	FAMILY NAME	MRN									
NSW GOVERNMENT Health	GIVEN NAME	☐ MALE ☐ FEMALE									
Facility:	D.O.B//	,									
	ADDRESS										
COMFORT OBSERVATION											
AND SYMPTOM ASSESSMENT	LOCATION / WARD										
CHART - ADULT	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE										

## USING THE COMFORT OBSERVATION AND SYMPTOM ASSESSMENT (COSA) CHART

- If the Initiating Last Days of life Management Plan has been completed and staff are aware of the management plan for this patient, then this chart replaces the the Standard Adult General Observation Chart (SAGO) or flowchart.
- · Consider if it is appropriate to change patient's care type to palliative care.
- · This chart may be used in addition to the SAGO chart for patients with symptom or comfort issues.

# **Instructions for Symptom Assessment**

- 1. Where possible, base the assessment on the patient's verbal response.
- 2. For non-verbal / semi-conscious patients look for visual cues of pain or discomfort.
- 3. Assess each symptom and document whether Absent / Mild / Moderate / Severe then enter 'P' for Patient, 'C' for Carer, and 'S' for Staff to identify source of assessment.
- 4. In case of discrepancy between assessments, (e.g. perception of carers and staff, or patient and carers), separately document relevant severity for each assessment with 'P' for Patient, 'C' for Carer, and 'S' for Staff.

# **Instructions for response to Symptom Rating**

- 1. This chart should be used in conjunction with standardised medication management guidelines
- 2. If no PRN medication charted, escalate to Medical Officer, senior nurse
- 3. Reassess symptom at least 1 hour following treatment If symptom not adequately addressed escalation to clinical review may be required
- 4. Record symptom severity, management, escalation and outcomes in the patients' health care record

### Instructions for Symptom Assessment – Family / Carer Distress

Document severity of family/carer distress observed (i.e. this is not an observation of the patient, but of their family/carer).

# PRESCRIBED FREQUENCY OF SYMPTOM ASSESSMENT AND COMFORT OBSERVATIONS

Observations must be performed routinely at a minimum of 4 hourly

If any treatment or escalation initiated more regular observation should occur

# REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

COMFORT ASSESSMENT PLANNING						
Cultural / Spiritual / Religious considerations						
Special needs and / or rituals related to dying and time after death identified and documented in health care record						
Religious / pastoral resources contacted where indicated						
Environmental considerations						
Need for single room assessed						
Visiting hours reviewed						
Overnight arrangements, includes afterhours access, meals and parking discussed with family/carer						

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PROMPTS FOR NON PHARMACOLOGICAL MEASURES FOR SYMPTOM MANAGEMENT

#### PAIN

- Ensure comfortable position; consider repositioning and/or alternative mattress
- · Exclude other causes of pain and distress (e.g. urinary retention, anxiety, fear); manage appropriately if present

#### **NAUSEA AND/OR VOMITING**

- · Regular and effective mouth and tongue care
- Sips of water and ice chips
- · Provision of tissues and vomit bag within easy reach

#### **RESTLESSNESS AND/OR AGITATION**

- Agitated delirium and terminal restlessness is a COMMON symptom that occurs in the last days of life.
- Non-pharmacological measures should be considered before medications are introduced:
- Exclude constipation; consider management with rectal laxatives if present
- Consider nicotine replacement therapy if the patient is a smoker

- Exclude urinary retention; manage with catheterisation if present

- Assess for emotional, psychological and existential distress; address appropriately if present

#### RESPIRATORY TRACT SECRETIONS

- Respiratory tract secretions are a normal part of dying process; they may not be distressing to the patient, but often are for family and carers.
- Prompt action is necessary if the symptom occurs;
- Reassure family with explanation of the symptom, cause, and measures taken used to relieve secretions
- Position patient semi-prone and on to alternate sides to encourage postural drainage; this may be sufficient
- Suction is NOT RECOMMENDED and can be distressing to the patient

#### **BREATHLESSNESS**

- · Breathlessness is often associated with significant anxiety in the last days of life
- Reassure the patient and family with explanation of cause and management
- Position to maximise comfort and airway
- Use a fan and/or an open window
- Maintain a calm environment

# **FAMILY/CARER DISTRESS**

COMFOR CHART -

RT OBSERVATION - ADULT

AND SYMPTOM

**ASSESSMENT** 

SMR110.055

- Consider the severity of the problem the family/carer is experiencing, e.g. anger, family conflict
  - If score is mild reassure the family/carer with explanation and support as required
- If score is severe escalate to senior staff and consider referral to Social Worker, Palliative Care service, Chaplain

# **Blue Zone Response**

#### IF THE PATIENT HAS ANY BLUE ZONE OBSERVATIONS YOU MUST

- 1. Initiate appropriate clinical care i.e. look for reversible causes
- 2. Consider non-pharmacological measures
- 3. Increase the frequency of symptom assessment and comfort observations as indicated by the patient's condition
- 4. Manage symptoms in consultation with the  ${\bf NURSE\ IN\ CHARGE}$
- $\textbf{5.} \ \ \textbf{If symptoms persist}-\textbf{even if assessed as mild}-\textbf{escalation is required}$

You can make a call to escalate the care at any time if worried or unsure whether to call

# Yellow Zone Response

# IF THE PATIENT HAS ANY YELLOW ZONE OBSERVATIONS YOU $\underline{\text{MUST}}$

- 1. Initiate appropriate clinical care i.e. look for reversible causes
- 2. Repeat and increase the frequency of symptom assessment and comfort observations as indicated by the patient's condition
- 3. Consult promptly with the NURSE IN CHARGE to decide whether a CLINICAL REVIEW (or other CERS) call should be made

#### When deciding to escalate care, consider the following:

- Is there more than one Yellow Zone criterion?
- Has the patient not responded to treatment as expected? Are symptoms persisting?
- Does the patient require any additional intervention to relieve their symptoms?



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Page 4 of 4 NO WRITING

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Action required: Y/N

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Any symptoms present (even mild) require action to address; persistent or severe symptoms require escalation.																				
	Date																			Date
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FAMILY NAME MRN NSW GOVERNMENT Health ☐ MALE ☐ FEMALE GIVEN NAME D.O.B. M.O. Facility: ADDRESS **COMFORT OBSERVATION** AND SYMPTOM ASSESSMENT LOCATION / WARD **CHART - ADULT** COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE **Instructions for Comfort Assessment and Management** 1. Assess and manage comfort at least every **four hours** 2. Assess each care need and tick ✓ when action completed - Note N/A if after assessment no action required If Further Action Required - document reasons and actions in patient health care record Date Time Assess Skin intact & clean Cleanse/moisturise Care Pressure re-distribution (when required) Skin Turn and reposition as indicated Manual handling equipment/ aids Assess Mouth/lips clean and moist Action Mouth care Assess Eyes are clean and moist Eye Swab with normal saline Action Care Assess Patient clean comfortable not agitated/distressed due to retention or Bladder incontinence Action Urinary aids as required Assess Patient clean comfortable not agitated/distressed Care due to constipation or diarrhoea Bowel Action Bowel movements documented Bowel care managed Assess | Spiritual / religious /

Spiritual/ Cultural Needs cultural needs Appropriate support person / pastoral care contacted and rituals facilitated as requested Assess | Patient and family /carer are supported Support Action Information brochures given; procedures explained; new concerns

**NO WRITING** Page 2 of 4 **NO WRITING** Page 3 of 4

Action

Initials

identified; referral to social work if required

Initials