Instructions for Response to Symptom Rating

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

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

IF THE PERSON HAS ANY YELLOW 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

Instructions for Symptom Assessment

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
  - If no urine output for >6 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

- Febrile:
  - Consider cool sponges and use of fans
  - Consider antipyretics PO or PR

- 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

- Environmental:
  - 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
### CPDP Ongoing Assessment

<table>
<thead>
<tr>
<th>Symptom Assessment</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Absent</th>
<th>Action required? Y / N</th>
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<tbody>
<tr>
<td>Pain</td>
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<td>Restlessness and agitation (delirium)</td>
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<td>Distress related to respiratory secretions</td>
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<td>Nausea and / or vomiting</td>
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<td>Distress related to breathlessness</td>
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<td>Other symptoms (specify)</td>
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<tr>
<td>Family / Carer(s) distress</td>
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</table>

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

#### 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.

#### 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.

#### Comfort Observations
- 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

#### Initials