Rapid Series Manual

Nursing Interventions for Constipation-Series 33

What is this series about?

Constipation is a very common problem for people managed with palliative intent with the majority of patients referred to palliative care services prescribed laxatives. Despite clinical guidelines suggesting medication combinations and daily monitoring, few data report how nurses assess the need for an intervention for constipation and whether or not the intervention is successful.

By completing this CRF you will be contributing to our understanding of whether nursing assessments and responses to constipation are effective. Your assistance is greatly appreciated. Thank you for your time and efforts in participating in this Rapid series.

Patient tracking

A log or spreadsheet should be developed in order track the patient medical record number and the study ID number allocated to each patient when medication/intervention commenced. This spreadsheet will be the only link between the data collected and the identity of the patient and remains the property of the participating site. This information should not be shared with the Palliative Care Clinical Studies Collaborative (PaCCSC). The spreadsheet should also contain the date and time of the data entry at each time point.

Patient PID	Patient name	Patient medical record number	Date of initial data entry	Time of data entry

Allocating Patient ID number

a) The ID number for each set of data collected is a composite number built up using a series of three codes.

i) Site identifier.

This is the number allocated to each participating site as a two or three digit number

ii) Medication/intervention number

The number for the nursing intervention – constipation series is **33.**

iii) Patient number

This is usually a three digit number e.g. **001**

Therefore, the full patient ID number will be;

Site identifier/medication number/patient number e.g., 01/33/001

Time points

There are 2 time points where data is required;

1. Commencement of the nursing intervention (baseline) (T_0)
2. 24hours after the intervention occurs (T_1)

Each medication/intervention of interest will have different time points for clinical benefit and harms according to its profile. Time points are determined by each Series subcommittee and are based on clinical experience and published product information.

Adverse Events/Harm assessment

Adverse events (or harms) are assessed using a standard scale from the National Cancer Institute Criteria for Adverse Events (NCI CTCAE). The NCI uses a scale between 1 and 5 ranging from mild to serious (resulting in death) symptoms or sequelae. The NCI criteria are provided as a reference document which is supplied separately and should be referred to for any events recorded is association with the patient's clinical course.

Each medication/intervention has a number of pre-populated expected adverse events (harms). These are listed at each time point, and the NCI grade is described and provided for easy reference. A grade should be provided for each listed adverse event.

If unexpected adverse events occur at any other time, either before or after any pre-determined time point, these should be recorded in the unexpected adverse event section of the CRF. Up to three other time points can be recorded.

Data entry

REDCap data entry link can be acquired by emailing **RAPID@uts.edu.au** and requesting the link to the series that is applicable to you.