Queensland Government

Care Plan for the Dying Person *(CPDP)* Ongoing Assessment

Supporting care in the last hours and days of life

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

All health professionals must sign the signature log upon initial entry

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

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
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

CPDP ONGOING ASSESSMENT ADDITIONAL PAGE

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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 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 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
- 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

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

DO NOT WRITE IN THIS BINDING MARGIN

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v6.00 - 03/2019
Mat. no.: 10207869

DO NOT WRITE IN THIS BINDING MARGIN

EXAMPLE

CPDP Ongoing Assessment

		Date																																				
		Time																																				
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)*	Severe																																				
	....	Moderate																																				
	....	Mild																																				
	....	Absent																																				
	....	Action required? Y / N																																				
	Family / Carer(s) distress	Severe																																				
		Moderate																																				
		Mild																																				
		Absent																																				
		Action required? Y / N																																				
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																																						

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

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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