Queensland Government

Care Plan for the Dying Person (CPDP)

Supporting care in the last days and hours of life

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Please order paper-based CPDP through WINC, using the WINC code: 1NY31713

- The Care Plan for the Dying Person (CPDP) aims to support but **does not replace clinical judgement**
- Care outlined in the CPDP **must be altered if it is not clinically appropriate** for the individual person

This care plan document comprises:

Commencement of Care Plan for the Dying Person

The following 3 items **must** be completed by an Authorised Health Practitioner and co-signed by a Registered Nurse.

1. **Person assessed by the Multidisciplinary Team (MDT) as being in the last days to hours of life?** *(Refer to the MDT review and decision-making guide on page 3)* ☐ **Yes**
2. **The person has a current *Acute Resuscitation Plan (ARP) (SW065)* that states resuscitation is NOT to be provided?** ☐ **Yes**
3. **The most senior treating Authorised Health Practitioner responsible for the person's care endorses use of the CPDP?** ☐ **Yes**

Treating Consultant/the most senior Authorised Health Practitioner (print name):

Authorised Health Practitioner (print name):	Signature:	Date: ... / ... / ...
Registered Nurse (print name):	Signature:	Date: ... / ... / ...
Ward:	Date commenced: ... / ... / ...	Time commenced (24hr): ... : ...

Evidence of Advance Care Planning (ACP) Check ACP Tracker for existing documents

Advance Health Directive (AHD)	☐ Yes → ◯ Copy reviewed and filed in the medical notes ☐ No ◯ Sent to Office of Advance Care Planning (OACP) to upload to ACP tracker (if applicable)
Enduring Power of Attorney (EPOA) (personal including health)	☐ Yes → ◯ Copy reviewed and filed in the medical notes ☐ No ◯ Sent to OACP to upload to ACP tracker (if applicable)
Statement of Choices	☐ Yes → ◯ Copy reviewed and filed in the medical notes ☐ No ◯ Sent to OACP to upload to ACP tracker (if applicable)
Queensland Civil and Administrative Tribunal (QCAT) (decision for health matters)	☐ Yes → ◯ Copy reviewed and filed in the medical notes ☐ No ◯ Sent to OACP to upload to ACP tracker (if applicable)

Communication

Where relevant, the following are notified that the person is expected to die within days or hours:

General Practitioner (GP):	☐ Yes ☐ No	Residential Aged Care Facility:	☐ Yes ☐ No
Community Service Providers:	☐ Yes ☐ No	Other members of the MDT:	☐ Yes ☐ No

Discontinuation of Care Plan for the Dying Person Complete only if applicable

Care Plan for the Dying Person document discontinued – Date: ... / ... / ... Time (24hr): ... : ...

New treatment and care options reviewed by MDT* and discussed with person, and their Substitute Decision-Maker(s) (SDM)*/family/carer(s) as appropriate: ☐ Yes ☐ No

Document reasons why the CPDP was discontinued and new treatment and care plan in the person's medical notes.

DO NOT WRITE IN THIS BINDING MARGIN

CARE PLAN FOR THE DYING PERSON (CPDP)

v9.00 - 05/2026
WINC Code: INY31713
SW270

Queensland Government

Care Plan for the Dying Person (CPDP)

Supporting care in the last days and hours of life

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Guidance for Health Professionals

Aim of the CPDP

- The CPDP document is a clinician guide for person and family care in the last days and hours of life.
- It supports the delivery of high quality care tailored to the individual's needs, when their death is expected.
- It does not replace clinical judgment and **must** be altered if not clinically appropriate for the individual.
- It is used in conjunction with, but does not replace, documents or processes such as an AHD, Enduring Power of Attorney (for health), ARP or ACP.

Clinical/Communication Requirements

- Regularly review person supported by the CPDP. This includes regular discussion and critical decision-making by the MDT to ensure decisions are appropriate for the individual person.
- The recognition of dying is always complex irrespective of previous diagnosis or history. Uncertainty is an inherent part of dying, and there are occasions when a person lives longer or dies sooner than expected. Seek specialist palliative care support or a second opinion as needed.
- Comprehensive and clear communication is pivotal, and all decisions leading to a change in care delivery should be communicated to the person (where appropriate) and to the substitute decision-maker(s)/family/carer(s). The views of all concerned **must** be listened to and documented.

Food and Fluids

- The CPDP does not preclude the use of artificial nutrition and hydration (e.g. subcutaneous fluids). All clinical decisions **must** be made in the person's best interest.

Documentation Instructions

- Family/Carer(s)* information sheet to be removed and provided to the family/carer(s) following a full explanation of the care plan.
- Clinicians should document in the CPDP clinical notes.
- This document **must** be completed as per local hospital documentation policy.
- All health professionals **must** sign the Signature Log *(page 4)* upon initial entry.
- 🗝 **Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health**
  Symbols suggest care by a primary professional stream.
- Additional *Care Plan for the Dying Person (CPDP) Comfort Observation and Symptom Assessment (COSA) (SW270a)* pages are available for extended treatment.
- Additional *Care Plan for the Dying Person (CPDP) Clinical Notes (SW270b)* pages are available if more space is required for documentation.
- Occasionally the CPDP may be discontinued. If the person's condition then deteriorates, a new document **must** be used.

Queensland Health Care Plan for the Dying Person Health Professional Guidelines

- This resource provides additional information on how to deliver high quality care in the last days and hours of life using the CPDP.

This documentation has been developed based on the work of the:

International Collaborative for Best Care for the Dying Person

Definitions* For the purposes of the CPDP document

- **The most senior treating doctor:** The most senior doctor (e.g. treating consultant or registrar) responsible for and familiar with clinical care decisions related to this dying person.
- **Authorised Health Practitioner:** Doctor or Nurse Practitioner with delegated responsibility from the most senior treating doctor to make decisions related to commencing this dying person on the CPDP.
- **MDT:** MDT minimally consists of an Authorised Health Practitioner and a Registered Nurse (Div 1) who is responsible for the care of this dying person, and should involve Allied Health as appropriate.
- **Family/Carer(s):** This term includes any people who are important to the dying person, whether they are spouse, sibling, friend or carer.
- **Substitute Decision-Maker(s) (SDM):** Is a person with legal power to make decisions on behalf of an adult when the person is no longer able to make their own decisions. This may be a person appointed in an Enduring Power of Attorney, Advance Health Directive document, a tribunal-appointed guardian or a statutory health attorney.

MDT Review and Decision-Making Guide

Assessment and clinical decision

- Deterioration in the person's condition suggests they will die within days or hours
  - » Exclude potentially reversible causes for the person's condition (e.g. opioid toxicity, renal failure, hypercalcaemia, infection)
  - » Consider a second opinion or consultation with specialist palliative care

The most senior Authorised Health Practitioner agrees that death is likely within days or hours and that the CPDP should commence

There is consensus between the person's SDM and MDT that the person is likely to die within days or hours (consider family meeting)

Individualised care planning

NO

- If 'No' to any of the above, do not commence the CPDP
- Reassess the person and review their plan of care in consultation with the person and their SDM, if appropriate
- Consider second opinion

YES

- If 'Yes' to all of the above, commence CPDP by reviewing and discussing the person's individual care needs and the needs of their SDM/family/carer(s)
- Change the care type to palliative Sub and Non-Acute Patients (SNAP) as per facility procedure, and complete phase and Resource Utilisation Groups (RUG) score information on page 4

Management

Comfort Observation Symptom Assessment (COSA)

- Daily clinical review by responsible Authorised Health Practitioner
- Minimum two (2) hourly symptom assessment and comfort observations

CPDP is discontinued

If the person improves:

- MDT reviews treatment and care options with person and SDM, as appropriate
- Consider second opinion and/or referral to specialist palliative care service

Care after death

The person has died

Refer to Care After Death *(page 17)*

Person and family communication

Specialist palliative care services are available for advice and support regarding any aspect of care especially if symptom control is difficult and/or there are other communication issues.

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Change to Care Type (SNAP) Complete phase and RUG scoring on admission, and on phase changes

Care type change to palliative: ☐ Yes ☐ No If *YES* – Date: ..... / ..... / ..... Time (24hr): ..... : .....

Date		On admission ..... /	..... /	..... /	..... / .....
Phase **01** Stable **03** Deteriorating **02** Unstable **04** Terminal care					
RUG score	Bed mobility				
	Toileting				
	Transfer				
	Eating				
	Total RUG score				

RUG Scoring Guide

Scoring key	**Bed mobility/ toileting/transfers**	**Eating**
Independence or supervision only: The patient may be independent with the use of a device. No hands on assistance required.	1	1
Limited physical assistance: The patient requires hands on assistance from one person only.	3	2
Other than 2 persons physical assist: The patient uses a device and requires assistance from one other person.	4	—
2 person physical assist: The patient requires hands on assistance from 2 people (tube feeding).	5	3

Signature Log Every person documenting in CPDP **must** supply a sample of their initials and signature

Initials	**Signature**	**Print name**	**Role**

Queensland Government

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Given name(s):

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Date of birth: Sex: ☐ M ☐ F ☐ I

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Initial Assessment Authorised Health Practitioner/Nurse joint assessment (with Allied Health as required)

Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health

Communication with the person ▲ ■ ◆

1.1 Is the person able to participate in the discussion? ☐ Yes ☐ No

- If *NO*, describe why the person is unable to participate (e.g. semi-conscious, unconscious, hearing, vision, speech, learning disabilities, dementia (use assessment tools), neurological conditions, confusion or other):

- Interpreter required: ☐ Yes ☐ No
  Language:
- If the person is **unable to participate** in the following discussion, complete section 1.3 with family/carer(s) to identify what is important to the person or refer to prior advance care planning completed by the person.

Initials: **Date:** / /

1.2 Does the person understand they are dying? ☐ Yes ☐ No

Initials: **Date:** / /

1.3 It is now important to ask the person the following questions:

- What is important for your care now (e.g. spiritual, cultural, social, emotional and practical needs/dying at home or home-like environment)?
- What is important to you at the time of death?
- What is important to you after death?
- Who else do you want us to share this information with?
- Is there anything else you need to tell us or ask us?

Initials: **Date:** / /

Communication with the person's family/carer(s) ▲ ■ ◆

2.1 Does the person have a SDM? ☐ Yes ☐ No

Note: *Check EPOA/AHD/ARP/SOC/QCAT decision, statutory health attorney, ACP tracker.*

- Name of SDM:
- Relationship to person:

Initials: **Date:** / /

2.2 Is the person's SDM able to participate in the discussion? ☐ Yes ☐ No

- If *NO*, describe why the SDM is unable to participate:
- Interpreter required: ☐ Yes ☐ No
  Language:

Initials: **Date:** / /

If 'No' or further documentation required, document in CPDP Clinical Notes.

Queensland Government

Care Plan for the Dying Person (CPDP)

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URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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

Initial Assessment Authorised Health Practitioner/Nurse joint assessment (with Allied Health as required) *(continued)*

Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health

Communication with the person's family/carer(s) *(continued)* ▲ ■ ◆

2.3 Does the person's SDM understand the person is dying? ☐ Yes ☐ No

- Names of other persons present: .....

.....

Initials: ..... **Date:** ..../..../....

2.4 It is important to ask the family/carer(s) the following questions:

- What is important for you now (e.g. spiritual, cultural, social, emotional and practical needs)? .....
- What is important for you at the time of the person's death? .....
- What is important to you after the person's death? .....
- Who else do you want us to share this information with? .....
- Is there anything else you need to tell us or ask us? .....

Initials: ..... **Date:** ..../..../....

2.5 Family/Carer(s) need for support and bereavement risk assessed: *(tick all that apply)*

☐ Limited social support ☐ Emotional distress ☐ Family conflict ☐ Mental illness
☐ Cumulative losses ☐ Sudden or unexpected deterioration/death ☐ Nil identified

- Name of family/carer(s) assessed/comments: .....

.....

Initials: ..... **Date:** ..../..../....

2.6 Allied Health/Support Services updated/referred to:

Tick all that apply	Person Yes	Person No	Family/Carer(s) Yes	Family/Carer(s) No	Name/Contact details
Social Worker	☐	☐	☐	☐	
Indigenous Liaison Officer/Health Worker	☐	☐	☐	☐	
Spiritual Carer/Chaplains/Cultural Advisor	☐	☐	☐	☐	
Psychologist	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	

- Additional information: .....

.....

Initials: ..... **Date:** ..../..../....

If 'No' or further documentation required, document in CPDP Clinical Notes.

Queensland Government

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Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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

Initial Assessment Authorised Health Practitioner/Nurse joint assessment (with Allied Health as required) *(continued)*

Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health

Communication with the person's family/carer(s) *(continued)* ▲ ■ ◆

2.7 Ensure up-to-date contact information for the person's SDM is documented below:

Primary contact person	Name:	
	Relationship to person:	Phone number:
	Staying with person overnight? ☐ Yes ☐ No	Contact: ☐ Anytime ☐ Not at night ☐ Other
Secondary contact person	Name:	
	Relationship to person:	Phone number:
	Staying with person overnight? ☐ Yes ☐ No	Contact: ☐ Anytime ☐ Not at night ☐ Other

2.8 The person's family/carer(s) is given a full explanation of the facilities available to them ☐ Yes ☐ No
(e.g. after hours access, staying overnight, tea and coffee facilities and toilets)?

Initials: ..... **Date:** ... / ... / ...

Review of the person's individual medical care ■

3.1 The person's diagnosis:

- Primary diagnosis: .....
- Associated co-morbidities: .....

Initials: ..... **Date:** ... / ... / ...

3.2 Baseline information about the person's condition:

☐ Alert ☐ Dyspnoea ☐ Respiratory tract secretions ☐ Emotional distress
☐ Confused ☐ Semi-conscious ☐ Bladder problems ☐ Unable to swallow
☐ Pain ☐ Agitated/Restless ☐ Unconscious ☐ Bowel problems
☐ Vomiting ☐ Other: .....

Initials: ..... **Date:** ... / ... / ...

3.3 Medications to manage the person's symptoms:

- Current medication assessed and nonessentials discontinued ☐ Yes ☐ No
- Convert appropriate oral medications to subcutaneous/alternative route ☐ Yes ☐ No
- PRN subcutaneous medication written up for symptoms below:
  ☐ Pain ☐ Agitation ☐ Nausea and vomiting ☐ Dyspnoea ☐ Respiratory tract secretions
- If ordered, continuous subcutaneous infusion set up within 4 hours: ☐ Already in place ☐ Not required
- Subcutaneous cannula:

Date inserted	Location
... / ... / ...	
... / ... / ...	
... / ... / ...	

Initials: ..... **Date:** ... / ... / ...

If 'No' or further documentation required, document in CPDP Clinical Notes.

Queensland Government

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Given name(s):

Address:

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

Initial Assessment Authorised Health Practitioner/Nurse joint assessment (with Allied Health as required) *(continued)*

Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health

Review of the person's individual medical care *(continued)* ■

3.4 The person's need for interventions is reviewed by the Authorised Health Practitioner:

	N/A	Discontinued	Continued
Artificial nutrition – type:	☐	☐	☐
Artificial hydration – type:	☐	☐	☐
Routine blood tests	☐	☐	☐
Intravenous antibiotics	☐	☐	☐
Blood glucose monitoring	☐	☐	☐
Routine recording of vital signs	☐	☐	☐
Oxygen therapy	☐	☐	☐
Oropharyngeal suction therapy	☐	☐	☐
Anticoagulant therapy	☐	☐	☐
Dressings	☐	☐	☐
Other(s):	☐	☐	☐

Implantable Cardioverter Defibrillator (ICD) is deactivated (if applicable)? ☐ Yes ☐ No ☐ N/A

Initials: ..... **Date:** ..... / ..... / .....

Review of the person's individual personal cares ▲

4.1 Nursing assessment of the following is undertaken:

- Mouth? ☐ Yes ☐ No
- Eyes? ☐ Yes ☐ No
- Skin integrity? ☐ Yes ☐ No
- Hygiene? ☐ Yes ☐ No

Initials: ..... **Date:** ..... / ..... / .....

Explanation of the plan of care ▲ ■ ◆

5.1 Full explanation of current care plan discussed with the person or SDM? ☐ Yes ☐ No

Initials: ..... **Date:** ..... / ..... / .....

5.2 Full explanation of current care plan discussed with the SDM/family/carer(s)? ☐ Yes ☐ No

- Name of persons present (e.g. person, family, carer(s) and health professionals): .....

.....

.....

.....

.....

Initials: ..... **Date:** ..... / ..... / .....

5.3 Family/Carer(s) Information Sheet provided? ☐ Yes ☐ No

Initials: ..... **Date:** ..... / ..... / .....

If 'No' or further documentation required, document in CPDP Clinical Notes.

Supporting care in the last days and hours of life

Family / Carer(s) Information

The healthcare team will have explained to you that there has been a change in your family member or friend's condition. They believe that the person you care about is now dying and in the last days or hours of life. The person and their care will be reviewed regularly.

You may like to be involved in elements of their care at this time, and the staff will talk to you about how you can help. This information sheet is to help you understand what to expect.

If you need more information or support, or do not agree with something, please ask the healthcare team. They are there to support you.

Comfort

Comfort is very important, please let the staff know if you feel the person is not comfortable. You can support the care given to your family member or friend in important ways such as spending time with them, sharing memories, bringing news of family and friends, or simply holding their hand.

Treatment and medications

Medications and tests that are not helpful may be stopped and new medicines to help manage symptoms will be prescribed. Medications for symptom control will only be given when needed. If the person cannot swallow medications they require, a small pump called a syringe driver may be used to give a continuous infusion under their skin.

Food and drink

Your family member or friend will be supported to eat and drink as long as possible, however, a loss of interest in, and a reduced need for food and solids is normal.

This can be hard to accept, even when you know the person is dying. Good mouth care is very important at this time and the nurses may ask if you would like to help with this care.

Spiritual, cultural and emotional care

As the person prepares to die, they may go through a process of looking back in search of meaning, saying goodbye to people and places, forgiving and being forgiven, expressing joy and gratitude, facing regrets and accepting death. Some people may not want, or be able to, do these things. It is important to take cues from them and be able to listen, share memories and find ways to say goodbye. Let the healthcare team know if you would like spiritual or emotional support, or if you have important cultural practices at this time.

Caring for yourself

Caring for someone who is dying can be a tiring and stressful time. The experience may bring up unresolved feelings or upsetting emotions. It may help you to talk through your thoughts and how you can look after yourself. Please ask the healthcare team for advice.

Changes you may notice

The dying process is unique to each person. Whilst it is almost impossible to predict the exact time or how a person will die, there are several signs and changes that often occur.

SC2600069

Confusion and restlessness

Shortly before death some people become confused and restless. This is known as terminal restlessness, and it affects people who are dying. There may be a variety of causes and sometimes medications are needed. A calm, quiet and peaceful environment, with reassurance from those close to the person, can often help to relieve this symptom.

Communication

Your family member or friend may find it hard to sustain a conversation. While it may be easier for them to talk after they have rested, just being there will help comfort and support them. You may also wish to hold or gently massage their hands or feet or play their favourite music softly. If they become unconscious, they may not be able to respond to you; however, they may still be aware of your presence and the voices around them.

Becoming unconscious

When or if this happens, repositioning can help prevent soreness and stiffness from lying in the one position for too long. A special mattress may also be used to improve their comfort.

Sometimes an indwelling catheter (tube) is inserted to relieve the feeling of a full bladder; however, it is normal for urine production and bowel movements to slow down or stop.

Sometimes people are unable to cough, and secretions can build up at the back of their throat. This causes a rattling or gurgling noise as they breathe but is unlikely to cause the person discomfort. Repositioning and medications may help.

Breathing and circulation

There may be periods of rapid breathing followed by short periods of no breathing at all. This is known as Cheyne-Stokes respirations and is very common. Again, this type of breathing is normal and is unlikely to cause discomfort. It is also normal for a person's hands, feet and legs to feel cool or cold as their circulation slows down.

Once death has occurred

When people die, they stop breathing and their heart stops beating. They will not respond to any stimulation and their mouth may fall slightly open. Their eyes may be open, but the pupils will be large and fixed on one spot. They may also lose control of their bladder and bowel. When this happens, a doctor or nurse will attend and confirm their death.

During this time, you may wish to contact a close friend or relative, spiritual carer or cultural advisor to be with you.

Take your time saying goodbye. The healthcare team will explain what the next steps are and help you access extra support if you need it.

Ward phone number:

_____

Questions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please provide this information sheet to the family/carer(s).

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Please document **all multidisciplinary notes** within the CPDP Clinical Notes

CPDP Clinical Notes

Date	**Time** (24hr)	*Add signature, printed name, staff category, date and time to all entries* **MAKE ALL NOTES CONCISE AND RELEVANT** Leave no gaps between entries

Continue documentation on next page ▶

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CPDP Clinical Notes *(continued)*

Date	Time (24hr)	*Add signature, printed name, staff category, date and time to all entries* **MAKE ALL NOTES CONCISE AND RELEVANT** Leave no gaps between entries

Continue documentation on next page ▶

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CPDP Clinical Notes *(continued)*

Date	Time (24hr)	*Add signature, printed name, staff category, date and time to all entries* **MAKE ALL NOTES CONCISE AND RELEVANT** Leave no gaps between entries

Continue documentation on next page ▶

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CPDP Clinical Notes *(continued)*

Date	Time (24hr)	*Add signature, printed name, staff category, date and time to all entries* **MAKE ALL NOTES CONCISE AND RELEVANT** Leave no gaps between entries

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Care After Death (this section **MUST** be completed)

Key: ▲ Nursing ■ Authorised Health Practitioner ◆ Allied Health

Verification of the person's death ▲ ■

An Authorised Health Practitioner and/or Registered Nurse(s) can verify death. *(Refer to hospital policy/procedures)*

- Where an Authorised Health Practitioner is unavailable immediately to sign a *Death Certificate* or to document that a person has died, other health professionals (Registered Nurses and Midwives) can **verify the fact of death.**
- There is a *minimum guideline for the clinical assessment* necessary to establish that death has occurred.
- Please refer to the *'Queensland Health Care Plan for the Dying Person Health Professional Guidelines'* for further guidance.

6.1 **Date of death:** ..... / ..... / ..... **Time of death (24hr):** ..... : .....

- ☐ No palpable carotid pulse
- ☐ No heart sounds for 30 continuous seconds
- ☐ No breath sounds heard for 30 continuous seconds
- ☐ Fixed dilated pupils
- ☐ No response to centralised stimuli
- ☐ No motor (withdrawal) response or facial grimace response to painful stimuli (e.g. pinching inner aspect of the elbow)
- ☐ Option ECG strip shows no rhythm

Authorised Health Practitioner/Registered Nurse (print name): **Signature:**

Coroner ▲ ■

7.1 **Is this likely to be a reportable Coronial death? If *YES*, refer to hospital policy/procedures** ☐ Yes ☐ No

Initials: **Date:** ..... / ..... / .....

Notifying and supporting family/carer(s) ▲ ■ ◆

8.1 **Person(s) present at time of death:**

- If family/carer(s) not present, have they been notified? ☐ Yes ☐ No

Name of person informed:

Relationship:

Initials: **Date:** ..... / ..... / .....

8.2 **The family/carer(s) can express an understanding of what they will need to do next?** ☐ Yes ☐ No

- The family/carer(s) are given relevant supporting information? ☐ Yes ☐ No
- Bereavement referral required and completed? ☐ Yes ☐ No

Initials: **Date:** ..... / ..... / .....

Care of the deceased ▲

9.1 **Care of the deceased person has been undertaken according to the person's/family/carer(s) wishes and hospital policy procedures?** ☐ Yes ☐ No

Initials: **Date:** ..... / ..... / .....

Other communication ▲ ■ ◆

10.1 **The person's death is communicated to (where relevant):**

- ☐ Community Service Providers
- ☐ Residential Aged Care Facility
- ☐ Other members of the MDT (e.g. Social Worker)
- ☐ General Practitioner

Initials: **Date:** ..... / ..... / .....

10.2 ***Death Certificate*** **completed according to hospital policy/procedures** ☐ Yes ☐ No

If 'No' or further documentation required, document in CPDP Clinical Notes.

Following the death of this person, do you need any support? Consider seeking support from colleagues. Support is also available through your local Employee Assistance Program (EAP). Phone: .....

DO NOT WRITE IN THIS BINDING MARGIN

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.

URN:
Family name:
Given name(s):
Address:
Date of birth:
Sex: ☐ M ☐ F ☐ I

(Affix identification label here)

Queensland Government

Care Plan for the Dying Person (CPDP) Comfort Observation Symptom Assessment (COSA)

Supporting care in the last hours and days of life

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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

Queensland Government

Care Plan for the Dying Person (CPDP) Comfort Observation Symptom Assessment (COSA)

Supporting care in the last hours and days of life

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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 Professorial 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/carer(s) is experiencing (e.g. anger, family conflict) » If score is mild, reassure the family/carer(s) 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