Guidance for using PACE

<table>
<tr><th>Date/Time</th><th colspan="2">Nursing Progress – PACE Framework (Person-centred, Assessment, Plan of Care, Evaluation)</th><th>Signature/ designation</th></tr>
<tr><td>01/12/16 14.05</td><td colspan="2">An summary of care since triage - presenting complaint, treatment received , placement plan.</td><td></td></tr>
<tr><td>What
P</td><td colspan="2">Subjective information, what is important to the person and how are they feeling, consider their preferences and ongoing individual needs.
BUILDING A PICTURE</td><td></td></tr>
<tr><td>How</td><td colspan="2">Effective communication with the person, family, carer, child, parent (guardian).</td><td></td></tr>
<tr><td rowspan="2">What
A</td><td rowspan="2">Continual process whereby needs are identified and prioritised for the duration that care/treatment/support is required</td><td>C = What person-centred plan of care/treatment/support Based on P and A.</td><td></td></tr>
<tr><td>☺Direct care ☺Teaching ☺Counselling ☺Prevention ☺Health co-ordinating ☺Collaboration ☺Health promotion ☺Disease maintenance & restoration ☺Rehabilitation</td><td></td></tr>
<tr><td rowspan="9">How</td><td rowspan="3">Collecting information:
• Pertaining to NEEDS (human responses) and Risk (vulnerability)and from their health condition and/or life process. Consider their strengths.</td><td>How In Partnership:</td><td></td></tr>
<tr><td>• Agreeing an action plan to meet the person's needs. Record Consent</td><td></td></tr>
<tr><td>• Agreeing outcomes.</td><td></td></tr>
<tr><td>• From the person, their family , their carers and multidisciplinary team</td><td>• Agreeing a discharge plan.</td><td></td></tr>
<tr><td>• From clinical observations , bed end charts, test results etc.</td><td>• Co-ordinating with multiprofessinal team.</td><td></td></tr>
<tr><td>• From triage assessment and ongoing records of care in persons notes</td><td>Planning:
PLAN</td><td></td></tr>
<tr><td>• From plans from other care settings e.g. district nursing</td><td>• Direct care /treatment / support</td><td></td></tr>
<tr><td>Under the following categories:</td><td>• Specific outcomes and frequency of review</td><td></td></tr>
<tr><td>• Physical, psychological, emotional, spiritual and cultural.</td><td>• What requires monitoring and the frequency, refer to bed end charts</td><td></td></tr>
<tr><td>• Specifically , using a framework such as Jones</td><td>• Other documents that require integration i.e. pathways , bundles</td><td></td></tr>
<tr><td>By:</td><td>• Education/Health promotion / Counselling</td><td></td></tr>
<tr><td rowspan="2"></td><td>• Looking , listening, feeling, smelling and conversing</td><td>Acting on:</td><td rowspan="2">Jane Green Staff Nurse</td></tr>
<tr><td>BUILDING A PICTURE</td><td>• Selection of evidence to guide practice – clinical nursing procedures</td></tr>
<tr><td>01/12/16 16.15
E
What</td><td colspan="2">Determining the progress towards attaining outcomes/meeting needs and the effectiveness of the plan .
Direct care -has the person deteriorated, stabilised or improved.
Teaching – has the person understood.
Collaboration – of the other members of the team.
EVALUATING</td><td rowspan="2">Paul White Staff Nurse</td></tr>
<tr><td>How</td><td colspan="2">Gathering subjective/objective information to evaluate the effectiveness of the plan.</td></tr>
<tr><td>01/12/16 19.30
R</td><td colspan="2">What: Has the process been successful? What is outstanding? Handover to the admission/transfer placement.
FOCUS</td><td rowspan="2">Jane Green Staff Nurse</td></tr>
<tr><td></td><td colspan="2">How Review the outcomes and communicate with the person , nursing colleagues and the multidisciplinary team</td></tr>
</table>

P – Commencement of record and throughout time in department

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

C - Following assessment of needs

E - After a plan is in place and the intervention has been carried out or if unable to be carried out