Use standardised medication management guidelines to respond to symptoms

The person should be supported to eat and drink for as

Spiritual / Cultural / Emotional needs supported

Problem / Symptom distress requires urgent intervention and escalation

If continuous subcutaneous infusion in place complete

Treat problem / symptom according to service protocols

Discuss the problem / symptom and agree on a plan of care

The frequency of assessment, repositioning and special

If no urine output for >8 hours consider a bladder scan

Monitor for constipation and diarrhoea

Initiate a MEDICAL / PALLIATIVE CARE REVIEW

Consider PRN analgesia for incident pain

Offer food / drink / rest

Staff just being at the bedside can be a sign of support and

Problem / Symptom distress requires a change in plan of care

Increase the frequency of symptom assessment and comfort observations

The person has not responded to treatment as expected and symptoms are persisting

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 Professorial Guidelines.

Instructions for Response to Symptom Rating

• Use standardised medication management guidelines to respond to symptoms
• If no PRN medication charted, liaise with Medical Officer
• 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

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 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
• It continues subcutaneous infusion in place complete

Restlessness and / or agitation:
• Assess the person for reversible causes including pain, incon tinence, 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

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 ZONE OBSERVATIONS YOU MUST:
1. Treat problem / symptom according to service protocols
2. Increase the frequency of symptom assessment and comfort observations

Symptom Rating – Moderate

• The person has more than one ‘Mild Symptom Rating’
• 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 a MEDICAL / 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 RED ZONE OBSERVATIONS YOU MUST:
1. Initiate appropriate clinical care
2. Initiate a MEDICAL / PALLIATIVE CARE REVIEW
3. Increase the frequency of symptom assessment and comfort observations

Instructions for Symptom Rating

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

• 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 ZONE OBSERVATIONS YOU MUST:
1. Treat problem / symptom according to service protocols
2. Increase the frequency of symptom assessment and comfort observations

Symptom Rating – Moderate

• The person has more than one ‘Mild Symptom Rating’
• 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 a MEDICAL / PALLIATIVE CARE REVIEW is required
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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 RED ZONE OBSERVATIONS YOU MUST:
1. Initiate appropriate clinical care
2. Initiate a MEDICAL / PALLIATIVE CARE REVIEW
3. Increase the frequency of symptom assessment and comfort observations
### Symptom Assessment

#### Pain
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

#### Restlessness and agitation (delirium)
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

#### Distress related to respiratory secretions
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

#### Nausea and/or vomiting
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

#### Distress related to breathlessness
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

#### Other symptoms (specify)

<table>
<thead>
<tr>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Absent</th>
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**Action required?** Y/N

#### Family/Care(s) distress
- **Severe**
- **Moderate**
- **Mild**
- **Absent**

**Action required?** Y/N

### 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:** Escalate to medical/palliative care team
- **Moderate:** Escalate to nurse-in-charge
- **Mild:** Routine symptom management
- **Absent:** No symptom/problem

### Comfort Observations

#### Symptom Assessment
- The person does not have urinary problems
- The person does not have bowel problems
- The person's comfort and safety regarding the administration of medication is maintained
- The person receives fluids to support their individual needs
- The person's mouth is moist and clean
- The person's skin integrity is maintained
- The person's personal hygiene needs are met
- The person receives their care in a physical environment adjusted to support their individual needs
- The person's psychological and spiritual well-being is supported
- The well-being of the family or carer or advocate attending the person is supported

#### Comfort Observations

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**Instructions for Comfort Assessment and Management**
- Assess and manage comfort at least every two (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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**Note:**

- SW270a is used for Ongoing Assessment.
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- Contact: Clinical_PATHWAYS@health.qld.gov.au