

Acute care needs (ongoing and changing)

- ✓ If person's need(s) change, a new and complete **PACE** record must be documented.
- ✓ There may be multiple **acute** care needs identified.
- ✓ **Acute** care needs can be ongoing, even when the person is discharged e.g. a community nurse, treatment room nurse, or the person themselves may be delegated aspects of self-care (with professional community support).

Existing care needs (ongoing and unchanging)

- ✓ If the person's care need is stable, **unchanging** and is not an **acute** care need, the **Assessment** and **Plan of Care** should be reviewed and rewritten at least weekly.
- ✗ Weekly revision and rewriting of the **PACE** record **IS NOT APPROPRIATE** if the person's:
 - Needs change (A)
 - Input into his/ her care or plan of care changes (C)
 - Condition changes in response to the care being delivered (E)

Existing care needs (ongoing and unchanging)

- ✓ If a previously documented **PACE** record is being referenced for an **existing** care need, a **clear timeline and note of the professional's name who prescribed the plan of care** should be recorded in the nursing record in order to indicate which **Assessment** and **Plan of Care** is being referenced.
- ✓ The **Assessment** and **Plan of Care** being referenced **MUST** be accurate, evidence informed, robust and the nursing professional who is referencing it **MUST** be satisfied that it is appropriate to the **PACE** framework.
- ✓ A daily **Evaluation** of the outcomes of care planned and delivered **MUST** be recorded.
- ✓ Nurses must use professional judgement and critical thinking when considering **existing** care needs.



Person centred **Assessment**
Plan of **Care** **Evaluation**

Person

- What is important to the person (in his/her words)? - hear from the person's perspective
- Feelings, concerns, questions, preferences
- Communication with family, carers, other important people e.g. nursing home staff

Assessment

- Continual process of collecting information at the point of admission and thereafter e.g. symptoms, clinical observations, test results, bed end charts, care pathways, care bundles, risk assessments
- Identifying & prioritising needs (nursing diagnosis) - ACUTE and EXISTING NEEDS
- Each assessment recorded should show how the nursing diagnosis based on the need identified affects the individual

Think PERSON-CENTREDNESS/DISCHARGE PLANNING

Person-centredness "implies recognition, respect and trust" (Kitwood, 1998, p. 8). "It is dependent on others recognising my status as a person" (McCormack and McCance, 2017, p. 17.)

"Recognise and respect the contribution that people can make to their own health and wellbeing" (NMC Code, 2018, p. 6.)

Plan of Care

Each co-produced plan of care linked to an assessment of need should show how the nursing team will:

- Educate and support the person to enable a return to his/her optimal health and wellbeing
- Provide care and treatment that is safe and effective with consent - remember: ACUTE and EXISTING NEEDS
- Consider the multi-professional team and its contribution
- Prioritise when the care is being delivered
- Be responsive to the changing condition of the person through appropriate changes of the plan of care

Think PERSON-CENTREDNESS/DISCHARGE PLANNING

"Make sure you deliver the fundamentals of care effectively" (NMC Code, 2018, p. 6) and "make sure any information or advice given is evidence-based (NMC Code, 2018, p. 9.)

Evaluation

- Review effectiveness of the plan of care
- Has the person e.g. improved/stabilised/deteriorated/ has the plan of care had the desired effect? - the response of the person
- Record a new plan of care, if necessary, based on person's reviewed needs - ACUTE and EXISTING NEEDS
- Record any outstanding care that is to be delivered

Think PERSON-CENTREDNESS/ DISCHARGE PLANNING

"Make sure you deliver the fundamentals of care effectively" (NMC Code, 2018, p. 6) and "make sure any information or advice given is evidence-based (NMC Code, 2018, p. 9.)