

Provincial Palliative Care Integration Project

RESOURCE MANUAL

Edmonton Symptom Assessment System (ESAS)

Description

The **Edmonton Symptom Assessment System (ESAS)** is a valid and reliable assessment tool to assist in the assessment of nine common symptoms experienced by cancer patients. The ESAS is one of the key assessment tools used in the Palliative Care Integration Project. The original tool was developed by the Regional Palliative Care Program, Capital Health in Edmonton, Alberta and slightly modified for this project.

Purpose of the ESAS

This tool is designed to assist in the assessment of: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well being, and shortness of breath. One blank scale is available for patients to use to assess an “other problem” as needed. The severity **at the time of assessment** of each symptom is rated from 0 to 10 on a numerical scale; with 0 meaning that the symptom is absent and 10 that it is the worst possible severity.

The ESAS was designed so that the patient, or his/her family caregiver, could self-administer the tool. Therefore, the patient should be taught how to complete the scale. It is the **patient’s opinion** of the severity of the symptoms that is the **gold standard** for symptom assessment.

The ESAS provides a clinical profile of symptom severity over time. It provides a context within which symptoms can be understood. However, it is not a complete assessment in itself. For good symptom management to be attained, the ESAS must be used as one part of a holistic clinical assessment.

How to do the ESAS

The patient circles the most appropriate number to indicate where the symptom is between the two extremes.

No pain 0 1 **2** 3 4 5 6 7 8 9 10 Worst possible pain

The circled number is then transcribed onto the medical chart (e.g., flow sheet) or the ESAS form is addressographed and placed in the medical chart.

Words for symptoms that may be difficult for some patients to understand include the following:

- Depression* - sad or blue
Anxiety - nervousness or restlessness
Tiredness - decreased energy level (but not necessarily sleepy)
Drowsiness - sleepiness
Well-being - overall comfort, both physical and otherwise; truthfully answering the question “How are you?”

If patients are in pain, they should mark on the Body Diagram where they hurt. This does not need to be done everyday, but changes need to be recorded. Discuss with your patient the best way to do this.

When to do the ESAS

a) Patient at home

It is good practice to complete the ESAS during each telephone contact or home visit (maximum of once per day). If symptoms are in good control and there are no predominant psychosocial issues, the ESAS can be completed weekly.

b) Patients Admitted to Hospital, Palliative Care Unit, or Long-Term Care Facility

It is good practice to complete the ESAS every day. Patients with good symptom control with no predominant social issues can complete the ESAS on a weekly basis.

c) Time of Day

Ideally, it is good practice to have patients complete the ESAS at the same time of day.

Who Should Complete the ESAS

Ideally, patients fill out their own ESAS. However, if the patient is cognitively impaired or for other reasons cannot independently do the ESAS, then it should be completed with assistance by the caregiver (a family member, friend) or a health professional closely involved with the patient’s care. If the patient cannot participate in the symptom assessment, the ESAS is completed by the caregiver or professional.

The method in which the ESAS is completed must be indicated on the flowsheet in the space provided as follows: by patient, caregiver assisted, by caregiver, or by health professional.

Where to Document the ESAS

The ESAS is always done on the ESAS numerical scale and the scores are transcribed into the medical chart, flowsheet, or the ESAS form is addressographed and placed in the medical chart.

Note: When the caregiver or professional completes the ESAS alone the subjective symptom scales are not done (i.e. tiredness, depression, anxiety, and wellbeing are left blank) and the caregiver assesses the remaining symptoms as objectively as possible, i.e. pain is assessed on the basis of a knowledge of pain behaviours, appetite is interpreted as the absence or presence of eating, nausea as the absence or presence of retching or vomiting, and shortness of breath as laboured or accelerated respirations that appears to be causing distress for the patient.