

# CARE PLANNING GUIDE

The purpose of the Care Planning Guide is to assist you in writing outcome statements and developing meaningful care plans for your residents.

The Care Planning Guide has example outcomes for you to refer to - these can be used to assist you in writing your resident's outcomes - you must ensure that the outcome matches the resident's outcome. The Guide also has a range of care interventions that can be included in the specific care plan to describe the care you provide to the resident to help them meet their defined outcomes - you must ensure that these match the care you actually deliver.

Also included in the guide is a care planning scenario that provides you with an example care plan and specific care plans for a fictitious resident. You can use this example to assist you in completing both the care plan and specific care plans for your residents.

Overleaf are some more guidelines on outcome statements and care interventions that may assist you.

*All residents should be assessed first to determine what outcome they want to achieve and what care interventions may meet their needs.*

*NOTE: The Care Planning Guide is a set of example outcome statements and care interventions - these cannot replace appropriate assessment and review by appropriately trained staff and should be used as examples to guide staff in the development of care plans only.*

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## REMEMBER:

**Outcome Statements** - these reflect what you want the resident to achieve through the care and support you give them.

Outcome (or goal) statements should be:

- resident centered - they should address what resident will do, when and where and how these will be accomplished;
- clear, concise, observable and measurable;
- linked to a reasonable timeframe;
- realistic - they must be achievable;
- decided in consultation with staff, the resident/representatives, and other health professionals.

**Care Interventions** - these are the actions you take to assist the resident to achieve their outcomes - this is the care you deliver to the resident. These interventions you write on the specific care plan to describe what you do for the resident.

Care interventions, actions, or strategies should:

- state what is to be done to assist the resident to achieve their outcomes;
- relate to the cause of the problem that has been identified during assessment;
- be specific and detailed so a colleague can deliver the intervention from the plan;
- be worded in a manner which is easily understood.

## PAIN

All residents will be as free as possible from pain

### Outcome Statements

*(Note: You must first assess the resident's acceptable pain level and then put those levels in the sentence below or, if the resident is unable to rate the pain using the numerical score, describe the signs they express when in pain.)*

The resident will express that their pain level is between  $X$  and  $X -$  which has been assessed as acceptable to them.

The resident will not display signs of experiencing pain, such as grimacing, calling out, restlessness *(insert whatever the pain assessment shows as the individual resident's expression of pain)*.

### Care Interventions for Assisting Residents in Pain

*These are examples of the types of things you would do to assist a resident in pain - these go on the specific care plan, if applicable to your resident.*

- Provide analgesia as per medication chart and assess the effectiveness of the analgesics by documenting in the progress notes.
- Provide the resident with hot packs, massage and/or liniment rubs to ease pain. Assess the effectiveness of these interventions and document in the progress notes.
- Assist the resident to find a position of comfort - *(insert examples) e.g. legs elevated, resting on their bed, in a comfortable chair.*
- Provide diversion for the resident - take them for a short walk, assist them to attend activities or read a book.
- Contact the doctor if the pain is not controlled by present strategies.

# Pain Management