COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT

CARITAS HEALTH GROUP

Alberta Health Services

Edmonton Symptom Assessment System (ESAS)

This form is for CHCS staff and patient/caregiver use only

Instructions: Circle the number that best describes each symptom.

(Bolded symptoms may be assessed and completed by the caregiver, family or Hospice staff if patient is unresponsive or cognitively impaired.)

Patient Name:		MRN:
Date and Time of Day:		
Completed by (check one): ___Patient	___Caregiver ___Caregiver Assistant	___Healthcare Professional/Assistant
no pain	0 1 2 3 4 5 6 7 8 9 10	worst possible pain
not tired	0 1 2 3 4 5 6 7 8 9 10	worst possible tiredness
not nauseated	0 1 2 3 4 5 6 7 8 9 10	worst possible nausea
not depressed	0 1 2 3 4 5 6 7 8 9 10	worst possible depression
not anxious	0 1 2 3 4 5 6 7 8 9 10	worst possible anxiety
not drowsy	0 1 2 3 4 5 6 7 8 9 10	worst possible drowsiness
best appetite	0 1 2 3 4 5 6 7 8 9 10	worst possible appetite
best feeling of well-being	0 1 2 3 4 5 6 7 8 9 10	worst possible feeling of well-being
no shortness of breath	0 1 2 3 4 5 6 7 8 9 10	worst possible shortness of breath
other problem	0 1 2 3 4 5 6 7 8 9 10	worst possible

- DEPRESSION: Blue or sad feelings
- ANXIETY: Nervousness or restlessness
- TIREDNESS: Decreased energy level (not necessarily sleepy)
- DROWSINESS: Sleepiness
- WELLBEING: Overall comfort, both physical and otherwise; truthfully answering the question, "How are you?"
- SHORTNESS OF BREATH: Difficulty breathing

0 = No symptoms

2 = Occasional mild symptoms that are not bothersome

4 = Daily mild symptoms

6 = Moderate distress, symptoms limit my activity

8 = Severe symptoms present most of the time

10 = Severe symptoms present all of the time

ESAS Tool developed and adopted from Regional Palliative Care Program, Capital Health, Edmonton, Alberta 2006

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT

Instructions on Use:

For Patients Who Can Answer Their Own Questions:

As hospice clinicians, it is important to us to know how you feel. We want to know if you are having symptom problems so that we can help you feel better by treating them the best way we know how.

We will be asking you to spend a few minutes to review a list of symptoms and rating if you have it, and how bad it was in the past day (24 hours) by circling a number from 0 – 10. For example, if pain was rated 0, it means you did not have any pain in the last day. If the pain was rated a 3, it probably was mild, and a score of 8 means that is was pretty bad.

For each symptom as the numbers get bigger, it means the symptom is getting stronger, with the number 10 meaning the symptom is as bad as you can imagine. You may use the reference numerical scale located at the bottom of the ESAS form (reverse side) to help you decide which number fits best.

Instructions on Use:

For Patients Unable to Answer Their Own Questions - Caregiver and/or family:

As hospice clinicians, we want to know if patients are having symptom problems so we can help them feel better by treating them the best way we know how. Because the patient is or may become confused and we are unable to ask **(him/her)** directly, we are asking you as someone who knows this patient well, to help us understand how **(he/she)** feels with regard to certain symptoms.

When the ESAS form is completed by the caregiver or family member alone, you only need to complete the scales that are in bold; the subjective symptom scales which include: fatigue, depression, anxiety, and wellbeing are left blank.

You will only assess the remaining symptoms as objectively as possible:

Pain may be rated by what pain behaviors you know and see, **appetite** means wanting or not wanting to eat, **nausea** means the absence or presence of retching or vomiting, **shortness of breath** means labored or fast respirations that appears to be causing distress for the patient, and **drowsiness** means sleepiness of the patient.

When a patient is irreversibly cognitively impaired and cannot participate in doing the ESAS, the caregiver continues to complete the ESAS as outlined above.

Adopted from: NAHC Hospice QAPI Program Development Collaborative

PAINAD (Pain Assessment in Advanced Dementia)

Assess breathing, negative vocalizations, facial expression, body language and consolability

	0	1	2	Score
Breathing, independent of vocalization	Normal	Occasional labored breathing, short period of hyperventilation	Noisy, labored breathing, long period of hyperventilation, Cheyne-stokes respirations	
Negative vocalization	None	Occasional moan or groan, low level speech with a negative or disapproving quality	Repeated trouble calling out, load moaning or groaning, crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense, distressed, pacing, fidgeting	Rigid, fists clenched, knees pulled up, pulling or pushing away, striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
			Total:	

Warden, Hurley and Volicer, 2001

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM
ROLE OF THE CAREGIVER TEACHING GUIDE

This sheet is used to document patient/caregiver education by the skilled nurse or social worker. Use one sheet for each teaching session. Enter signature, title, and date.

Patient Name: _____ Case Number: _____ Date:

CHECK ISSUES REVIEWED	COMFORT CHECK-LIST	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	1. Is the person comfortable? Are the bedsheets clean, dry, without wrinkles?		
	2. Is the room temperature OK? Is there a need for more/less covers, fresh air, or is the room too light or too dark?		
	3. Is the room environment complete? (presence of favorite candles, pictures, music, religious/spiritual materials, etc.)		
	4. Is the person hungry or thirsty? Can the person access food/drink easily?		
	5. Is the person constipated or having problems passing urine?		
	6. Is the person short of breath, anxious, or just generally restless?		
	10 STEPS: HOW TO ***BE*** AT THE BEDSIDE		
	1. TRUST YOURSELF; your inner knowing and open heart is a true guide.		
	2. SHARE THE LOAD; it helps relieve you and it helps others express their care.		
	3. TAKE CARE OF YOURSELF; get rest, take time off, keep doing things that you enjoy too.		
	4. TOUCH AND BE NEAR; it helps the person know they are not alone.		
	5. KEEP SHARING; even when person is not conscious they can hear you.		
	6. CONSIDER UNFINISHED BUSINESS; is there someone with whom closure must occur?		
	7. IT'S OK TO TALK ABOUT DEATH; fears and anxieties can often be relieved through simple talking.		
	8. SAY THE IMPORTANT THINGS; let the person know they are cared for.		
	9. RESPECT SILENCE; it takes a lot of energy for the person to carry on a conversation.		
	10. KEEP HOPE ALIVE; always hope for a peaceful outcome for all involved.		

_____ _____ _____

Signature Title Date

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM

FINANCIAL PLANNING TEACHING GUIDE

This sheet is used to document patient/caregiver education by the skilled nurse or social worker. Use one sheet for each teaching session. Enter signature, title, and date.

Patient Name: _____ Case Number: _____ Date:

CHECK ISSUES REVIEWED	AREAS OF POSSIBLE CONCERN	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	Last Will and Testament Written Attorney_____	Copies Located: a. b. c.	
	Power of Attorney	Designee: _____	
	Funeral Arrangements a. Burial or Cremation b. Service Planned (clothes, songs/hymns, readings, location, etc.) c. Cost d. Obituary Written e. Memorial Donation Designee f. Death Certificate procurement process clear to caregiver/family	Funeral Home _____	
	Medical Insurance for Survivors		
	Life Insurance		
	Pension(s)		
	Social Security		
	Medical Bills		
	Savings Account(s)		
	Checking Account(s)		
	Stocks		
	Bonds		
	Trusts		
	Outstanding Debt		
	Other		

_____ / _____ / _____

Signature Title Date

HS#429 Rev 11/14

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COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM
INDICATORS OF EMOTIONAL DISTRESS TEACHING GUIDE

This sheet is used to document patient/caregiver education by the skilled nurse or social worker. Use one sheet for each teaching session. Enter signature, title, and date.

Patient Name: _____ Case Number: _____ Date:

CHECK ISSUES REVIEWED	CONTRIBUTING FACTORS	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	Apprehension and fear of the unknown		
	Anticipatory grieving of the loss of one's life and loved ones		
	Physical pain or other distressing physical symptoms		
	Changes in body image, functional ability, and role performance		
	Fear of how family members will manage after death		
	INDICATORS OF DISTRESS		
	Increased frequency or severity of pain or other physical symptoms (i.e. restlessness)		
	Withdrawal and decreased communication with loved ones; teary		
	Mood swings from serene acceptance to anxious overactivity/panic to anger/depression		
	Outbursts of anger and/or frustration at loss of control		
	Statements such as: "Why me?", "I don't want to be a burden.", "What's the use?", "No one really understands.", "I guess this is what I deserve."		
	Desire to bargain with God for more time		
	POSSIBLE INTERVENTIONS		
	1. Talk about your feelings and ask for assistance from family/friends or staff/volunteers.		
	2. Arrange/provide a comfortable, peaceful environment		
	3. Take breaks/respite		
	4. Connect with your "inner child" – find time to laugh/play.		
	5. Allow expression of negative as well as positive feelings from yourself and others.		
	6. Assert your right to make your own decisions.		
	7. Decide what you still want to do, and do it.		
	8. Identify concrete needs, i.e. transportation, child-care, meals, shopping assistance, funeral arrangements, and work with supports to fill them.		
	9. Administer adequate pain medication and symptom relief medication as ordered. Report unrelieved pain and symptoms to hospice promptly.		
	10. Relaxation activities: mediation, prayer, music, or spiritual/religious readings.		
	11. Tell your story (verbally or written).		
	12. Encourage or limit visitors, based on your needs.		

Taken in part from *"When You Know You Are Dying"* by James E. Miller

_____ _____ _____

Signature Title Date

HS #407 Rev 11/14

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM
GENERAL INDICATORS OF PHYSICAL DECLINE TEACHING GUIDE

This sheet is used to document patient/caregiver education by the skilled nurse or social worker. Use one sheet for each teaching session. Guidelines for Care of Terminally Ill and Hospice under Medicare are found in the home chart. Sign, title, and date.

Patient Name: _____ Case Number: _____ Date: _____

CHECK ISSUES REVIEWED	CONTRIBUTING FACTORS	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	Progressive disease		
	EXPECTED CHANGES		
	Withdrawal from daily activities		
	Withdrawal from family and friends		
	Decreased communication		
	Episodes of confusion or disorientation		
	Decreased appetite with weight loss		
	Frequent naps throughout the day		
	In bed more than 50% of the day		
	Episodes of incontinence urine/stool		
	Generalized weakness/risk for falls		
	Loss of oral route for medication administration		
	PRIMARY CAREGIVER COMFORT CARE INTERVENTIONS		
	Establish alternate methods of communication through quiet activities, touch, presence, music		
	Provide safe environment		
	Recognize decreased need for food/fluids (no weights)		
	Recognize increased need for rest		
	Plan activities at peak energy times		
	Turn and reposition for comfort		
	Skin care		
	Administer medications sub-lingual or rectally		

Guidelines for Care of the Terminally Ill. Pages 1-14 reviewed.

Signature _____ Title _____ Date _____

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM

SIGNS OF APPROACHING DEATH TEACHING GUIDE

This sheet is used to document patient/caregiver education by the skilled nurse or social worker. Use one sheet for each teaching session. Guidelines for Care of Terminally Ill and Hospice under Medicare are found in the home chart. Sign, title, and date.

Patient Name: _____ Case Number: _____ Date:

CHECK ISSUES REVIEWED	CONTRIBUTING FACTORS	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	Disease process		
	Multiple system failure		
	EXPECTED CHANGES		
	Restlessness		
	Cyanosis of extremities		
	Cheyne - stokes respirations		
	Incontinence of urine and stool		
	Skin pale and cool to touch		
	Moist respirations		
	Decreasing level of consciousness		
	Talking with unseen people or difficult to understand thoughts		
	Eyes glazed		
	Increased pain or other symptoms		
	PRIMARY CAREGIVER COMFORT CARE INTERVENTIONS		
	Appropriate administration of prescribed medications (scheduled and breakthrough)		
	Mouth care		
	Position for comfort		
	Keep bedding clean/dry		
	Provide safe environment		
	Acceptance of impending death		
	Talk to patient		

Guidelines for Care of the Terminally Ill. Pages 15-20 reviewed.

Signature _____ Title _____ Date _____

Caring and serving since 1883

COMMUNITY HEALTH AND COUNSELING SERVICES
HEALTH SERVICES DEPARTMENT
HOSPICE PROGRAM
WHEN DEATH OCCURS

The RN/Social Worker uses this sheet to document patient/caregiver education. Use one sheet for each teaching session. Guidelines for Care of the Terminally Ill and Hospice under Medicare are found in the home chart.

Patient Name: _____ Case Number: _____ Date: _____

CHECK ISSUES REVIEWED	SIGNS OF DEATH	PATIENT/CAREGIVER RESPONSE	PLAN FOR REVIEW
	Absence of respiration and pulse		
	Incontinence of bowel and bladder		
	Unable to arouse		
	Eyelids may be slightly open with fixed stare		
	Jaw relaxed with mouth slightly open		
	CAREGIVER EDUCATION NEEDS		
	This is not an emergency		
	Say "good-bye" in a personal way		
	Care of the body (removal of equipment such as O_2, foley or IV)		
	Role of hospice nurse at time of death (visit may be optional)		
	Role of funeral home		
	Disposal of unused medication		
	NOTIFICATION PROCESS		
	CALLS TO BE MADE AT TIME OF DEATH:		
	DO NOT CALL 911 - Call hospice office		
	Primary MD_____ phone		
	Funeral Home_____ phone		
	Clergy_____ phone		
	Volunteer Agency_____ phone		
	Other family/friends_____ phone		
	name_____ phone		
	CALLS TO BE MADE BY HOSPICE NEXT WORKING DAY:		
	DME Provider_____ phone		
	Other name_____ phone		
	Other name_____ phone		

Guidelines for Care of the Terminally Ill. Page 20 reviewed.

Signature _____ Title _____ Date _____