PACOP palliative aged care outcomes program

OUTCOMES COLLECTION

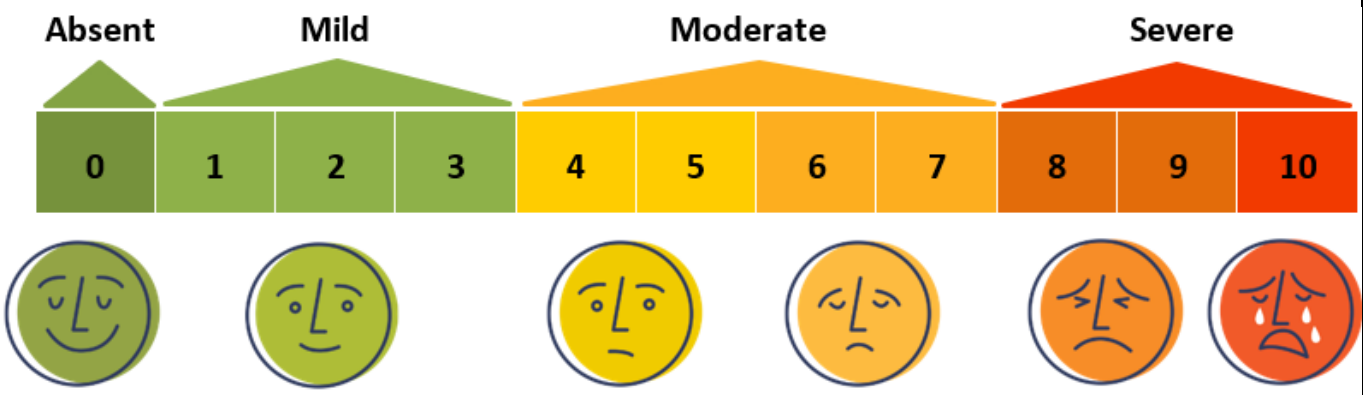
Daily symptom assessment

(Please complete or affix Label here)

UPI:
Surname
First name:
DOB:

Daily PCOC Symptom Assessment Scale (SAS)

Please use this form to ask the Resident about the symptoms that bothered, worried or distressed them over the previous 24 hours. This information will help us to meet their needs.



1. Use the scale above to choose a number between 0 and 10 that shows how bothered, worried or distressed the resident is.
2. You can add and rate other symptoms in the blank space at the bottom of the list.

Date									
Time									
Distress from Pain									
Distress from Fatigue									
Distress from Breathing problems									
Distress from Bowel problems									
Distress from Nausea									
Distress from Appetite problems									
Difficulty Sleeping									
Distress from Other Symptom									
Specify 'Other Symptom'									
Rated **by:** **R**=Resident **F**=Family/unpaid carer **C**=care worker **H**=Health Care Professional									
Staff initials									

CARE WORKER ACTIONS BASED ON SAS SCORES			
Absent (0) **No action required**	**Mild (1-3)** Report to RN/Supervisor **WITHIN SHIFT**	**Moderate (4-7)** Report to RN/Supervisor **WITHIN 30 MINUTES**	**Severe (8-10)** Report to RN/Supervisor **IMMEDIATELY**

SYMPTOM	SAS SCORE GUIDE
PAIN	**Any discomfort, ache, soreness, stabbing, sharp or dull pain**
0 1 – 3 	Score 0 resident states no distress from pain **OR** does not show signs of distress from pain
	Scores 1-3 **OR** may appear slightly uncomfortable or unsettled
4 - 7 	Scores 4 to 7 **OR** shows signs such as groaning, moaning, grimacing, being agitated or restless
8 - 10 	Scores 8-10 **OR** shows signs such as crying, groaning, grimacing, holding/guarding parts of the body, signs appear to worsen on movement, being very restless or agitated or aggressive
FATIGUE	**Loss of strength, low energy, very tired, weakness**
0 1 – 3 	Score 0 resident states no distress from fatigue **OR** does not show signs of distress from fatigue
	Scores 1-3 **OR** appears mildly frustrated when trying to complete usual activities
4 - 7 	Scores 4 -7 **OR** appears moderately frustrated/annoyed when trying to complete usual activities. Disinterested in usual activities.
8 - 10 	Scores 8-10 **OR** appears very irritated and/or frustrated when attempting to complete usual activities. Resident may not attempt activities or gives up easily, or is sleepy at inappropriate times (e.g., meals).
BREATHING	**Rapid breathing, noisy breathing, shallow breathing, irregular breathing**
0 1 – 3 	Score 0 Resident states there is no distress from breathing **OR** does not show signs of distress from breathing
	Scores 1-3 **OR** seems a bit breathless and worried. Gets breathless when moving around.
4 - 7 	Scores 4- 7 **OR** seems quite short of breath, and is taking big breaths in and out, and appears to be concentrating/fixating on their breathing. Gets breathless when talking uninterrupted for a time.
8 - 10 	Scores 8-10 **OR** seems short of breath and signs of panic such as grabbing onto staff, refusing to eat or drink, avoiding talking more than a couple of words at a time, is restless or agitated
BOWELS	**Constipation, diarrhoea, abdominal discomfort**
0 1 – 3 	Score 0 Resident states no distress from bowels **OR** does not show signs of distress from bowels
	Scores 1-3 **OR** appears concerned with opening their bowels, or mild lower stomach discomfort shown by holding or touching lower stomach
4 - 7 	Scores 4-7 **OR** appears quite concerned with opening their bowels, appears have pain or discomfort in their lower stomach, may request to go to the toilet constantly and sits for long periods on the toilet. Straining to open bowels **OR** may be upset by diarrhoea or faecal incontinence
8 - 10 	Scores 8-10 **OR** very fixated with opening their bowels, appears to have severe pain/discomfort in lower stomach, may be restless/agitated, may not have opened bowels for a few days but has a small amount of runny faeces, may refuse food **OR** may be highly distressed by diarrhoea/faecal incontinence.
NAUSEA	**Feeling sick, wanting to vomit, dislike of food odours**
0 1 – 3 	Score 0 Resident states no distress from nausea **OR** does not show signs of distress from nausea
	Scores 1-3 **OR** shows dislike of food & drink, may dry retch, may vomit
4 - 7 	Scores 4-7 **OR** may actively push away or turn away from food, may dry retch, may vomit, and appears upset when this happens
8 - 10 	Scores 8-10 **OR** is refusing food and drink, gags, dry retches or vomits often, and appears very upset and/or exhausted when this happens
APPETITE	**Not wanting to eat, decrease in food intake**
0 1 – 3 	Score 0 Resident states no distress relating to appetite **OR** are eating and drinking normally
	Scores 1-3 **OR** may only eat part of their meal and appears mildly frustrated
4 - 7 	Scores 4-7 **OR** attempts to eat and drink, may sigh, and stop eating or attempts to eat/drink but gives up partway through meal/snack and appears frustrated or annoyed
8 - 10 	Scores 8-10 **OR** may refuse food/drink and appears very irritated/frustrated/annoyed. May push food away or is upset by sight of food. Refuses to attend dining room **OR** upset when food is placed near them.
SLEEPING	**Awake during the night-sleeping during the day, restless and/or irritable during the night**
0 1 – 3 	Score 0 Resident states no distress from sleeping **OR** shows no signs of distress from sleeping
	Scores 1-3 **OR** may be tossing and turning throughout the night or when trying to sleep
4 - 7 	Scores 4-7 **OR** may be tossing/turning when trying to sleep, sighing, or calling out for staff, unable to sleep for more than short periods. Upset about being tired and sleepy during the day.
8 -10 	Scores 8-10 **OR** unable to fall asleep/stay asleep, very restless, very agitated, repeatedly calling for staff, constantly tired, low mood, irritable. Falls asleep during normal activities (e.g., shower, meals)