Virtual Palliative Assessments

CPG: Virtual Health

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Introduction:

Virtual care is healthcare at a distance and many assessments need to be adapted in the absence of a face-to-face interaction[1]. Clinical assessments involve the use of tools and instruments which are not available in virtual healthcare settings. Information will need to be gathered in other ways, such as listening to the patient's cough, or the audible presence of adverse breath sounds, such as wheezing. As with conventional assessments, determine if the patient is experiencing a particular problem and focus on that area first. If no particular problem is present, complete a generalized assessment of the relevant system[2].

Paramedics providing palliative care ought to practice "relationship-based care" by adopting a humble, self-reflective clinical practice and positioning themselves as a respectful and curious partner when providing care. In particular, paramedics should seek to respect and learn about Indigenous (First Nations, Métis, and Inuit) and different cultural approaches to palliative care while reflecting on their own values and beliefs. Acknowledging what the differences and the effects of a paramedics' values and beliefs can have on others is an important step towards cultural humility.

Consult with patients' usual care team for the creation of a collaborative symptom management plan. If the usual care team is not available or the patient is not under a care team, consider contacting CliniCall (1-833-829-4099 or 604-829-4099) for the creation of a collaborative symptom treatment plan. Where the patient has not followed their symptom management plan, paramedics may encourage the patient/caregiver to administer any medications recommended as part of that plan[3,4].

The person is recognized as a palliative patient or at end-of-life by one or more of the following:

- Person is diagnosed with a life limiting illness
- Care is currently focused on comfort and symptom management rather than curative interventions
- Person presents with Goals of Care Designation consistent with treatment in place
- Person is under care of a physician and/or home care providing palliative care services

Essentials[5]:

1. **Set-up:** Before initiating a virtual visit, make sure you are set up properly, have access to the patient chart, and any additional information that may be required.
2. **Connect:** Determine the most appropriate method for communicating with the patient (either phone or video chat). Confirm that your audio and video connections are working properly.
3. **Get started:** Once you begin the visit, perform a rapid assessment to determine if any immediate interventions are needed. For example, does the patient appear very sick, or are they too short of breath to speak? If so, go directly to asking key clinical questions. If no immediate interventions are required, establish what the patient hopes to gain from the visit (i.e., clinical assessment, referral, reassurance).
4. **History:** Ask questions to determine a history of the present illness.
5. **Examination:** Perform a modified physical exam and ask functional inquiry questions.
6. **Vitals:** The patient may be able to take their own measurements if they have access to vitals equipment at home (i.e., blood pressure monitor, pulse oximeter, scale). Interpret results with caution and use them to support findings in the context of your wider assessment.
7. **Decision and action:** Based on your findings, decide if the patient is able to receive the most appropriate care for their condition and if their symptoms can be successfully managed in their location of choice, or if they exhibit red-flag symptoms

and require conveyance to hospital.

8. **Report to the patient's most responsible provider.**

Assessment Overview[6]:

1. The purpose of the Virtual Palliative Assessment CPG is to provide paramedics with guidance in assessing and supporting management of symptoms for people who are currently undergoing palliative care or end-of-life experience. These symptoms are most likely to be nausea/vomiting, pain, delirium/agitation, or dyspnea.
2. Drug and non-drug therapies are equally important.
3. Palliative care is an approach that aims to reduce suffering and improve the quality of life for people who are living with a life-limiting illness.
4. The intent of this care is to provide relief from distressing symptoms, not the treatment of any underlying disease process.
5. Palliative care patients are sometimes conveyed to hospital by ambulance when they would have preferred to remain in their own home. The aim of the palliative care pathway is to ensure that palliative care patients receive the most appropriate care for their condition and remain in their own home as per their wishes, when appropriate.

6. Patients approaching end-of-life may experience pain or other symptoms that cause severe distress. These symptoms are usually managed very well by appropriate interventions and medications administered by the primary care/community health/specialty palliative care team, and sometimes by the family members.
7. Patients who are on the BC Palliative Care Benefits Program have a life expectancy of up to 6 months.
8. Hospice services are available in many communities and can serve to offer additional services to people and their families.

Virtual Assessments:

Palliative Assessment [7]		
Section	**Component**	**Question**
MODIFIED EXAM	**Neurological**	Does the patient appear restless, and easily distracted?
		Does the patient appear agitated?
		Does the patient appear to be hallucinating?
		Does the patient appear drowsy or lethargic?
		Does the patient appear to have a decreased level of consciousness?
		Does the patient appear physically or emotionally withdrawn?
	Respiratory	Does the patient appear to have an increased work of breathing?
		Do the patient's respirations appear to be unusually slow or unusually fast?
		Is the patient able to complete a sentence without stopping to breathe?
		Does the patient have a cough? • If so, does it sound dry or wet? • Is the cough new onset?
	Circulatory	Does the patient's skin appear pale or cyanosed?
		Does the patient's skin appear clammy or diaphoretic?
FUNCTIONAL INQUIRY	**Psychological**	Does the patient feel restless, or unable to maintain concentration?
		Does the patient feel agitated?
		Is the patient hallucinating?
		Does the patient feel depressed or emotionally withdrawn?

		Does the patient feel depressed or emotionally withdrawn?
	Neurological	Does the patient feel drowsy?
		Does the patient feel a newer onset of extreme fatigue?
	Pain	Does the patient feel any new pain?
		Has the patient been able to manage their pain effectively?
		Has the patient changed their pain medications since the last visit?

	Respiratory	Does the patient have difficulty breathing?
		• Is this new for them, or has their breathing become worse?
		  ○ What makes their breathing feel worse (position, exertion, etc.)?
		  ○ What has the patient tried to feel less short of breath?
		  ■ Have any of these treatments helped?

		Does the patient have a new cough?
		• If so
		  ○ Is the cough productive?
		  ○ What colour is the phlegm?

	Circulatory	Does the patient feel any new chest pain/pressure of discomfort?
FOCUSED ASSESSMENT	**Delirium**	Assess for predisposing factors, which include: • Age over 65 years • Dementia • Visual or hearing impairment • Immobility • Functional dependence • Malnutrition • Substance use • Multiple chronic comorbidities • Multiple medications • Admission to hospital
		Assess for signs and symptoms of delirium, including: Acute onset. • Fluctuating over the course of a day. • Attention disturbance; restlessness. • Altered reasoning/rambling thinking. • Agitated, angry, emotionally labile, depression, lethargy. • Disorientation to: time, person and place. • Sleep-wake cycle disturbance. • Memory impairment. • Hallucinations – visual; nightmares. • Language fluency disturbance. • Myoclonus, miosis, seizures, tremors (opioid neuro-toxicity) – specific symptoms. • Tachypnea (sepsis, hypoxemia, central processes) – specific

		symptoms.

		Delirium assessment
		• **O**nset
		  ○ When did it begin?
		  ○ How long does it last?
		  ○ How often does it occur?
		• **P**rovoking /Palliating
		  ○ What brings it on?
		  ○ What makes it better?
		  ○ What makes it worse?
		• **Q**uality
		  ○ What does it feel like?
		  ○ Can you describe it?
		  ○ Do you feel confused?
		  ○ Are you seeing or hearing anything unusual?
		  ○ How are you sleeping?

		• **R**egion/Radiation
		  ○ Not Applicable
		• **S**everity
		  ○ How bothered are you by this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
		  ■ Right now?
		  ■ At worst?
		  ■ On average?
		  ○ Are there any other symptom(s) that accompany this symptom?
		  ○ Do you know what day/month/year it is?
		  ○ Do you know where you are right now?
		  ○ Can you tell me your full name?
		• **T**reatment
		  ○ What medications and treatments are you currently using?
		  ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices?
		  ■ How effective are these?
		  ○ Do you have any side effects from the medications and treatments?
		  ○ What have you tried in the past?
		  ○ Do you have concerns about side effects or cost of treatments?
		• **U**nderstanding
		  ○ What do you believe is causing this symptom?
		  ○ How is it affecting you and/or your family?
		  ○ What is most concerning to you?
		• **V**alues
		  ○ What overall goals do we need to keep in mind as we manage this symptom?
		  ○ What is your acceptable level for this symptom (0-10)?
		  ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?

	Fatigue	Assess for underlying causes of fatigue:

	Fatigue	Assess for underlying causes of fatigue: • Advanced aging-Frailty • Liver Failure (end-stage) • Anemia • Medications – monitor regularly • Anorexia - cachexia • Metabolic disorders • Autonomic dysfunction • Muscle abnormalities • Bleeding • Neuro-muscular Diseases (ALS, MS) • Cancer: tumor, host-derived factors, cytokines • Nutritional deficiencies • Cardiac disease (CHF) • Paraneoplastic neurological syndromes • Central nervous system (CNS) abnormalities • Psychological issues • Deconditioning (bed rest/immobility) • Renal Failure (end-stage) • Dementia (end-stage)
		• Respiratory disease (copd, ild) • Dehydration • Side-effects of Treatment • Endocrine disorders • Sleep disorders (insomnia) • Electrolyte imbalances • Unrelieved symptoms • Gastro-intestinal symptoms • HIV-AIDS (end-stage) • Hypoxemia • Infection • Other symptoms (dyspnea, pain, drowsiness, depression) • Over-exertion

		Fatigue Assessment
		• **O**nset
		  ○ When did you start to feel fatigued?
		  ○ How long does it last?
		  ○ How often does it occur?
		• **P**rovoking /Palliating
		  ○ What brings it on?
		  ○ What makes it better?
		  ○ What makes it worse?
		• **Q**uality
		  ○ What does it feel like?
		  ○ Can you describe it?
		• **R**egion/Radiation
		  ○ Not Applicable
		• **S**everity
		  ○ How severe is this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
		  ■ Right now?
		  ■ At worst?
		  ■ On average?

		■ On average? ○ How bothered are you by this symptom? • **T**reatment ○ What medications and treatments are you currently using? ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? ■ How effective are these? ○ Do you have any side effects from the medications and treatments? ○ What have you tried in the past? ○ Do you have concerns about side effects or cost of treatments? • **U**nderstanding ○ What do you believe is causing this symptom? ○ How is it affecting you and/or your family? ○ What is most concerning to you? ○ How is this affecting your emotional, spiritual and social health? ○ Have you had to change any of your daily activities? ○ Does it impact your ability to ■ Work? ■ Enjoy hobbies?
		■ Exercise? ■ Visit with family and friends? ○ Are there any other symptom(s) that accompany this symptom (e.g., shortness of breath)? • **V**alues ○ What overall goals do we need to keep in mind as we manage this symptom? ○ What is your acceptable level for this symptom (0-10)? ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family
	Pain	Assess for possible causes of pain
		Ask the patient to describe their pain • **O**nset ○ When did it begin? ○ How long does it last? ○ How often does it occur? • **P**rovoking /Palliating ○ What brings it on? ○ What makes it better? ○ What makes it worse? • **Q**uality ○ What does it feel like? ○ Can you describe it? ■ If unable to describe, ask is the pain • sharp • Dull • Aching • Burning • Pins and needles

		• Pills and needles
		• **R**egion/Radiation
		  ○ Where is it?
		  ○ Does it spread anywhere?
		  ■ Use a body map to illustrate location and number of pain areas
		• **S**everity
		  ○ How severe is this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
		  ■ Right now?
		  ■ At worst?
		  ■ On average?
		  ○ How bothered are you by this symptom?
		  ○ Are there any other symptom(s) that accompany this symptom?
		• **T**reatment
		  ○ What medications and treatments are you currently using?
		  ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices?
		  ■ How effective are these?
		  ○ Do you have any side effects from the medications and treatments?
		  ○ What have you tried in the past?
		  ○ Do you have concerns about side effects or cost of

		treatments?
		• **U**nderstanding
		  ○ What do you believe is causing this symptom?
		  ○ How is it affecting you and/or your family?
		  ○ What is most concerning to you?
		  ○ What are your beliefs about opioid/narcotic medications?
		• **V**alues
		  ○ Are you having to make compromises such as decreasing activities or enduring side effects to deal with your pain?
		  ○ What overall goals do we need to keep in mind as we manage this symptom?
		  ○ What is your acceptable level for this symptom (0-10)?
		  ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family

	Dyspnea	Assess for possible causes of dyspnea, including:
		• Pulmonary
		  ○ Airway obstruction
		  ○ COPD/asthma
		  ○ Damage from chemotherapy, radiation or surgery
		  ○ Emboli
		  ○ Fibrosis
		  ○ Effusion
		  ○ Primary or metastatic tumour.
		• Cardiac
		  ○ CHF

- CHF
- CAD
- Arrhythmias
- Pericardial effusion.

- Neuromuscular
  - ALS
  - CVA
  - Poliomyelitis
  - Myasthenia gravis
- Other
  - Anxiety
  - Fatigue/deconditioning
  - Weakness
  - Pain
  - Severe anemia
  - Infection
  - Carcinomatosis
  - Hepatomegaly
  - Phrenic nerve lesion
  - Peritoneal effusion

Dyspnea Assessment

- **O**nset
  - When did it begin?
  - How long does it last?
  - How often does it occur?
- **P**rovoking /Palliating
  - What brings it on?
  - What makes it better?
  - What makes it worse?

- **Q**uality
  - What does it feel like?
  - Can you describe it?
  - Is it worse lying down or sitting?
- **R**egion/Radiation
  - Not Applicable
- **S**everity
  - How severe is this symptom?
  - What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
    - Right now?
    - At worst?
    - On average?
    - When you are walking, climbing stairs, or doing activities of daily living?
  - How bothered are you by this symptom?
  - Are there any other symptom(s) that accompany this symptom (e.g., pain in your chest, anxiety, fatigue)?
- **T**reatment
  - What medications and treatments are you currently using?
  - Are you using any non-prescription treatments, herbal remedies, or traditional healing practices?
    - How effective are these?

		○ Do you have any side effects from the medications and treatments? ○ What have you tried in the past? ○ Do you have concerns about side effects or cost of treatments? • **U**nderstanding ○ What do you believe is causing this symptom? ○ How is it affecting you and/or your family? ○ What is most concerning to you? • **V**alues ○ What overall goals do we need to keep in mind as we manage this symptom? ○ What is your acceptable level for this symptom (0-10)? ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family? ○ What are you having trouble doing because of this symptom that you would like to do?
	Respiratory Congestion	Assess for risk factors of respiratory congestion, including: • A Prolonged dying phase • Cerebral or pulmonary malignancy • Pneumonia • Dysphagia • Head injury
		Respiratory congestion assessment • **O**nset ○ When did it begin? ○ How long does it last? ○ How often does it occur? • **P**rovoking /Palliating ○ What brings it on?
		○ What makes it better? ○ What makes it worse? ○ Can the secretions be cleared by coughing or swallowing? • **Q**uality ○ What does it sound like? ○ Can you describe it? ○ Is it worse lying down or sitting? • **R**egion/Radiation ○ Does it seem to be in the chest? Or throat? • **S**everity ○ Does the patient appear comfortable? ○ Are the sounds louder or quieter with change of positions? ○ How bothered are you by this symptom? ○ Are there any other symptom(s) that accompany this symptom? • **T**reatment ○ What medications and treatments are you currently using? ○ Are you using any non-prescription treatments,

		herbal remedies, or traditional healing practices? ■ How effective are these? ○ Do you have any side effects from the medications and treatments? ○ What have you tried in the past? ○ Do you have concerns about side effects or cost of treatments? ○ Could other treatments be worsening this symptom (e.g., artificial hydration)? • **U**nderstanding ○ What do you believe is causing this symptom? ○ How is it affecting you and/or your family? ○ What is most concerning to you? ○ Does the patient appear distressed? • **V**alues ○ What overall goals do we need to keep in mind as we manage this symptom? ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?
	Cough	Assess for possible causes of the cough, including: • Cancer state ○ Airway obstruction by tumour ○ Pleural tumor ○ Chemotherapy induced ○ Pulmonary aspiration ○ Acute pulmonary embolism • Non-cancer state ○ End stage weakness ■ Heart failure ■ Kidney failure ■ Respiratory failure ○ ALS ○ CVA ○ MS ○ Late stage dementia
		• Unrelated to primary disease ○ Asthma ○ Chronic bronchitis ○ Infection ○ GERD ○ Sleep apnea
		Cough assessment • **O**nset ○ When did it begin? ○ How long does it last? ○ How often does it occur? • **P**rovoking /Palliating ○ What triggers your cough? ○ What makes it better? ○ What makes it worse? ○ Is it worse in the morning, after a meal, at night? ○ Smoking history/environmental exposures? Is it positional?

		positional? ○ Can you talk on the phone? Eat? Drink? • **Q**uality ○ What does it sound like? ○ Can you describe it? ○ Sputum? If yes: ■ What colour/amount/frequency? ■ Does it contain any blood? ○ Does it affect your voice? ○ Cause anxiety? • **R**egion/Radiation ○ Does it feel like it is coming from your chest or throat? • **S**everity ○ How severe is this symptom? ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)? ■ Right now? ■ At worst? ■ On average? ○ How bothered are you by this symptom? ○ Are there any other symptom(s) that accompany this symptom? (e.g., pain, shortness of breath)? ○ Does your cough affect these? ○ Do you have ■ Chills/fever/joint pain? ■ Wheezing? ■ Night sweats/weight loss? ■ Allergies? ■ Reflux? • **T**reatment ○ What medications and treatments are you currently using? ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? ■ How effective are these? ○ Do you have any side effects from the medications and treatments? ○ What have you tried in the past?
		○ Do you have concerns about side effects or cost of treatments? • **U**nderstanding ○ What do you believe is causing this symptom? ○ How is it affecting you and/or your family? ○ What is most concerning to you? • **V**alues ○ What overall goals do we need to keep in mind as we manage this symptom? ○ What is your acceptable level for this symptom (0-10)? ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?
	Nausea and Vomiting	Assess for possible causes of nausea and vomiting, including: • Chemical

	Vomiting	• Chemical • Cortical • Cranial • Vestibular • Visceral or serosal • Gastric Stasis (impaired gastric emptying)

		Nausea and vomiting assessment
		• **O**nset
		  ○ When did it begin?
		  ○ How long does it last?
		  ○ How often does it occur?
		• **P**rovoking /Palliating
		  ○ What brings it on?
		  ○ What makes it better?
		  ○ What makes it worse?
		• **Q**uality
		  ○ What does it sound like?
		  ○ Can you describe it?
		  ○ Do you vomit or just feel nauseated?
		  ○ Does it change when you change position?
		• **R**egion/Radiation
		  ○ Not applicable
		• **S**everity
		  ○ How severe is this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
		  ■ Right now?
		  ■ At worst?
		  ■ On average?
		  ○ How bothered are you by this symptom?
		  ○ Are there any other symptom(s) that accompany this symptom?
		• **T**reatment
		  ○ What medications and treatments are you currently using?
		  ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices?
		  ■ How effective are these?
		  ○ Do you have any side effects from the medications and treatments?
		  ○ What have you tried in the past?
		  ○ Do you have concerns about side effects or cost of

		treatments?
		• **U**nderstanding
		  ○ What do you believe is causing this symptom?
		  ○ How is it affecting you and/or your family?
		  ○ What is most concerning to you?
		• **V**alues
		  ○ What overall goals do we need to keep in mind as we manage this symptom?
		  ○ What is your acceptable level for this symptom (0-10)?
		  ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?

	Constipation	Assess for causes of constipation, including: • Advanced age • Decreased intake • Inactivity • Low fiber diet • Depression • Poor fluid intake • Sedation • Physical or social impediments • Bowel obstruction

		Constipation assessment
		• **O**nset
		  ○ When did it begin?
		  ○ How long does it last?
		  ○ How often does it occur?
		  ○ When was your last bowel movement?
		• **P**rovoking /Palliating
		  ○ What brings it on?
		  ○ What makes it better?
		  ○ What makes it worse?
		  ○ What is your appetite like?
		  ○ How is your daily intake of food and fluids?
		  ○ How is your mobility?
		  ○ Do you need help to the bathroom/commode?
		  ○ Do you have enough privacy?
		  ○ Do you have pain or any other problems?
		• **Q**uality
		  ○ What is your normal bowel pattern?
		  ○ Are your bowel movements (BM) less frequent than usual?
		  ○ What do the stools look like?
		  ○ Are they smaller or harder than usual?
		  ○ Do you have discomfort or strain when passing stool?
		  ○ Is there controllable urge or sensation, prior to BM?
		  ○ Are you able to empty your bowels completely when desired?
		  ○ Do you have stool leakage or incontinence?
		• **R**egion/Radiation
		  ○ Not applicable
		• **S**everity
		  ○ How severe is this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?

		■ Right now? ■ At worst? ■ On average? ○ How bothered are you by this symptom? ○ Are there any other symptom(s) that accompany this symptom? • **T**reatment ○ What medications and treatments are you currently

		using? ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices? ■ How effective are these? ○ Do you have any side effects from the medications and treatments? ○ What have you tried in the past? ○ Do you have concerns about side effects or cost of treatments? • **U**nderstanding ○ What do you believe is causing this symptom? ○ How is it affecting you and/or your family? ○ What is most concerning to you? ○ Do you get any other symptoms: ■ Pain ■ Nausea/vomiting ■ Loss of appetite ■ Bloating ■ Gas ■ Blood or mucous in stools ■ Headaches or agitation? ○ Do you have any urinary problems? ○ Do you have any previous trauma which may impact how we manage your bowel movements ■ (e.g., rectal interventions may re-traumatize people with past abuse)? ○ How can we make sure you feel safe and respected? Are you worried about incontinence? • **V**alues ○ What overall goals do we need to keep in mind as we manage this symptom? ○ What is your acceptable level for this symptom (0-10)? ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?
	Dehydration	Dehydration assessment • **O**nset ○ When did you start feeling dehydrated? ○ Have you experienced this before? ○ How long does it last? ○ How often does it occur? • **P**rovoking /Palliating ○ What brings it on? ○ What makes it better? ○ What makes it worse? • **Q**uality ○ What does it feel like (dry mouth / skin, thirst)? ○ Can you describe it?

		• **R**egion/Radiation
		  ○ Not applicable
		• **S**everity
		  ○ How severe is this symptom?
		  ○ What would you rate it on a scale of 0-10 (0 being none and 10 being the worst possible)?
		  ■ Right now?
		  ■ At worst?
		  ■ On average?
		  ○ How bothered are you by this symptom?
		  ○ Are there any other symptom(s) that accompany this symptom?
		• **T**reatment
		  ○ What medications and treatments are you currently using?
		  ○ Are you using any non-prescription treatments, herbal remedies, or traditional healing practices?
		  ■ How effective are these?
		  ○ Do you have any side effects from the medications and treatments?
		  ○ What have you tried in the past?
		  ○ Do you have concerns about side effects or cost of treatments?
		• **U**nderstanding
		  ○ What do you believe is causing this symptom?
		  ○ How is it affecting you and/or your family?
		  ○ What is most concerning to you?
		• **V**alues
		  ○ What overall goals do we need to keep in mind as we manage this symptom?
		  ○ What is your acceptable level for this symptom (0-10)?
		  ○ Are there any beliefs, views or feelings about this symptom that are important to you and your family?

Risk Identification:

Traffic light system for identifying risk in palliative patients			
	• **Green Flag - Low Risk** • **Document visit and report as normal**	• **Yellow Flag - Medium Risk** • **Report to Primary Care Provider**	• **Red Flag - High Risk** • **Arrange Transport to Hospital**
Colour (of skin, lips, fingers)	• No new rashes, wounds, or open areas since last contact	•	• New rashes, wounds, or open areas since last contact
Activity	• No change in activity • Walks independently • Walking using aids • No falls since last contact • No new problems with sleeping	• Spends most time in bed, but **can** get out • New difficulties sleeping	• Always in bed • Patient has fallen since last contact
Neurological	• Alert	•	• Confusion • Decreased level of consciousness • New onset distraction • Hallucinations
Respiratory	• No new onset of shortness of breath	•	• New onset of shortness of breath
GI/GU	• Eating and drinking normal, or less than normal • Normal bowel movements	• Eating little due to nausea and/or vomiting • Increased bowel movements • Decreased bowel movements	• Not hungry at all, only drinking fluids • No bowel movements for more than 3 days
Pain	• No new onset of pain • Pain level of <3/10 on pain medication • Utilizes <3 breakthrough doses in 24 hrs	• New onset of pain • Pain level of 3-6/10 on pain medication • Utilizes 3 breakthrough does in 24 hrs	• Pain >6/10 on pain medication • Utilizes >3 breakthrough doses in 24 hrs
Other	• Feels better or the same as the day before • No change in family support • No change to medications • No new problems with anxiety	• Feels worse than the day before • Decrease in family support • Change to medications • New onset of anxiety	•

4,7,8

Decision and Action:

1. All patients with worsening symptoms (yellow) should be referred to their primary care provider for assessment.
2. Patients with red flag symptoms should be managed without delay. Consult with the patients' usual care team for the creation of a collaborative symptom management plan. If the patients' usual care team is not available, contact the AHPNS. If neither is available or the patient is not under a care team, contact CliniCall (1-833-829-4099 or 604 829-4099) for the creation of a collaborative symptom treatment plan.

References & Further Reading:

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