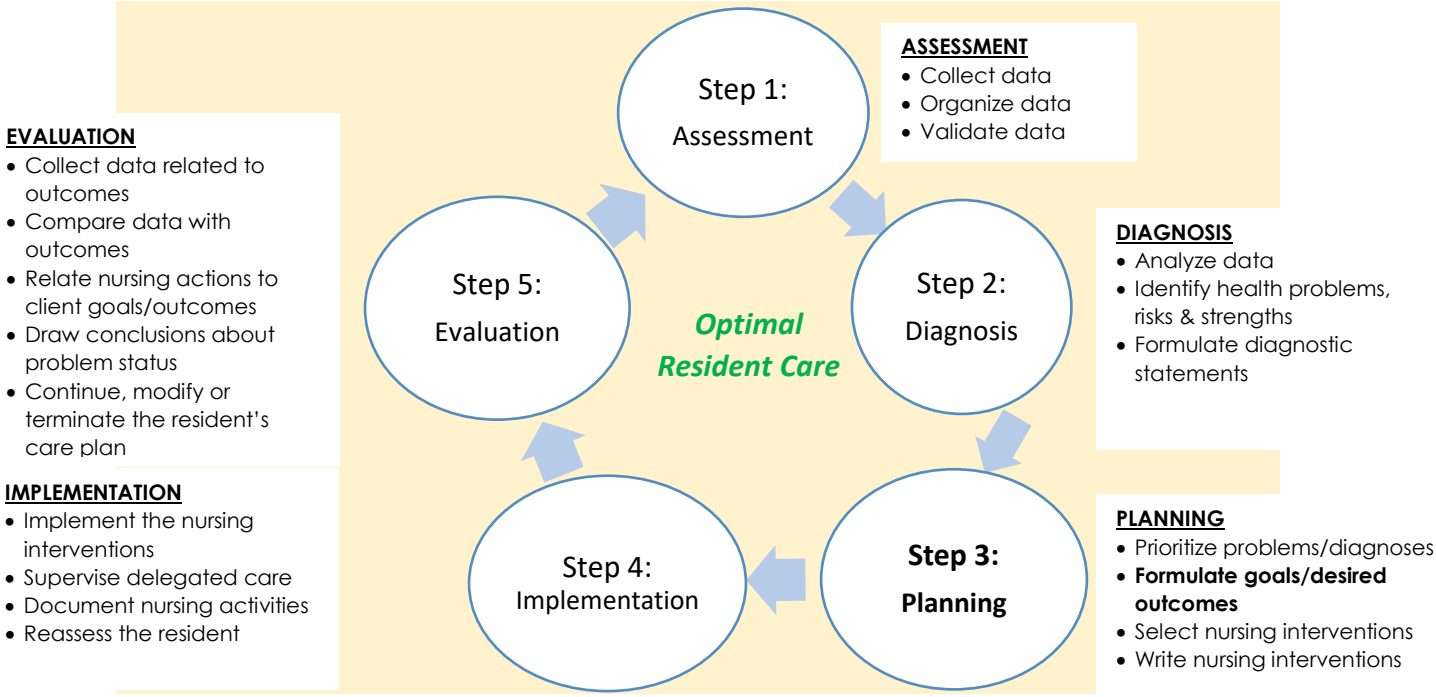
Goals of Care Resource Guide

Developing goals of care for a resident is one of the five-steps of the nursing process. These steps provide an invaluable tool in ensuring optimal resident care:



What are goals?

- Measures used to evaluate the resident's progress (outcome).
- Expected outcomes are what the resident, alternate decision-maker and interdisciplinary team set out to achieve.
- Statements that describe measurable behaviour of the resident, family or group that shows a favorable status (changed or maintained) after nursing care has been delivered.

Goals are how we measure what we're doing is helping to improve or maintain the resident's health

Tips for establishing goals:

- Be specific
- Make sure goals are achievable for the resident
- Measurable with a timeline
- Clearly identify if the goal is a long-term of short-term goal
- Set goals together with the resident and the alternate decision-maker

- Use verbs to describe what is to be achieved/maintained
- Identify if the goal is positive (i.e. something *will* happen) or negative (something *will not* happen)

Sample Goals of Care

Focus	Goals of Care
Activity/Exercise	Resident will maintain current ambulation ability
	Resident will not experience any decline in ambulation ability
	Resident will maintain current transfer ability
	Resident will not experience decline in transfer ability
	Resident will progress activity tolerance to:
	Resident will be able to climb one flight of stairs by:
	Resident will be able to walk to the dining room independently by:
	Resident will consistently use his/her walker to walk
	Resident will demonstrate improved exercise tolerance by:
	Resident will not be short of breath with transferring by:
	Resident will not be short of breath with ambulation by:
	Resident will be able to lift 1 pound hand weights by:
	Resident will not decline in his/her ability to move in bed independently
	Resident will maintain current bed mobility
	Resident will maintain current functional range of motion
	Resident will increase left knee range of motion to 90 degrees by:
	Resident will not experience pain with transfers
	Resident will turn and position without assistance
	Resident will not develop contractures of the elbows and knees
	Resident will state that he/she is comfortable during transfers
	Resident will not communicate fear during transfers
	Resident will demonstrate the use of adaptive devices to increase mobility
	Resident will participate physically and/or verbally in feeding/dressing/toileting/bathing activities
	Resident will demonstrate increased ability to dress self
	Resident will demonstrate ability to use adaptive devices to assist with dressing
Cognitive/Perceptual	Resident will relate an increase in psychological comfort
	Resident will demonstrate effective coping mechanisms in managing anxiety, as evidenced by (e.g. controlled breathing)
	Resident will demonstrate fewer acting-out episodes by:
	Resident's vital signs will remain within normal limits (e.g. heart rate, blood pressure, respiratory rate)

Focus	Goals of Care
Cognitive/Perceptual (continued)	Resident will state that his/her feelings of apprehension/ fear/helplessness have lessened
	Resident will experience decreased frequency of hallucinations from: to:
	Resident will continue to be free of mood or behavioural disturbances
	Resident will demonstrate change in behaviour through:
	Resident will express positive statements about self
	Resident will express positive statements about current capacity
	Resident will express one positive statement daily
	Resident will experience reduced number of incidents related to:
	Resident will demonstrate less sexually inappropriate behaviour
	Resident will reduce number/attempts to leave the building/premises
	Resident will reduce the frequency of dangerous behaviour towards other residents
	Resident will reduce the frequency of room entering to other resident's rooms
	Resident will report less frustration with changing cognitive abilities
	Resident will make decisions about: independently
	Resident will maintain current cognitive abilities
	Resident will read the newspaper out loud by:
	Resident will experience decreased episodes of confusion
	Resident will not develop delirium
	Resident will have diminished episodes of combativeness
	Resident will participate to the maximum level of independence in a therapeutic milieu
	Resident will have decreased frustration when environmental stressors are reduced
	Resident will not have any episodes of combative behaviour
	Resident will increase hours of sleep at night
	Resident's weight will stabilize or increase
	Resident will verbalize feelings related to his/her emotional state
	Resident will identify personal strengths and accept support through the nursing relationship
	Resident will develop/improve/maintain positive relationships with others
	Resident will exhibit peace and comfort with situation
	Resident will demonstrate control of behaviour with assistance from others
	Resident will have a decreased number of violent responses
	Resident will report an increase in enjoyable activities

Focus	Goals of Care
Elimination	Resident will communicate the need to have a bowel movement to staff
	Resident will evacuate a soft formed stool every other day or every third day
	Resident's clothing will be protected from soiling due to either bowel or bladder incontinence
	Resident's skin integrity will be maintained
	Resident will toilet him/herself independently
	Resident will demonstrate ability to use adaptive devices to facilitate toileting
	Resident will void on the toilet with assistance from nursing staff
	Resident will achieve a state of dryness that is personally satisfactory
Intake	Resident will increase intake of fluids to a specified amount according to age and metabolic needs
	Resident will not demonstrate signs and symptoms of dehydration
	Resident's edema will resolve by:
	Resident will not demonstrate signs and symptoms of edema
	Resident will not experience aspiration
	Resident's intake will be sufficient to maintain a target body weight
	Resident will ingest daily nutritional requirements in accordance with his/her activity level and metabolic needs
	Resident will describe the rationale for an altered texture diet
	Resident will lose x kg/lbs by:
	Resident will make healthy food choices
	Resident will demonstrate an increased ability feed him/herself
	Resident will demonstrate an increased ability to use adaptive devices
	Resident will demonstrate an increased interest and desire to eat
Family/Caregiver	Resident's family will report decreased caregiver role strain
	Resident's family will report a positive relationship with the resident
	Resident's family will not mistreat the resident
	Resident's family will provide support to the resident
Comfort/Safety	Resident will report decreased symptoms of (e.g. nausea, vomiting, pruritis)
	Resident will not display signs of pain as evidenced by (decreased guarding/crying/moaning/blood pressure/pulse)
	Resident will report satisfactory pain relief
	Resident's behaviour will improve/settle in response to pain-relieving measures
	Resident will communicate his/her pain to nursing staff

Focus	Goals of Care
Comfort/Safety (continued)	Resident will participate in activities that stimulate and balance physical, cognitive, affective and social domains
	Resident will wash his/her hands before meals
	Resident will relate the need for isolation
	Resident will wear his/her corrective lenses as needed
	Resident's room will be clutter free
	Resident will not hoard food items in his/her room
	Resident verbalize one positive aspect of the move to the PCH
	Resident will express concerns regarding the move to the PCH
	Resident's alternate decision-maker will share in decision-making regarding the new environment
	Resident's alternate decision-maker will participate in care planning with the resident
	Resident will become involved in activities in the PCH
	Resident will report adjustment to living in the PCH without physiologic or psychological disturbances
	Resident will report an optimal balance of sleep and activity
	Resident will sleep x hours uninterrupted
Communication	Resident will resolve conflicts with staff/residents as evidenced by:
	Resident will show decreased resistance/refusals to care as evidence by:
	Resident will make 2-3 simple needs known daily
	Resident will make eye contact in response to his/her name
	Resident will remain alert to person, place, time, family/staff, general surrounding
	Resident will respond to simple yes/no questions
	Resident will validate understanding of verbal communication
	Resident's needs will be anticipated and met as evidenced by:
	Resident will communicate his/her needs by:
	Resident will be able to make needs known by:
	Resident will communicate his/her needs using a communication board
	Resident will demonstrate an improved ability to express him/herself as evidenced by: by:
	Resident will report decreased frustration with communication
	Resident will wear a hearing aid
	Resident will communicate using a notebook for writing messages
	Resident will demonstrate preferences in self-care activities (e.g. time, products, location)
	Resident will demonstrate optimal hygiene after assistance with care

Focus	Goals of Care
Lifestyle	Resident will acknowledge an alcohol/drug abuse problem
	Resident's use of alcohol will decrease by xx (state amount)
	Resident will use alcohol safely in a supervised environment
	Resident will reduce the number of cigarettes smoked each day from: to:
	Resident will use nicotine replacement therapy instead of smoking by:
	Resident will stop smoking by:
	Resident will decrease tobacco use from: to: by:

REFERENCE:

Morris, K (2006). Using the decision-making process, Vol 6, 22-23. Cited on Canadian Nurses Association Website. Retrieved on September 23, 2024 from: Application of the nursing process in a complex health care environment (cna-aiic.ca)