PALLIATIVE CARE COLLABORATIVE CARE PLAN:

Fatigue (cancer patients)

Collaborative Care Plan for Fatigue

Definition of Fatigue

Fatigue is a subjective state of overwhelming, sustained exhaustion and decreased capacity for physical and mental work that is not relieved by rest. Cella et al. 1998.

1. Assessment

Many symptoms may be mistaken for the symptom of fatigue. These may include the physical abnormalities encountered in hypoactive delirium, the mental symptoms of depression or the spiritual troubles of those afflicted by advanced illness. A careful history must always be taken to differentiate fatigue from these other symptoms.

The patient's own description of fatigue is the most reliable indicator of severity. Fatigue severity should be screened daily ***using the tiredness scale*** on the Edmonton Symptom Assessment System (ESAS). **Note:** Be aware of relationship between fatigue and other symptoms measured on the ESAS, e.g., pain, nausea, depression, anxiety, drowsiness, appetite, feeling of well being and dyspnea.

ESAS should be used to evaluate fatigue daily if the patient is in an institution or once per visit day in the community. Documentation of the results on the ESAS flow sheet allows for easy recognition of trends and interrelationships between fatigue and other symptoms.

In addition to the ESAS, consider the following for a **more in-depth assessment of Fatigue:**

Assess:

- Pattern (e.g., generalized weakness, limb heaviness), onset, duration, intensity, aggravating and alleviating factors
- Effects on activities of daily living (ADL), general activity level and lifestyle. Patients may experience: a perceived need to struggle to overcome inactivity; decreased motivation or interest to engage in usual activities; post-exertional fatigue lasting several hours.
- Effects on cognitive abilities, e.g., diminished concentration or attention, short-term memory
- Effects on appetite, nutrition intake and/or weight changes
- Effects on sleep and/or rest patterns. Patients may have insomnia or hypersomnia. The experience of sleep may not be restorative.
- Effects on social, occupational, or other important areas of functioning. There may be marked emotional reactivity to feeling fatigued e.g., sadness, frustration, or irritability
- Patient's or caregiver's ideas and concerns about the symptom of fatigue

Identify contributing factors:

- Co morbidities e.g., neuro-endocrine, cardio-pulmonary, hepatic or renal dysfunction, hypothyroidism, infection
- Underlying disease and disease related signs and symptoms e.g., anemia, dyspnea, pain, fever, dehydration, fluid and electrolyte imbalance, nutritional deficiencies
- Effects of treatments, including side effects e.g., radiotherapy, neurotoxic therapies

Fatigue (cancer patients)

1. Assessment *continued*

Identify contributing factors *continued*:

- Effects of medications including side effects e.g., chemotherapy, opioids, benzodiazepines, antiemetics
- Effects of psycho-social influences e.g., depression and anxiety/stress, sleep disturbances
- Effects of underlying psychiatric conditions e.g., major depression, somatization disorder, somatoform disorder, or delirium

Other important assessments:

- Previous level of physical fitness and activity as a baseline for activity recommendations.
- Functioning, e.g., ability to perform activities of daily living (ADLs)

> **Caution**
> Particular attention should be paid to differentiating between generalized weakness and weakness secondary to spinal cord compression. **Spinal Cord Compression (SCC)** may manifest itself as back pain radiating bilaterally, and reflex changes, weakness of the legs/arms, sensory loss, and, finally, loss of sphincter control (urine and/or fecal incontinence). **If SCC is suspected immediate medical assessment / intervention is indicated.** (The Merck Manual, www.merck.com)

2. Pharmacological Therapy

Consider:

- Review the medication list for appropriateness of current medications.
- Treating sleep disorders; careful use of hypnotics
- Psycho-stimulants after ruling out other causes of fatigue, e.g., methylphenidate
- Treat contributing conditions

3. Non-pharmacological Interventions

- Validate feelings of fatigue
- Promote communication of fatigue issues within the family
- Stress management
- Consider active modalities such as, physiotherapy, acupuncture or distraction
- Relaxing positions during lovemaking
- Assist with the development of a plan to maintain sleep hygiene e.g., establish regular bed and waking times
- Complimentary modalities such as guided imagery, relaxation and visualization may be useful
- Support groups
- Correct contributing factors

Collaborative Care Plan for Fatigue

4. Activity

All activity recommendations must be individualized based on ability and physical condition.

- Develop **realistic** activity objectives
- Encourage optimal level of activity **within patient's ability:**
  - Rule out contraindications or restrictions to activity, e.g., pain, bone metastasis, neutropenia, fever
  - Encourage activity / rest cycles

Palliative Performance Scale (PPS) > 30%:

- Individualize exercise program to prevent deconditioning
- Consider referral to physiotherapy
- Where possible start an activity program before treatment occurs.
- Consider referral to occupational therapy for energy conservation and assistive devices, if needed
- *Encourage:*
  - Restorative therapy (e.g., going for walks and or enjoying activities in nature) as appropriate
  - Use of an exercise diary

Palliative Performance Scale < 30 %

- Encourage activity according to the patient's ability, desire and comfort level

Collaborative Care Plan for Fatigue

5. Psycho-Social

Consider the influence of the following on fatigue:

- Family dynamics
- Socio/cultural circumstance
- Financial (economic status, resources, medical costs, loss of income related to illness, cost of caregivers and respite)
- Patient's emotional state e.g., anger, anxiety
- Psychological factors e.g., self-esteem
- Modifications to lifestyle may be difficult for patients / family to accept

Possible Interventions:

- Identify and facilitate resources available: Insurance benefits, disability, support for transportation needs and delivery of medications, other resources.
- Promote communication of fatigue issues within the family
- Adjustment counseling

6. Referrals and Contacts

Contact information for the services listed below can be found in **Appendix B: Resources/Referrals**
Palliative Care Medicine Service

Dietitian /Nutrition Services:

- Nutritional assessment
- Nutrition education regarding the relationship between nutrition and fatigue
- Adequate hydration
- High Protein High Energy Guidelines
- Small frequent meals and snacks
- Maintain weight or preventing weight loss.
- Work toward meeting nutritional requirements
- Provide dietary prescription
- Promote alternate meal choices and nutritional supplementation if warranted.
- Promote energy saving meal preparation tips

Social Work:

- Understanding / negotiating and accessing available resources (including financial, transportation, etc.).
- Counseling
- Sleep hygiene

Collaborative Care Plan for Fatigue

6. Referrals and Contacts *continued*

Physio/Occupational Therapy

- Consider referral to physiotherapy for a conditioning and/or a physical activity program, when appropriate.
- Consider referral to occupational therapy for energy conservation, assistive devices, if needed e.g., simplify dressing using velcro closures for shoes, easy care clothes (not requiring ironing) etc.

Other

- Provincial Home Care Program (Community Care Access Centre in Ontario)
- Community Pharmacist to ensure that medications are available after discharge
- Psychologist / Psychiatrist
- Spiritual and Religious Care
- Volunteers e.g., respite, transportation, visiting

7. Patient and Family Education

- Use of ESAS to self-monitor fatigue
- Adapt teaching according to individual patient / family needs
- Advise about treatment and cancer related fatigue; emphasize that fatigue is not always related to tumor progression
- Assist the patient to develop realistic goals
- Help the patient and family to identify the most exhausting activities and develop specific strategies to change them
- Provide educational materials such as **Your Bank to Energy Savings** booklet (2003); available through Ortho Biotech: (416) 382-5000 or 1-800-387-8781

Teaching:

- Activity within ability
- Patient to use alternative ways of performing activities to maximize comfort and maintain independence e.g. planning and pacing activities
- Position as tolerated; Use pillows, lift sheets, etc.
- Use assistive devices such as braces, splints, walker, hospital bed, lift, recliner and commode
- Energy conservation:
  - Set priorities, pace, delegate, schedule activities at times of peak energy and use labour saving devices
  - Postpone non-essential activities
  - Naps that do not interrupt night-time sleep
  - Structured daily routine
  - Attend to one activity at a time
  - Distraction such as music, reading and socializing
  - Encourage proper body mechanics
  - Return to usual activities gradually

Collaborative Care Plan for Fatigue

7. Patient and Family Education *continued*

- Provide instructions for tiredness measure greater than 7 on the ESAS scale
  - Make a contact list and post in an easily accessible location
  - When to call for increasing intensity or prolonged fatigue e.g., if the patient is too tired to get out of bed in the last 24 h, feels confused or cannot think clearly, or if the fatigue has become more severe

8. Planning

- Transfer forms and / or telephone communication should be used to support communication as the patient moves from one location of care to another. Level of fatigue using ESAS and the fatigue management plan needs to be highlighted
- Ensure patient / family have instructions for telephone contacts, re: emergency situations and death event

9. Expected Patient Outcomes

Patient:

- Expresses satisfaction that fatigue management goals are met
- Demonstrates understanding of fatigue and its management
- Tracks fatigue with the ESAS scale
- Demonstrates awareness of non-pharmacological modalities available
- Fatigue management is maintained without interruption when patient transferred from one health care facility to another
- Demonstrates alternative ways of performing activities to maximize comfort and energy conservation
- Demonstrates understanding of who to contact if unable to manage fatigue effectively