NSW GOVERNMENT Health

Facility:

COMFORT OBSERVATION AND SYMPTOM ASSESSMENT CHART - ADULT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
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	**✓/X**
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	**✓/X**
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 urinary retention; manage with catheterisation if present
  - Exclude constipation; consider management with rectal laxatives if present
  - Consider nicotine replacement therapy if the patient is a smoker
  - 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
- 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 **NURSE IN CHARGE**
5. If symptoms persist – even if assessed as mild – 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 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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Any symptoms present (even mild) require action to address; persistent or severe symptoms require escalation.

	Date	Date
	Time	Time

Attend observations 4 hourly routinely – Enter 'P' for Patient, 'C' for Carer, and 'S' for Staff to identify source of assessment

Pain	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / sleeping in no apparent distress	Absent
	Action required: Y / N	Action
Nausea and/or Vomiting	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / sleeping in no apparent distress	Absent
	Action required: Y / N	Action
Distress related to Respiratory Secretions	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / sleeping in no apparent distress	Absent
	Action required: Y / N	Action
Restlessness & Agitation	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / sleeping in no apparent distress	Absent
	Action required: Y / N	Action
Distress related to Breathlessness	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / sleeping in no apparent distress	Absent
	Action required: Y / N	Action
Family / Carer Distress	Severe	Severe
	Moderate	Moderate
	Mild	Mild
	Absent / not witnessed	Absent
	Action required: Y / N	Action
	Initials	Initials

NH700138 280417

NO WRITING

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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	
Skin Care	Assess	Skin intact & clean	
	Action	Cleanse/moisturise	
		Pressure re-distribution (when required)	
		Turn and reposition as indicated	
		Manual handling equipment/ aids	
Mouth care	Assess	Mouth/lips clean and moist	
	Action	Mouth care	
Eye care	Assess	Eyes are clean and moist	
	Action	Swab with normal saline PRN	
Bladder Care	Assess	Patient clean comfortable not agitated/distressed due to retention or incontinence	
	Action	Urinary aids as required	
Bowel Care	Assess	Patient clean comfortable not agitated/distressed due to constipation or diarrhoea	
	Action	Bowel movements documented	
		Bowel care managed	
Spiritual/ Cultural Needs	Assess	Spiritual / religious / cultural needs	
	Action	Appropriate support person / pastoral care contacted and rituals facilitated as requested	
Support	Assess	Patient and family /carer are supported	
	Action	Information brochures given; procedures explained; new concerns identified; referral to social work if required	
		Initials	

NO WRITING