

Comfort Observations and Symptom Assessment (COSA) Adult – Additional Criteria

Quick Reference Guide

Following the documentation of the **Comfort Observations and Symptom Assessment (COSA)**, a **Symptom Rating** will be calculated, and an alert will populate on the clinician's screen.

The clinician will be able to navigate to **Additional Criteria**; a button on the **Managing Deterioration Page** that provides the clinician with required actions and additional information regarding symptom management.

It prompts the clinician on the correct path of escalation dictated by the symptom rating of the patient.

To review the **Additional Criteria** for an adult patient that is prescribed a **COSA Specialty To change to the Palliative Care COSA Adult Specialty Chart**:

1. Navigate to the top right-hand corner and select the **Additional Criteria** button in the **Managing Deterioration** page.
2. The **Additional Criteria** fly-out window appears.
3. Clinicians are prompted: **For escalation guidance select one of the following**: by selecting one of the options it will populate the **Escalation and Action** requirements.

Palliative Care COSA (Comfort Observations and Symptom Assessment) Specialty Chart (Powerchart)

For escalation guidance select one of the following options.

*Note: all images are direct copies from the EW score paper charts.

Select COSA Escalation:
[Adult COSA Escalation Required](#)
[Paediatric COSA Escalation Required](#)

Additional Chart Information:
[Adult COSA Active Management](#)
[Paediatric COSA Active Management](#)
[Paediatric COSA Additional Instructions](#)

Emergency call response if any of the following:

- Unmanaged distress or suffering

4. For **COSA Escalation** click the hyperlink for **Adult COSA Escalation Required**.

Select COSA Escalation:
[Adult COSA Escalation Required](#)
[Paediatric COSA Escalation Required](#)

5. The **Adult COSA Escalation** table populates on the left-hand side.

Palliative Care COSA (Comfort Observations and Symptom Assessment) Specialty Chart (Powerchart)	
For EW Score escalation guidance select one of the following: Select COSA Escalation: Adult COSA Escalation Required Paediatric COSA Escalation Required Additional Chart Information: Adult COSA Active Management Paediatric COSA Active Management Paediatric COSA Additional Instructions	Symptom Rating – Absent • Problem / Symptom distress absent • Continue with current care Symptom Rating – Mild • Problem / Symptom distress present, but managed by existing plan of care IF THE PERSON HAS ANY YELLOW 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 to escalate to Authorised Health Practitioner review Symptom Rating – Moderate • The person has not responded to treatment as expected and symptoms are persisting • 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 2. Increase the frequency of symptom assessment and comfort observations
Emergency call response if any of the following: • Unmanaged distress or suffering	

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Symptom Rating – Moderate • The person has not responded to treatment as expected and symptoms are persisting • 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 2. Increase the frequency of symptom assessment and comfort observations
Symptom Rating – Severe • 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. Initiate an AUTHORISED HEALTH PRACTITIONER / PALLIATIVE CARE REVIEW 3. Increase the frequency of symptom assessment and comfort observations

6. Clinicians will navigate the relevant section for the relating Symptom Rating and follow the instructions.

Note: Clinicians may escalate concerns at

their discretion, regardless of the prompts in the escalations required.

7. **DO NOT MINIMISE** the **Additional Criteria** window; this will minimise the patient's chart.
8. Click the **X** in the top right-hand corner to return to **Managing Deterioration**.

In addition to the **Escalation Required**, the **Additional Criteria** page also contains **Adult COSA Actions Management**

To access the **Adult COSA Actions Management**:

1. Navigate to the top right-hand corner and select the **Additional Criteria** button in the **Managing Deterioration** page.
2. The **Additional Criteria** fly-out window appears.
3. Clinicians are prompted: **For EW Score escalation guidance select one of the following**: by selecting one of the options it will populate the **Escalation and Action** requirements.

Palliative Care COSA (Comfort Observations and Symptom Assessment) Speciality Chart (Powerchart)

For escalation guidance select one of the following options.

*Note: all images are direct copies from the EW score paper charts.

Select COSA Escalation:
[Adult COSA Escalation Required](#)
[Paediatric COSA Escalation Required](#)
 Additional Chart Information:
[Adult COSA Actions Management](#)
[Paediatric COSA Actions Management](#)
[Paediatric COSA Additional Instructions](#)

Emergency call response if any of the following:

- Unmanaged distress or suffering

4. Click the hyperlink for the **Adult COSA Actions Management**.

Additional Chart Information:

[Adult COSA Actions Management](#)
[Paediatric COSA Actions Management](#)
[Paediatric COSA Additional Instructions](#)

5. The **Adult COSA Actions Management** table populates on the left-hand side.

Palliative Care COSA (Comfort Observations and Symptom Assessment) Speciality Chart (Powerchart)			
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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 - Always look for reversible causes and consider non-pharmacological measures - 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 <table border="1"> <tr> <td> 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 - If no urine output for >8 hours consider a bladder scan Nausea and / or vomiting: - Consider anti-emetics </td> <td> 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 Febrile: - Consider cool sponges and use of fans 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 Care </td> </tr> </table>		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 - 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 Febrile: - Consider cool sponges and use of fans 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 Care
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Prompts for Comfort Assessment and Management <table border="1"> <tr> <td> 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 </td> <td> 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 nonverbal 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 </td> </tr> </table>		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 nonverbal 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
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