Pain Care Goal Plan

Insert provider logo here

Resident's Name: Date of Assessment:

People involved:

Instructions: This care plan provides a summary of how we will work together to manage your pain so that you can do the things you would like to do.
Note to staff: Formulate goals that the resident wants to achieve through managing their pain (e.g. eliminating pain, reducing pain, being able to participate in certain activities, being able to increase movement or function etc.)

WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?

GOALS (specific or general)	**ACHIEVABLE GOALS (skip this step if the goals are already framed as realistic and attainable)**	**ACTIONS OR TREATMENTS (be specific)**	**TIMEFRAME**	**EVALUATION at Resident of the Day (Met/Unmet/Partially Met) & DATE**

USING THE PAIN CARE GOAL PLAN

The Pain Management Goal Plan promotes a person-centred approach, which focuses on ***what matters* to the resident**, rather than "*what is the matter* with them?". The template can be used to encourage residents to identify what they want to achieve from their pain treatment plan.

Staff can then assist residents to formulate goals that are achievable, individualised and person-centred and provide support. In order to ensure that goals are achievable and realistic, staff must consider the resident's health factors (e.g. severity of illness and diseases). There are five elements of the Pain Management Goal Plan to be completed.

Using the Pain Care Goal Plans

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1. **Goals:** Ask the resident what they want to achieve through pain management. These may be general (e.g. to feel comfortable most of the time) or specific (e.g. to be able to move without pain in order to participate in the gardening program).
2. **Achievable goals** (skip this step if the goals identified by the resident are already realistic and attainable): Some goals expressed by residents and family may not seem to be achievable by the care team. If so, it is important for staff to re-examine their own practice, to re-address both their own and the resident's expectations and to collaborate on formulating achievable goals. For example, if a resident wants to achieve complete elimination of their pain while beginning an exercise program, and this seems unachievable to the care team due to the severity of the resident's health condition, staff should work with the resident to formulate a strategy. In this case, the strategy may be to break up the goal into smaller steps.
3. **Actions or treatments** (be specific): Generate actions or treatments that will be put into place so that goals will be achieved. This should include specific therapies (non-pharmacological and pharmacological). Details of the actions/ therapies should be planned with the resident and noted (e.g. the resident will attend a physical therapy session for an hour once a week to strengthen muscles). Also specify the support available and quantify the actions (e.g. the PCA will provide encouragement and escort the resident for a walk each day).
4. **Timeframe**: Specify a time period for goals to be achieved. This will make it more likely that actions will be taken towards meeting goals. If some goals need to be actioned on an ongoing basis, note this and ensure evaluation and reassessment is also planned on an ongoing basis.
5. **Evaluation and date**: Review progress towards meeting the resident's pain care goal plan on a regular basis, as appropriate. This can be done as part of their existing planned pain assessments.

Who should talk to the resident about their pain management goals and complete the pain care goal plan?

The multidisciplinary care team should work with the resident to complete the pain care goal plan. Depending on the goals identified, certain members of the team should be consulted. Whichever staff member completes the goal plan with the resident should communicate information with the rest of the team to support what the resident has identified is important to them.

How should a discussion take place about the pain care goal plan?

Talking with residents and families should be exploratory rather than interrogational. It is a collaborative process and may require flexibility and creativity. You may need to reframe the discussion to help the resident express their goals if they have difficulty. You may rephrase questions, for example to 'what is important to you?' and 'what things would you like to do through reducing or eliminating your pain?'. Once what the resident has expressed has been translated into achievable goals, an individualised action plan can be created collaboratively.

How to make sure goals are achievable?

Residents' goals should be action-oriented. Some people may have broad or unrealistic goals. The SMART strategy may be useful:

SMART Goal Strategy

Specific: Target a specific care approach for improvement of pain. Being specific ensures that the goal is individualised for the resident.

Measurable: How will we know when the goal is achieved? Staff should quantify or at least suggest an indicator of progress.

Achievable: What results can be realistically achieved given available resources? Collaboration and advice from other staff members may be necessary (e.g. from the GP). Any barriers and solutions can be identified at this stage.

Relevant: The goal must be important to the resident, and any actions must take into account their wants and needs.

Time limited: Specify when the results can be achieved, and ensure to follow up when the specified time period is over.

Advanced topic: Goal Attainment Scaling (GAS)

The Pain Goal Plan is a simplified version of the Goal Attainment Scaling tool (GAS). GAS is a comprehensive and widely used tool for goal planning. The strength of GAS is that it quantifies the extent that a person's goals are being met. GAS is free to use but does requires some training.

Follow this link for more information: https://www.sralab.org/rehabilitation-measures/goal-attainment-scale