Guidance for using PACE

Date/Time	Nursing Progress – PACE Framework (Person-centred, Assessment, Plan of Care, Evaluation)		Signature/ designation
01/12/16, 14.05	An admission summary - Review of the reason for admission/presenting complaint.		
P = What	Subjective information, what is important to the child/ young person and how are they feeling, consider their preferences and ongoing individual needs.		
How	Effective communication with the child/ young person, family, carer, parent (guardian). ***BUILDING A PICTURE***		
A = What	***Continual process*** whereby needs are identified and prioritised	**C = What** ***person-centred*** plan of care/treatment/support Based on P and A.	
	for the duration that care/treatment/support is required	☺Direct care ☺Teaching ☺Counselling ☺Prevention ☺Health co-ordinating	
How	**Collecting information:**	☺Collaboration ☺Health promotion ☺Disease maintenance ,restoration ☺Rehabilitation	
	• Pertaining to NEEDS (human responses) and Risk (vulnerability)	**How In Partnership:**	
	and from their health condition and/or life process. Consider their strengths.	• Agreeing an action plan to meet the person's needs. Record Consent	
	• From the child/ young person, family , carers and multidisciplinary team	• Agreeing outcomes.	
	• From clinical observations , bed end charts, test results etc.	• Agreeing a discharge plan.	
	• From initial assessment/ongoing records in child/ young person's notes	• Co-ordinating with multiprofessinal team.	
	• From plans from other care settings e.g. district nursing	**Planning:**	
	Under the following categories:	• Direct care /treatment / support ***PLAN***	
	• Physical, psychological, emotional, spiritual and cultural.	• Specific outcomes and frequency of review	
	• Specifically , using a framework such as Activities of Living (AL)	• What requires monitoring and the frequency, refer to bed end charts	
	By:	• Other documents that require integration i.e. pathways , bundles	
	• Looking , listening, feeling, smelling and conversing	• Education/Health promotion / Counselling	
		Acting on:	*Jane Green*
	BUILDING A PICTURE	• Selection of evidence to guide practice – clinical nursing procedures	*Staff Nurse*
01/12/16, 16.15 **E = What**	Determining the progress towards attaining outcomes/meeting needs and the effectiveness of the plan .Direct care -has the child/ young person		
	deteriorated, stabilised or improved. Teaching – has the child/ young person understood. Collaboration – of the other members of the team.		*Paul White*
How	Gathering subjective/objective information to evaluate the effectiveness of the plan. ***EVALUATING***		*Staff Nurse*
01/12/16, 19.30	R **What:** Has the process been successful? What is outstanding? What needs to be reassessed or handed over to the next shift? ***FOCUS***		*Jane Green*
	How Review the outcomes and communicate with the person , nursing colleagues and the multidisciplinary team		*Staff Nurse*

P - At the beginning of a shift and throughout shift

A - Depending on the need - ongoing care/episodes of care/emergency & critical care

C - Following assessment of needs

E - Throughout the shift, after a plan is in place and the action has been carried out or if unable to be carried out

When to record PACE	
P	At the beginning of a shift and throughout shift
	If the nurse has communicated with the child/ young person and/or his/her family and /or carers - identifying any needs then record at the time
A	Depends on the need - ongoing care/episodes of care/emergency & critical. Different needs will be assessed at different times of the day, not necessarily all at once. Assessment is a continual process (begins with initial) that is not predictable
C	Directly following assessment - if the nurse has identified a need then a plan of care/treatment/support must be put in place
E	Throughout shift, after a plan is in place and the *intervention has been carried out, not all plans will be evaluated at the same time. *nursing interventions – direct care , teaching , counselling , coordinating, collaborating , health promotion, disease prevention, health maintenance , restoration, rehabilitation

Examples:

Direct care e.g. reduced function

Example

A child/ young person requires assistance to eat and drink

P - Identify the child/young person's needs/preferences
A – Assessing the child/young person's needs relating to eating and drinking at the start of the shift
E - Evaluating if plan is working
C - Continue with previous plan or prescribe a new plan, co-ordinate with dietitian.
E - Liaising with the dietitian after they have attended the person.

Episodes of care are not ongoing therefore assessment would be carried out when a plan is being actioned.

Example

A child/ young person has a wound that requires changing alternate days, if the wound is changed in the afternoon, the nurse will complete the assessment at this time.

A treatment plan is in place. Following the intervention the nurse will record;

E - Evaluating if the previous plan is working
P - Identify the child/young persons needs
A - Complete a wound assessment using both subjective (smell of wound , talking to person) and objective (measurements – length/width/depth of wound)
C - Continue with previous plan or prescribe a new plan

Emergency/critical care , there will be times when the person deteriorates rapidly or is very unstable

Example

A child/ young person becomes unresponsive due to respiratory distress

Once stabilised the nurse will record ;

P - how was the child/young person feeling leading up to the episode and now (if responsive)
A - what was the information telling you leading up to the episode and now– i.e. clinical observation
C – the treatment/care that was given
E - the child/young persons responses to treatment
C – plan required to maintain stable condition, prevent deterioration