

 Queensland Government Care Plan for the Dying Person (CPDP) Comfort Observation Symptom Assessment (COSA) Supporting care in the last hours and days of life Facility:	(Affix identification label here)
	URN:
	Family name:
	Given name(s):
	Address:
	Date of birth:
	Sex: ☐ M ☐ F ☐ I

- This form **must** be used in conjunction with the *Care Plan for the Dying Person (CPDP)* (SW270)
- All health professionals **must** sign the CPDP Signature Log (*page 4*) upon initial entry

Instructions for Response to Symptom Rating

- Use standardised medication management guidelines to respond to symptoms (e.g. PalliMeds App)
- If no PRN medication charted, liaise with Authorised Health Practitioner
- Any symptoms present (even mild) require action to address; moderate or severe symptoms require escalation
- Reassess symptom at least 1 hour following treatment – if symptom not adequately addressed a change in the plan of care may be required
- Record actions and outcomes in the CPDP Clinical Notes

PREScribed FREQUENCY OF SYMPTOM ASSESSMENT AND COMFORT OBSERVATIONS

Observations must be performed routinely at a minimum of 2 hourly
If any treatment or escalation initiated more regular observation should occur

Refer to your local hospital procedure for instructions on how to escalate care

Symptom Rating – Absent (score 0)

- Problem/Symptom distress absent
- Continue with current care

Symptom Rating – Mild (score 1–3)

- Problem/Symptom distress present, but managed by existing plan of care

IF THE PERSON HAS ANY YELLOW ZONE OBSERVATIONS YOU MUST:

1. Treat problem/symptom according to service protocols
2. Increase the frequency of symptom assessment and comfort observations
3. If more than one 'Mild Symptom Rating,' escalate to NURSE-IN-CHARGE to decide if an AUTHORISED HEALTH PRACTITIONER/PALLIATIVE CARE REVIEW is required

Symptom Rating – Moderate (score 4–7)

- The person has not responded to treatment as expected and symptoms are persisting and/or worsening
- Problem/Symptom distress requires a change in plan of care

IF THE PERSON HAS ANY ORANGE ZONE OBSERVATIONS YOU MUST:

1. Consult promptly with the NURSE-IN-CHARGE to:
 - a. Discuss the problem/symptom and agree on a plan of care
 - b. Decide whether an AUTHORISED HEALTH PRACTITIONER/PALLIATIVE CARE REVIEW is required
3. Increase the frequency of symptom assessment and comfort observations

Symptom Rating – Severe (score 8–10)

- Problem/Symptom distress requires urgent intervention and escalation
- Plan of care is ineffective, and change is required

IF THE PERSON HAS ANY PURPLE ZONE OBSERVATIONS YOU MUST:

1. Initiate appropriate clinical care
2. Consult promptly with the NURSE-IN-CHARGE and initiate an AUTHORISED HEALTH PRACTITIONER/PALLIATIVE CARE REVIEW
3. Increase the frequency of symptom assessment and comfort observations

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Instructions for Symptom Assessment

- Where possible, base the assessment on the person's verbal response
- For non-verbal/semi-conscious person, look for visual cues and use assessment tools
- Consider reversible causes and non-pharmacological measures, as appropriate
- Discuss all changes to the plan of care with the person and their substitute decision-maker(s)/family/carer(s), as appropriate
- Involve family/carer(s) in providing care (e.g. mouth care), as appropriate

The following prompts are intended to provide basic information only. For additional information, please refer to the *Queensland Health Care Plan for the Dying Person Health Professional Guidelines*.

Prompts for Symptom Management

Pain	- Consider position change - Consider PRN analgesia for incident pain
Medication	- The person should only receive medication that is beneficial - If continuous subcutaneous infusion in place complete 4 hourly checks
Restlessness and/or agitation	- Assess the person for reversible causes including pain, incontinence, fever, breathlessness, urinary retention, faecal impaction - Consider position change - Consider benzodiazepine/psychotropic - If no urine output for >8 hours, consider a bladder scan
Nausea and/or vomiting	Consider anti-emetics
Respiratory tract secretions	- Consider position change (use semi-prone position) - Anticholinergic medication more effective if given as soon as symptom occurs
Breathlessness	- Consider position change and use of fan - Consider benzodiazepine/opioid
Febrile	- Consider cool sponges and use of fans - Consider antipyretics
Family/Carer(s) distress	- Consider the severity of the problem the family/carers is experiencing (e.g. anger, family conflict) - If score is mild, reassure the family/carers with explanation and support as required - If score is severe, escalate to senior staff and consider referral to Social Worker, Palliative Care Service, Spiritual Carer

Prompts for Comfort Assessment and Management

Food and fluids	• The person should be supported to eat and drink for as long as tolerated and consider the use of thickened fluids • Monitor for signs of aspiration and/or distress • If appropriate consider clinically assisted (artificial) hydration
Skin care	• The frequency of assessment, repositioning and special aids (e.g. pressure relieving mattress) should be determined by skin inspection and the person's individual needs
Mouth care	• Frequency of mouth care depends on individual need • Aim is to keep the person's mouth clean and moist
Eye care	• Eyes are clean and moist • Swab with normal saline PRN
Bladder care	• Use of pads, urinary catheter or penile sheath as required
Bowel care	• Monitor for constipation and diarrhoea • Bowel movements documented
Environment	• Single room; curtains/screens; clean environment; sufficient space at the bedside; consider fragrance; silence; music; lighting; pictures; photographs; nurse call bell accessible
Spiritual/Cultural needs	• Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication; use of listening skills; information and explanation of plan of care given • Use of touch if appropriate • Spiritual/Cultural/Emotional needs supported
Support	• Offer food/drink/rest • Check understanding of all visitors • Listen and respond to worries and fears; provide age appropriate information • Use clear language; avoid euphemisms or jargon • Allow the opportunity to reminisce • Assess bereavement risk and refer as needed

CPDP – Comfort Observation and Symptom Assessment (COSA) Response Chart

Date		Time (24hr)																										
Symptom Assessment																												
Pain	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Restlessness and agitation (delirium)	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Respiratory secretions	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Nausea	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Vomiting	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Breathlessness	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Other symptoms (specify)	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Family/Carer(s) distress	Severe	8–10																										
	Moderate	4–7																										
	Mild	1–3																										
	Absent	0																										
	Action required?	Y/N																										
Comfort Observations																												
The person remains free of urinary problems																												
The person remains free of bowel problems																												
The person's comfort and safety regarding the administration of medications are met																												
The person receives fluid to support their individual needs																												
The person's mouth is clean and moist																												
The person's skin care needs are met																												
The person's personal hygiene needs are met																												
The person's physical environment supports their individual care needs																												
The person's psychosocial, spiritual and cultural needs are met																												
The well-being of the family/carer(s)/ substitute decision-maker attending the person is supported																												
Initials																												

All health professionals must sign the Signature Log (page 4) upon initial entry

Instructions for Symptom Assessment and Management

- Observations must be performed routinely at a minimum of 2 hourly
- When graphing observations, place a dot (•) in the appropriate box and join the preceding dot (e.g. )
- If any treatment or escalation initiated, more regular observation should occur.

Symptom Rating Scale

SEVERE

(Score 8–10)

Escalate to AUTHORISED HEALTH PRACTITIONER/ PALLIATIVE CARE TEAM

MODERATE

(Score 4–7)

Escalate to NURSE-IN-CHARGE

MILD

(Score 1–3)

Routine symptom management

ABSENT

(Score 0)

No symptom/problem

Instructions for Comfort Assessment and Management

- Assess and manage comfort at least every 2 hours. Refer to comfort assessment and management prompts for further details
- Assess each care need and document with 'Yes' or 'No' (Y/N) – note N/A if after assessment no action required
- No' should always prompt an action. Document problem, action and outcome of action in CPDP Clinical Notes.

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