurse with similar experience in similar circumstances would take. Four elements must be established to prove negligence. They are:

1] Duty to meet the standard of care.
2] Breach of duty to meet the standard of care.
3] Breach of duty, which causes foreseeable harm.
4] Causing actual harm or injury.

The following will briefly describe what these four terms mean.

1. Duty to meet the standard of care
   • Once the nurse picks up the phone a relationship is established with the caller. A legal duty to provide care is established.

2. Breach of duty
   • When a nurse fails to follow the standards of care that are written, a breach of duty may be considered.

3. Foreseeable harm
   • This is failure of the nurse to recognize or advise on an aspect of care that could cause harm. The nurse has the duty to explain to the caller the consequences of not following the advice given. For example, it is essential that the client be warned to seek medical advice if certain symptoms, such as fever, appear after receiving chemotherapy. The injury in “foreseeable harm” must be a reasonably anticipated result of the nurse’s negligent actions or omissions. A nurse will not be held accountable if the injury that resulted was unforeseeable or uncontemplated.
4. Actual harm or injury
   • This is the actual harm that happened to the patient directly caused by the information or omission of information provided by the telephone triage nurse.

   As well, call documentation is extremely important. It promotes continuity and consistency of care as well as providing evidence of the nurse’s reasonable actions should there be any legal proceedings. (Mikels, 1999)

**Accountability:**

“The health record demonstrates nurse’s accountability and gives credit for their professional practice “ (CNO, 2002). Also CNO Professional Standards 2002 states, "Each nurse is accountable to the public and responsible for ensuring that her /his practice and conduct meets legislative requirements and the standards of the profession".

**Nurses are legally accountable to the following:**

1) Client  
2) Employer  
3) Professional body

**Confidentiality:**

A caller is required to reveal personal information in order to be effectively treated. As a nurse you are legally required to safeguard confidentiality. You may divulge confidential client information when your client authorizes you to do so provided that your client has legal capacity to consent release of health information. This consent should be in writing and follow your institution’s policies and procedures. The consequences of an unauthorized disclosure may result in the client taking legal action. A nurse may be sued for negligence, breach of confidentiality, or defamation.

**Summary:**

In conclusion nurses have to be able to communicate well both in writing and orally. They must be aware and follow the standards of care established for telephone nursing practice. Good resources for nurses include the Ontario Telehealth Telephone Standards and The Legal Aspects of Telehealth Nursing chapter in the Telephone Nursing Practice Core Curriculum. More legal information can be obtained through the Canadian Nurses Protective Society.
COMMUNICATION CHALLENGES

Difficult Callers

The nurse must remember that the goal is to assist the patient to find a means to regain or maintain health and well-being. The patient, due to stress or personal circumstances, may not be able to effectively communicate with the nurse. The nurse must deal with the patient's actual feelings and then the problem itself.

- Avoid prematurely reacting to the patient's emotions
- Empathize with the patient. Do not judge
- Listen to understand though not necessarily agree with the patient
- Remain calm and non-confrontational
- Allow the patient to ventilate
- Use reflective statements to clarify the patient's feelings
- Attempt to help the patient by asking such questions as "What can I do for you?"
- Know when and how to terminate a call
- Do not become complacent with frequent/familiar callers, as something important may be missed.

Emergency Situations

*An emergency can strain the patient's ability to communicate clearly.*

- Reassure and engage the patient. Statements such as: "I'm listening, please continue" help calm the patient.
- Provide calm and specific advice. By providing specific actions, the nurse assists the patient in gaining control of the situation.

Refusal to Follow Advice

- If the patient refuses to follow the advice given, the nurse should clearly state and document the consequence of that action. "Do you understand what could occur if you do not follow this advice?"
- If the patient refuses to follow the advice, the nurse should find out what they intend to do. The response should be documented.

Obscene Calls

Obscene/threatening calls are upsetting.

- Consider whether the use of foul language is 'normal' for this patient
- Focus on getting to the root of the problem and attempting to calm the patient
- Do not match the patient's frustration level and/or obscene language
- If abusive or obscene language continues, the nurse needs to be prepared to follow the organization's policies; this may include informing the patient that the call will be terminated if the language continues.
- Thorough documentation is necessary.
TELEPHONE PROTOCOLS AND GUIDELINES

Guidelines, protocols and algorithms are words that are often used interchangeably. Guidelines are more general, steering the course of action that a nurse should take, whereas protocols and algorithms provide specific information that direct practice. Well-written guidelines utilize the nursing process, are symptom-based, have assessment steps that include consistent disposition criteria, contain homecare advice with education and counseling text. They provide structure for telephone nursing assessment by ensuring consistency, accuracy, completeness and quality of practice regardless of the nurse’s individual background, education and experiences.

Using a telephone guideline, that highlights the questions to be asked, can facilitate obtaining a thorough assessment over the phone. No one knows everything; therefore, the guidelines can assist the nurse through the decision-making process. The guidelines will help structure the call and organize any information that should be considered.

Guidelines do not replace the critical thinking skills that nurses employ on a daily basis and clinical judgment must be utilized in all patient care situations. Though a nurse may be familiar with a guideline, the selected guideline should be opened and followed with each applicable call. This is a reminder of important facets of care that should be considered and evaluated, and helps the nurse to stay focused - even if physically or mentally exhausted.

Deviation from the disposition indicated by a guideline may be done on occasion-based on the nurse’s judgment. Documentation of the rationale is required. A guiding principle should always be that when in doubt, err on the side of caution for the patient.
Case Study #1

Dianne is a 55-year old woman who was diagnosed with stage III invasive breast cancer. She underwent neoadjuvant chemotherapy followed by a modified mastectomy and axillary node dissection. This showed residual disease in the breast tissue with 4/16 nodes positive. She has now started 4 cycles of Docetaxel. After cycle #1, Dianne who is a patient you see in clinic calls to discuss her symptoms of mucositis with you to ensure she is doing all that she can do to prevent other complications.

On initial assessment, she sounds alert, oriented and calm over the phone. On questioning, Dianne had her first treatment 11 days ago. She describes open sores on the roof of her mouth, buccal mucosa bilaterally and ulcers on the right side of her tongue. She finds it difficult to eat much of anything due to the pain in her mouth and pain on swallowing. She has been pushing her fluids as much as possible. In addition to the fluids she has been performing all of the standard mouth care procedures listed in her chemotherapy booklet and in the treatment centre’s mucositis guideline. She has not taken anything for her mouth pain and denies seeing any cream-colored patches in her mouth.

Because of the severe case of mucositis you decide to go further with your assessment. In addition to the mucositis protocol you pull the fever guideline:

Questions

1. What finding has triggered your concern most?
   (a) Dianne is on chemotherapy- Docetaxel and has mucositis
   (b) Dianne called with questions and concerns
   (c) Dianne’s pain and discomfort swallowing
   (d) Dianne indicated it is day 11 in her chemotherapy protocol and she is suffering from severe mucositis

2. Considering the risk of neutropenia and possible infection, you want to explore whether Dianne has any other symptoms that you should act on or have the patient monitor. What questions would you ask?
   List 3 questions.

3. Based on this information you decide:
   (a) Dianne is at low risk for febrile neutropenia, review comfort measures including monitoring her temperature and encourage Dianne to call if mucositis worsens, experiences fever +/- chills/cold.
   (a) Dianne is at moderate risk and you ask if she can come in for a blood count in the next 2-4 hours. If she feels flushed or hot, you advise Dianne to take her temperature and record it.
   (a) Dianne has suspected febrile neutropenia and you advised her to go to her nearest emergency department for further assessment and medical work-up.
4. What are the legal implications specific to this phone call and what actions would you take to lower any nursing practice risk related to assessing a patient over the phone?

5. What would you include in your documentation up to this point?

6. What questions would you consider during a review: List 4 review questions that would assist self-evaluation and protocol evaluation.

You gather your completed telephone advice documentation form and Dianne’s chart, review the patient’s history, current status and your actions with her oncologist with the goal of receiving the order for a CBC & differential. If Dianne is experiencing febrile neutropenia, you confirm with the oncologist that Dianne will be directed to the Emergency department. If she has a low grade temperature with a normal white blood cell count you will call him to discuss whether there are any other abnormal findings on examination.

Dianne meets you in the clinic after she has her blood test. On examination she appears slightly flushed, her temperature is 38°C, Pulse 90, Blood pressure 110/60, Respirations 16.

CBC and Differential: White blood cell count is 0.9 x 10^9/L, Hemoglobin 112 g/L, platelets 100 x 10^9/L, neutrophils 0.03 x 10^9/L 
Physical examination was deferred since you will be sending Dianne to the emergency department for a thorough examination and septic workup immediately. You quickly review the process and procedures that will occur in the Emergency department and answer Dianne’s questions. Reassurance and support are provided regarding the fact that Dianne called you today. Your next step will include informing the Emergency department that she is on her way and will require prompt interventions. You write down the chemotherapy protocol and blood test results for Dianne to submit to the triage nurse. You also inform her oncologist and Dianne’s husband at Dianne’s request.

It’s helpful to take the opportunity to re-examine each component of the nursing process as applied during the telephone call. Self-evaluation may occur concurrently during the call or retrospectively after the call.

**PLEASE SEE PAGE 55 FOR CASE #1 ANSWERS**
Case Study #2

May 7 - Mr. P is a 47-year-old man who was seen in the cancer clinic for an Unknown Primary. He had a three-day history of increasing shortness of breath (SOB), night sweats, ten pound weight loss and headaches. CXR showed cardiomegaly, CT Scan showed pleural effusion and Cytology showed adenocarcinoma. Patient was diagnosed as having advanced stage carcinoma with malignant effusion and most probable lung primary. Patient was offered chemotherapy for symptom management but declined. His father had died one-year prior of lung cancer and “he saw what chemotherapy did to him”. He appeared angry and resistant to assistance but did accept a referral to CCAC for Palliative Nursing Care.

May 12 – Mr. P was assessed for symptom management. Patient was taking Tylenol #2 prn for pain and was complaining of constipation and pain. Medications were changed to MS Contin 15 mg BID, Tylenol # 3 for breakthrough, Senokot 1-2 tabs BID and Colace 1-2 tabs BID.

May 27 – Patient contacts Primary Nurse by telephone. Patient sounds distressed and complains of no bowel movement for six days. In talking to the nurse he also makes reference to developing a cough, increase in night sweats and interrupted sleep.

When assessing the patient, his answers are as follows: he is passing ‘gas’, no nausea or abdominal cramping, eating even though his appetite has been ‘off’ since no bowel movement, drinking 6-8 glasses of fluid a day and for his bowels he is taking colace and senokot daily at breakfast.

Questions

1. What medication(s) advice would the nurse provide for his constipation and why?

2. Does the above advice meet the Ontario College of Nurses Standards?

3. Is recommending Milk of Magnesia considered ‘prescribing’ by the Ontario College of Nurses Standards?

4. Is it within the Ontario College of Nurses Standards for the nurse to communicate the prescription to the community pharmacy?

5. What teaching should the nurse do on analgesics, cough suppressant medication and constipation?

6. What patient instructions and follow-up care would the nurse do?

PLEASE SEE PAGE 58 FOR CASE #2 ANSWERS
Case Study #3

Mr. J.Y. is an 79 year old gentleman with a history of low grade lymphoma. He originally presented with a mass in the left lower quadrant. Biopsy showed follicular cell malignant lymphoma that was CD 20 positive. He was treated with six cycles of CVP combination chemotherapy, consisting of cyclophosphamide, vincristine and oral prednisone. He had resolution of his intra-abdominal mass and all lymphadenopathy. On routine follow-up 6 months after completion of chemotherapy he had evidence of recurrence and was started on chemotherapy with fludarabine. He has just completed 4 cycles and is awaiting CT scan for restaging.

Mr. Y’s wife calls concerned regarding her husband’s pain. His major complaint is right-sided low back pain.

The Pain Guideline would be accessed as a reference.

1. What is your first course of action in response to Mrs. Y?

2. What aspects of his pain do you need to assess to complete your assessment?

3. Are there any other symptoms that you would specifically ask about?

In response to your assessment, Mr. Y replies: His pain is specifically over the iliac crest and radiates down his right thigh to his knee. He states the pain is variable in intensity, describes it as sharp and continuous, sometimes throbbing, worse with movement and with lying position, improved with sitting.

Mr. Y. reports that he has had pain for about a month but it has become more intense over the past week. His denies any change in sensation to his lower extremities but has nocturia and has noticed some decrease in his stream. His bowels move every 2 days with Senokot® 2 tablets. His sleep is disturbed by difficulty finding a comfortable position. He rates his pain as 7/10 at present, 10/10 at worst, 6/10 at best and acceptable. He feels that heat and cold are ineffective in relieving pain. His family physician has prescribed oxycocet 1- 2 tablets every 4 hours. He is only taking 1 tablet as he finds it makes his thinking “fuzzy”. He has some relief with the oxycocet but it only lasts about 1-1 ½ hours.

4. Based on the information you have received you decide:
   a. his symptoms may be related to a previous history of degenerative disc disease and refer him to his family physician
   b. he is not using his medications effectively and advise that he increase his oxycocet to 2 tablets every 4 hours
   c. he cannot manage his pain with present medications particularly with side effects noted so arrange to refer him to Pain Management or Palliative Care Service
   d. he needs to be assessed by the oncologist urgently and arrange for him to be seen in Clinic later in the day

PLEASE SEE PAGE 60 FOR CASE #3 ANSWERS
APPENDIX I

The Nursing Process

The nursing process provides the blueprint for the consistent delivery of patient care in all practice settings. Telephone nursing includes responsibilities and accountabilities consistent with quality care. The nursing process involves assessment, problem analysis, planning, implementation and evaluation.

Assessment:

1. Interview: Questions should be asked in a logical sequence with attention and sensitivity to the acuity level of the presenting need and in a manner that encourages a detailed description of the present situation.

2. Collect data: Data include not only verbal responses to questions, but to other indicators that can be picked up over the telephone. Is the patient calm or agitated, are there background noises that may indicate that there are other people around, etc. All factors must be taken into account to aid in determining how to proceed with the interview and prioritizing the needs of the patient. The best situation involves the nurse speaking directly to the patient whenever possible.

3. Assess: The nurse's assessment of the patient's presenting symptom(s) or need(s) is key to proceeding with the interaction. The nurse must consider the clinical acuity of the need presented as well as the patient's perceived acuity of the need. These two views may not agree and the nurse must be aware of susceptibility to stereotyping and prejudice as a potential risk to accurately assessing patients. The patient's tone of voice, perceived social-economic situation, communication style, community location, gender or cultural traits may inform of the significance of the patient's need and determine how the nurse will address the concerns the patient has verbalized. Lack of face-to-face contact eliminates the nurse's advantage of utilizing all physical sensory input - visual, olfactory, tactile as well as verbal and nonverbal communication to assess the patient's current status. The nurse must be sensitive to auditory, verbal and emotional cues communicated through speech. The patient consequently shares greater accountability in assisting the nurse with the assessment, intervention and evaluation of outcome. The nurse needs to stay sensitive to the patient's ability to communicate his/her current situation accurately with open-ended questions and prompts until all necessary information has been gathered.

4. Prioritize: This process focuses on establishing the level of acuity indicated by the presenting circumstances. Prioritization of calls requires that the nurse immediately identify emergent situations and initiate the necessary interventions. Triage guidelines help to determine the level of urgency and, thus, facilitate appropriate call disposition.
Analyze and Plan:
While assessing the patient's presenting signs and symptoms and collecting other relevant information, the nurse continually analyzes the information to develop an effective plan of care. After ruling out emergencies, the plan of care is initiated with the selection of appropriate guidelines, the referencing of other resources, and/or collaborating.

1. **Guidelines**: Guideline selection is based on the nurse's determination of the chief presenting symptom of the patient, using the interviewing and assessment phase to support the decision. Supported by the guideline, the nurse advises the patient on options for intervention and/or referral.

2. **Referring to other Resources**: Should there be no guidelines available for the patient's presenting need, other written materials or healthcare professionals can be consulted. An example would be a patient seeking information on a particular medication or procedure.

3. **Collaboration**: Group decision-making has the advantage of considering the patient problem from multiple points of view. Interdisciplinary collaboration may be necessary with home health care or community service individuals so that the patient has the support services necessary to maintain care in the home.

Implementation:

1. **Problem solving**: Problem solving is an important tool in the skill set of the nurse. The nurse must be able to collaborate with the patient to elicit the most complete information, most accurate problem identification and the most workable solution. In this way, the patient plays a key role in achieving the desired outcome.

2. **Intervening**: Intervention may include the following: providing emergency directions, health teaching, scheduling appointments, counseling, and acting as a liaison in finding resources. Activities may involve family members/caregivers of the patient. Information relayed should be in accordance with approved guidelines. Timelines must be elaborated and the expected outcome of the care must be clarified as well as potential consequences of not complying with the outlined plan of care. Information should include instructions about when to call again or seek further help.

3. **Patient education**: Providing accurate and complete information is essential if the desired outcome is to be achieved. It is critical that the nurse provide information slowly and deliberately, assessing the patient's comprehension, anxiety and distress throughout the education process.

4. **Providing support**: Support may be psychological in nature. A calm, empathetic listener that assists a patient to successfully manage a difficult situation is key in providing the confidence that enables the patient to continue on and do what is necessary. If a patient perceives a lack of appreciation for his/her concerns, discouragement, frustration and hostility may be the potential result. The nurse can provide support by coordinating resources such as home care services.
5. **Facilitating appropriate follow-up care**: Follow-up care may involve a variety of interventions: a scheduled phone call for a progress report or a clinic visit to see a physician. Reinforcing with the patient why this follow-up care is important is necessary because there are risks associated with non-compliance that the patient must understand. For example: a febrile, neutropenic chemotherapy patient reports a fever of 39 degrees but is reluctant to seek immediate attention in the local emergency department. It is the nurse's duty to explain the dire consequences that can occur if the patient does not comply with her advice, which is to seek medical attention immediately.

**Evaluation:**

1. **Documentation**: Documentation must be complete, accurate, contemporary, legible and concise. The nursing assessment and intervention must be documented and is fundamental in maintaining the patient's health record. If there are gaps in documentation, or information is unclear, a potential legal risk will exist for both the nurse and employer not to mention the implications for the care of the patient.

2. **Communication**: Written and verbal communication skills are necessary. The nurse and the patient need to understand each other. Information needs to be concisely relayed to other members of the healthcare team.

3. **Follow-up**: This subject is broad and can include a nursing phone call to emergency to inform them of a patient on route, or phone call to the patient the following day to review their progress or clear instructions to the patient that he/she should call back if the symptoms progress or do not improve.

4. **Analysis**: Evaluation of the call can review the effectiveness of professional practice and/or may indicate the need to make changes in the components of a guideline.
APPENDIX II
College of Nurses of Ontario - Telephone Standards

Telephone Nursing Practice Standards

for Registered Nurses and Registered Practical Nurses in Ontario

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College of Nurses of Ontario

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Ce fascicule existe en français sous le titre : Normes sur les soins infirmiers téléphoniques.
INTRODUCTION

Who should use these standards?

Although telephone contact with clients is a primary role for nurses who practice in call centres or health information service environments, it is a potential activity in almost all practice settings. These standards are the College of Nurses of Ontario's expectations for telephone practice, and should be used by every nurse who uses the telephone to communicate with a client.

What is telephone nursing practice?

Telephone nursing practice (also referred to as telemonitoring) is based on the therapeutic nurse-client relationship and involves using a telephone to provide nursing care to clients at a distant location from the nurse.

The care provided in telephone nursing practice is interactive and is expected to encompass client assessment, planning and provision of information as well as support, evaluation and documentation. Telemonitoring can occur in a variety of settings, including ambulatory care clinics, call centers created specifically for providing health advice or counseling/disease management services, physician's offices, hospital units, emergency departments, visiting nursing agencies, and public health departments.

Examples of telephone nursing practice include:

- explaining the purposes and effects of a medication;
- talking to a new mother about infant feeding;
- answering questions about laboratory tests;
- providing disease-specific information, counseling, and/or linking to resources via an AIDS hotline, Mother-Risk service, poison control center or teenage phone line;
- phoning a recently discharged client to inquire about his or her health status;
- performing telephone triage for clients with immediate health concerns;
- providing mental health crisis intervention;
- providing routine monitoring of chronic diseases such as asthma or diabetes;
- immunization assessment and counselling; and
- assisting travelers to obtain health care at their travel destinations.

How is telephone nursing practice related to telepractice?

Telephone nursing practice is one component of telepractice. Telepractice, also called telehealth, has been defined as Industry Canada as the use of communications and information technology to deliver health and health care services and information over large and small distances.

Telepractice utilizes electronic technology such as the Internet, videoteleconferencing, telemedicine, computer information systems and teleinformatics, to enable health professionals to reach clients, transmit information and consult with other health professionals over geographical distances.

For example, using video, computer and data equipment, health professionals can listen from their office to the heartbeat of a client sitting at home, send images of a skin lesion to a plastic surgeon in another city, transmit x-rays to a radiologist located in a distant site, or even perform surgery on a client who is miles away.

With the expansion of telepractice, legal, regulatory and labour issues are rapidly being identified. These issues are beginning to be examined and addressed by government, industry and stakeholder associations such as the Ontario Hospital Association, the Ontario Nurses Association and the Canadian Nurses Association. Accordingly, this document is considered a work in progress and will be revised as new information becomes available.

CNO ASSUMPTIONS REGARDING TELEPHONE NURSING PRACTICE

The role of the nurse in telephone nursing practice is based on the following nine assumptions:

1. The goals of telephone nursing practice are to:
   - enhance access to health care;
   - provide clients with information about their health care needs;
   - support the client's decision-making about the most efficient and cost-effective health care resource to meet their health needs;
   - support clients coping at home with acute or chronic illness to facilitate client choice and convenience regarding health care needs;
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   - support clients coping at home with acute or chronic illness to facilitate client choice and convenience regarding health care needs;
3. Risk associated with telephone nursing practice

The lack of face-to-face contact with the client and the nurse reliance on the caller to provide accurate and comprehensive information about the particular health concern pose unique risks in telephone nursing practice. The risk is also reduced if the client is already under care and known to the nurse, such as in family practice settings or community visiting nursing situations. The risk may also be minimized when care is provided by nurses who possess the knowledge, skills, judgement and experience required to meet the type of client care needs generally encountered in telephone practice.

4. Determining the appropriate category of care provider

Registered Practical Nurses (RPNs) provide telephone nursing care in situations where the needs of the client are known such as a specific health information line on HIV or birth control. They also provide care where there is immediate access to colleagues or information resources, such as in a family practice clinic.

Registered Nurses involve complex client care needs and unpredictable situations. In unknown circumstances the nurse needs to be prepared to manage the most complex client care needs. This need puts the triage role beyond the limits of practice for the RPN.

For a more in-depth discussion of the factors involved in determining the appropriate category of care provider see CNO's Decision Guide: Determining the Appropriate Category of Care Provider (1997).

5. Telephone nursing practice across provincial and international borders

Nurses registered with CNO provide telephone nursing care to clients in distant locations, including other provinces and countries. An Ontario Nurse working in an Ontario practice setting who provides telephone nursing to a client outside of Ontario is considered to be practising nursing in Ontario, and is accountable for maintaining the professional standards of practice as set out by CNO.

The outcome of care for the client does not differ according to the nurse's location. The nurse informs the client of his/her geographical location if indicated or requested. It may not be necessary to inform the client of the nurse's location in situations involving the provision of health advice, information, or triage of a health concern. Informing the client of the nurse's location may be indicated if a client living in a remote location requires a referral to a local community resource.

6. Use of standardized protocols in telephone nursing practice

For the purpose of this document protocol also refers to a clinical algorithm, guideline or standardized interview.

CNO supports the use of standardized protocols. However, in cases where the nurse's judgement conflicts with the protocol there needs to be a provision for overriding the protocol. The following expectations ensure that standardized protocols are practical and useful to nurses:

- Nurses who provide care via the telephone are accountable for their actions, and the quality of their practice. They use critical thinking skills in implementing practice setting policies or standardized protocols.
- In situations where telephone advice is a frequent activity, standardized protocols are available to guide the information obtained from the caller and the advice or disposition of the call.
- Telephone practice nurses apply their clinical judgement in all client care situations and use protocols as guidelines.
- The nurse documents situations in which her/his clinical judgement necessitated a variance from an established protocol.
- A variance from an established protocol is discussed with the health care team and is considered during the protocol review process.
- If protocols are not available, the nurse advocates for the development of a standardized interview tool that contains key questions asked of all clients, and space for documentation.
- Standardized protocols are reviewed and updated at regular intervals.

7. Informed consent and confidentiality of client information

Telephone nursing practice is subject to the same principles of client confidentiality as all other types of nursing care. CNO's Ethical Framework for Nurses in Ontario (1999) outlines the ways in which nurses demonstrate regard for privacy and confidentiality. Examples include:

- Keeping all personal and health information confidential within the obligations of the law and standards of practice, including that which is documented or recorded electronically.
- Informing clients or substitute decision-makers that other health care team members will have access to any information obtained while caring for clients.
- Informed clients or substitute decision-makers when information is used for purposes other than client care (e.g. research, quality improvement), and
- Refraining from collecting information that is unnecessary for the provision of health care.

The client's informed consent is required before a treatment is provided. Telephone nursing practice generally involves taking a health history, or assessing a person to determine the general nature of the person's condition (Health Care Consent Act 1996 HCMA). These activities are not designated as treatments by the HCMA. Technically, therefore, informed consent is not required. Nonetheless, there is an overall principle that requires informed consent to be obtained for care provided in non-emergency situations.
Accordingly, for telephone nursing practice, informed consent includes telling the client:

- the nurse’s name and category (Registered Nurse/Registered Practical Nurse);
- the nature of the help the nurse will give (e.g., “I will ask you questions and then provide some information/advice”);
- whether there is a possibility that another individual will be listening to the client’s call, and if the call is being tape recorded; and
- how the client would reach the same nurse or call center if further information is needed.

Such information may be provided by the nurse or by a recorded message the caller hears before speaking to the nurse.

8. Clinical experience and telephone nursing practice

Nurses providing telephone nursing care possess a current and in-depth knowledge base in the clinical area(s) relevant to the role, as well as expert communication skills. Some telephone nursing practice requires competence, expertise, and knowledge beyond that obtained in a basic nursing program. Competence in the role of telephone practice nurse may be enhanced through completion of a focused educational program.

9. Quality practice settings and telephone nursing practice

An environment where nurses practice is a major determinant of quality care. Factors such as professional support, technical resources, adequate lighting and work breaks contribute to a practice setting that supports nurses in providing quality care to clients.

Features of a quality practice setting include:
- informing clients and nurses if and when their interactions are being monitored for quality improvement and performance management purposes;
- respecting nurses’ clinical judgments in regard to varying from established protocols;
- recognizing that telephone nursing practice involves individualizing client care;
- supporting an adequate length of time for each nurse-client telephone interaction;
- facilitating client follow-up activities as deemed appropriate by the nurse, which may include referral, consultation and return phone calls;
- supporting the development and/or updating of clinical protocols and guidelines appropriate for the client population;
- providing standardized protocols (computerized or paper) to facilitate interviewing and decision making and to promote quality and consistency in telephone nursing care;
- providing a paper or computer-based form to enable documentation of telephone interactions with clients, including instructions that occur after a client returns home from an in-patient setting (especially in settings where the client chart is computer-based and becomes inaccessible to nurses upon the client’s discharge);
- providing nurses with relevant professional development opportunities;
- providing sufficient staff resources to enable best nursing practice; and
- considering and providing for staff needs related to areas such as ergonomics, lighting, noise reduction, and work breaks.

YOUR RESPONSIBILITIES IN PROVIDING TELEPHONE NURSING CARE

Providing care

Nurses who provide telephone nursing care use the nursing process to identify client needs, provide and evaluate care.

The nursing process has been identified as a standardized process for problem solving that is appropriate for assessing the needs of both individuals and groups regardless of the setting in which the telephone nursing practice is taking place. It application to telephone nursing practice is outlined below.

Assessment

- a standardized telephone interview tool or a computer-based protocol is used for each telephone interaction; and
- every effort is made to speak directly to the individual with the health concern.

While the assessment protocol may need to be customized according to the situation, in general the assessment data to be collected includes:

- caller’s concerns/needs; including history of concerns, and signs and symptoms;
- the client may be asked to the nurse to who the next call is directed.

Describe telephone nursing care

Nurses who provide telephone care document the telephone interaction and store the document according to CNON’s Standards for Nursing Documentation (1998). Documentation may occur in a written form or via computer. As a minimum, the information to be documented includes:

- the date and time of the call;
- the nurse, telephone number and address of the client (unless anonymity is required); and
- the information received from the client, including the reason for the call, signs and symptoms described, the specific protocol.
used to manage the call (where applicable), the advice or information given, any
referrals made, the required follow-up and the nurse's signature and designation.

Documents are stored according to the rele-
vant legislation or regulations, in general for
10 years.

Using the telephone to seek advice
from another nurse

- Document the interaction, including
  the date, time, and name of contact person.
- Documentation may be in the client's
  chart or on a separate form or computer
  record.

Using the telephone to provide advice
to another nurse:

- Use a consistent method of collecting
  information from the nurse who calls (e.g.
  column headings on a telephone log, or a
  protocol listing the questions to be asked
  by the caller).
- Document the telephone interaction
  including:
  - date and time of the call;
  - the name of the nurse who called;
  - the name of the client being discussed
    (when applicable);
  - the information received including the
    reason for the call;
  - the client information provided;
  - the advice or information given;
  - any follow-up required/provided; and
  - signature and designation.

FREQUENTLY ASKED QUESTIONS ABOUT
TELEPHONE NURSING PRACTICE

What are some of the legal issues
associated with providing telephone
nursing care?

As noted on page 5, the lack of face-to-face
contact with the client has contributed to the
view of telephone nursing practice as being
high-risk. Although, in Ontario as of October,
1998, there were no statutes or case law involv-
ing telehealth, the Canadian Nurses Protective
Society has reported situations in other
provinces where nurses were accused of, and in
some cases, found liable for, negligence for giv-
ing inappropriate or inadequate advice, making
improper referrals, or failing to make referrals.

Ontario nurses who provide telephone care
to clients living in other jurisdictions such as
another province or country should be aware
that under the "long arm statute" of some juris-
sdictions they may be required to travel to
the distant location to defend against an alle-
gation of malpractice.

Accordingly, nurses may want to ask
employers about liability issues, such as provi-
sions for legal counsel, policies and procedures
regarding liability, and whether the employer
advises/requires the nurse to purchase mal-
practice insurance.

Do I need a formal education program to
provide telephone nursing care?

Not necessarily, because acquiring the com-
petence required to provide effective nursing
care using the telephone (i.e., competence
beyond the basic level in communication,
interpersonal skills and clinical knowledge)
may be gained directly from clinical experi-
ence. However, telephone nursing education
programs that provide a review of the princi-
ples associated with communication and inter-
viewing, and introduce the nurse to a call
centre environment equipped with the tech-
nology utilized when providing telepractice,
may offer the opportunity to develop and/or
enhance competence in the provision of tele-
phone nursing care.

Are there special considerations when
providing care to clients over the internet?

It is generally accepted that confidentiality is
less secure when utilizing internet technology.
In addition, providing advice using the in-
ternet may entail a higher risk than telephone
nursing practice because you cannot hear the
client's voice, and/or may not be in direct (real-
time) communication with the client. Trage
de imediate health concerns will generally
not take place over the internet. If you are pro-
viding direct advice to an identified client via
the internet, a nurse-client relationship is estab-
lshed, and therefore the information pre-
sented in this document would apply to the
nursing care provided.

What are CNO's expectations of nurses
who employ telepractice technology as
part of their direct client care activities?

Nurses participating in telepractice may
involve such care as utilizing a hand-held ca-
mera to transmit an image of a client's limb, or
using a computer to relay electro-cardiogram
data. Although these activities use technology,
they still involve direct contact with clients
and therefore there is no difference in nursing
practice. As with all client care, the nurse is
expected to self-assess his/her competence at
utilizing the technology, identify knowledge
gaps, and seek training or education to close
any gaps identified.

What are some of the ethical issues
associated with telephone nursing practice?

No specific ethical issues for Ontario nurses
have been brought to CNO's attention. In the
U.S., nurses providing telephone care in a for-
mal call centre environment have posed ethi-
cal questions related to the expectation that
they will carry out market research surveys or
gather information about product use and
sales. CNO's Ethical Framework for Nurses in
Ontario provides information about working
trough situations that may cause an ethical
dilemma.

OTHER RESOURCES

The Internet has several sites about tele-
phone nursing. As of the publishing date,
these websites were providing information.

- Bussy Signals: A Canadian electronic
telehealth newsletter at
  www.cyberhealth.bc.ca
- The American Nurses Association at
  www.nursingworld.org/roadrooms/
tele2.htm
- Telephone Nursing: A U.S.
  site on telephone nursing services at
  www.nurseline.com
- The website of the National Council
  of State Boards of Nursing (U.S.) at
  www.ncsbn.org
- Nurses may also try:
  - The references cited in the bibliography.
  - The Telehealth Association of
    Ontario can be reached by phone
    (416)968-9226, fax (416)968-9517,
    or by e-mail at oat@teliast.com
- The Ontario newspaper Hospital News
  features a regular telehealth column.


1. Recognizing that Dianne’s mucositis is severe, you are alerted to other possible problems. You know that the epithelial layer of the skin and lining of oral mucosa and internal organs is a person’s physical barrier between the body’s internal milieu and bacteria. Bacterial colonization or penetration of the epithelial barrier results in infection. This is the first line and most important barrier. The most common areas for bacteria to enter and/or colonize are the alimentary tract (ie. mouth, pharynx, esophagus, bowel), sinuses, lungs and skin (Pizzo, 1999). You also reflect on the number of days since treatment. Proliferating progenitor cells that produce the mature granulocytes, erythrocytes and thrombocytes in the peripheral circulation are commonly destroyed by chemotherapy drugs. As immature cells in the marrow and pre-existing mature cells are destroyed, the nadir becomes apparent usually 7-14 days after treatment (Ellerhorst-Ryan, 1997). Answer: d

2. Dianne hasn’t brought up any other concerns but you want to make sure she isn’t exhibiting any other signs or symptoms. It is important to see if she has a temperature plus or minus feelings of being cold/chills. Contrary to popular myth, fever can be present in immunocompromised and neutropenic patients. An elevated temperature is produced by the monocytes, not the neutrophils. The monocyte secretes an endogenous pyrogen that affects the thalamus which houses the body’s temperature control resulting in a rise in temperature (Pizzo, 1999). When the hypthalamic set point is shifted upward to a warmer level, heat conserving mechanisms are brought into place to elevate body temperature to the new set point range. These include shivering (the friction of muscle spindle fibres generate heat), vasoconstriction, increased metabolic rate and heat seeking behaviours.

Did she have an interim count arranged by her oncologist? At times the team will arrange an interim blood count to see how neutropenic a patient becomes on a myelosuppressive treatment. This information helps to decide about the addition of granulocyte macrophage-colony stimulating factor rather than wait to see if the patient experiences a febrile neutropenic episode with subsequent potential morbidity risks, and subsequent delays in treatment or changes in drug dosing. In some institutions it is based on the specific chemotherapy protocol, in others it is physician specific and based on the desire to monitor the patient. Answer: Does the patient have a temperature? Does she have any other signs/symptoms of infection? Does she have an interim count previously arranged?

Dianne indicated that she has felt flushed on/off since this morning but has not taken her temperature. She denies any chills and does not have any interim blood counts arranged. Her follow-up appointment and treatment #2 is scheduled in 10 days. You ask whether she is taking any other medications and focus quite specifically on acetaminophen and acetylsalicylic acid since she is having significant discomfort in her mouth. She has been taking only a multivitamin but that’s it. She denies any other symptoms like shortness of breath, cough, urinary burning or urgency, problems with bowel movements,
rashes or redness/swelling particularly at her PICC site. She states her mouth is worse today than yesterday and is feeling fatigued “from all of this mouth discomfort”.

3. In early compensatory symptoms of sepsis you see skin warm and flushed because of arteriole dilation, decreased peripheral vascular resistance, normal to increased cardiac output and mild hypotension. Peripheral resistance results in loss of fluid to the interstitial space. If myocardial function and fluid replacement are adequate, the syndrome may not progress provided immediate and appropriate antibiotics are instituted. The duration of this early phase may vary from 30 minutes to 16 hours (Ellerhorst-Ryan, 1997).

You think that she is at moderate risk for febrile neutropenia and decide it would be helpful to do a complete blood cell count with a differential (CBC & Diff.). Coming in for an assessment would also allow you to perform a quick physical examination that includes vital statistics and oral examination.

You also note use of acetaminophen or acetylsalicylic acid due to the antipyretic effects, which displaces the body’s hypthalamic set point shifting it downward with subsequent compensatory cooling mechanisms (Carpenter, 1998). This would mask a temperature that she might be experiencing.

You and Dianne discuss coming into the centre and why. It is mid-day and you have open time to see Dianne, she indicates that she can come to the centre in the next hour to meet you at the drop-in clinic. **Answer: b**

4. When the nurse participates in a phone call, the nurse is professionally and legally accountable for the advice given. The most common allegations of negligence are: providing inappropriate or inadequate advice; improper referrals; and failure to refer. (Canadian Nurse Protective Society, 1997; McLean, 1998).

The actions to take:
- Limit medical jargon as much as possible so that the patient clearly understands your questions and advice.
- Thoroughly assess and collect data that allows you to critically analyze the situation.
- Keep in mind not to overreact or underreact.
- Refer to the institutional practice guideline. Make conscientious use of the guidelines/protocols and use independent judgement for each call and decide whether you need to override the protocol if the situation requires it.
- Clarify any unclear information with the patient.

5. Documentation should include:
Date and time of call, name, telephone number and address, information received, advice or information given, referral and follow-up information, the patient’s verbal response and understanding of information, designation of the person taking the call.
6. 
- Did the assessment gather adequate information from the patient?
- Was this patient screened for associated symptoms that would be considered emergent?
- Was the most appropriate guideline used to support the nursing process?
- Was the level of urgency or directive for care the most appropriate level?
- Were all the appropriate and available resources considered in developing the plan?
- Did the implemented plan provide the desired result?
- Was documentation complete, concise and accurate?
- Was communication made to other parties as appropriate to enhance quality of care?
- What could the nurse have done better?
- What was the patient’s level of satisfaction with the care provided?

References:

Case Study #1:


1. The nurse advises the patient to increase Senokot and Colace up to 2 tabs BID. Why? Colace is a ‘detergent laxative’ and acts by reducing surface tension and allows penetration of water and fats into the stool. Senokot is a ‘large bowel stimulant’ that stimulates colonic motility.

2. Yes, the physician had prescribed Colace 1-2 tabs BID and Senokot 1-2 tabs BID. The nurse is practicing within her/his scope of practice when advising the patient to increase the medication in accordance with the physician’s order.

The nurse then *recommends* to the patient to take Milk of Magnesia (MOM) 30 mLs immediately for his bowels. It is the professional opinion of the nurse that MOM is appropriate to recommend because although the patient has not has a bowel movement for six days he is able to tolerate oral medications.

3. No, given Milk of Magnesia is considered an over the counter (OTC) medication it therefore does not require a prescription. The CNO state that nurses are *solely accountable* for recommending OTCs to patients and for any outcomes of that recommendation. Before recommending OTCs, nurses must have the knowledge, skill and judgment about the patient’s situation, their condition and medication profile and the medication. Prior to recommending OTCs to patients, nurses need to be aware whether their facility has a policy requiring OTCs to be ordered by a physician or RN(Extended Class).

The nurse informs the patient that she will need to speak to the physician about his constipation, cough, night sweats and interrupted sleep. The physician is informed of the symptoms and what she has advised the patient to do about his constipation. The physician writes a prescription for codeine syrup for the cough and Ativan for the lack of sleep. The physician requests the nurse to inform the patient of the new prescriptions and to liaise with the community pharmacy.

4. Yes, but it is recommended in this scenario the prescription is faxed to the community pharmacy. The CNO advocates the use of faxes as a way to “reduce the incidents of verbally communicated prescriptions and medication errors”. Further, the CNO asks us to “advocate for optimal communications systems for transmitting and confirming prescription details between health professionals”.

5. The nurse needs to reinforce teaching on: when and how to take Colace and Senokot and diet – increase fibre intake, increase fluid intake.

6. The patient should be encouraged to call back if there is no bowel movement within 24 hours or to call immediately if the patient experiences S & S of bowel obstruction (severe abdominal pain and/or bloating, nausea & vomiting).
Follow-up care should include an immediate verbal or written update to the community nurse.

A follow-up telephone call to the patient should occur within 24-48 hours to assess if bowels are 'open'. If bowels are not open, or they are open but the patient’s description of the stool sounds like he may be still experiencing problems, then the nurse should advise the patient he requires medical assessment to rule out such things as 'narcotic bowel syndrome', obstruction or impaction. Assessment by a dietitian may also be indicated.

References:

Case Study #2:


1. If at all possible, request to speak to the patient directly.

If not possible document the location of the patient in reference to the Mrs. Y and the reason Mr. Y was unable to speak with you.

2. a. Is this a “new” pain? Similar experience in the past.
   b. Provocative parameters: aggravating/alleviating
   c. Quality/Severity of the pain: Description in patient’s own words to describe the pain: throbbing, stabbing, ache, burning; use of pain scale i.e. 0-10
   d. Does it Radiate? To and from where?
   e. Associated Symptoms: N/V, dizziness, constipation,
   f. Timing: onset, frequency, duration
   g. Medication review: what is he using for pain, how effective is it?
   h. Impact on ADL

3. KEY finding reported by patient: “worse with movement and with lying position and improved with sitting”. SCC, unlike strain or old injury, causes pain that is unrelieved or increased in the recumbent position. (Flounders & Ott, 2003; Osowski, 2002)

The patient must be asked about the existence of other symptoms, such as muscle stiffness, feelings of heaviness, difficulty climbing stairs, and coordination problems. Motor weakness is the second most common symptom of SCC, occurring in 80% of cases, and it can be present at the same time as sensory loss.

Sensory dysfunction is also present in SCC. Therefore, the nurse must question the patient about the existence, location, and onset of numbness, tingling, or coolness in the arms, hands, fingers, legs, feet, toes, and trunk.

The patient should also be asked about constipation or urinary retention because these symptoms are early indicators of injury to the autonomic nerves.

The presence of urinary and/or bowel incontinence indicates advancing autonomic involvement, and perianal numbness indicates cauda equina syndrome, a condition requiring immediate decompression. (Osowski, M, 2002)

4. He needs to be assessed immediately.

Surgical intervention within 48 hours of the onset of symptoms generally improves sensory and motor deficits and urinary and rectal function. (Osowski, 2002).
SCC requires immediate response both to maintain or achieve good pain control, and to prevent, reverse, or limit potentially permanent neurological damage. For these reasons it should be considered not only an oncological emergency but also a palliative care emergency. The most important determinant of neurological outcome is the degree of neurological impairment at the start of therapy. Delay in treatment may result in paralysis and lack of bowel and bladder control (Frank, 1998).

SCC is most frequently associated with primary cancers that cause bony metastases such as breast, lung and prostate followed by lymphoma, myeloma and renal carcinoma.

SCC usually arises from extradural tumours as in bony metastases to the vertebrae. Other mechanisms can include, extravertebral tumours or adenopathy of prevertebral lymph nodes causing growth into the epidural space and seeding of the CSF from cancers of CNS with spread into the subarachnoid space and along the spinal cord (Flounders & Ott, 2003)

Sequence of SCC symptoms are pain, motor weakness, sensory loss, motor loss, autonomic dysfunction.

References:

Case Study #3:

