EXEMPLAR
OF PDOC STANDARDISED OBJECTIVES SHEET

This PDOC standardised objective sheet is an exemplar of the current tool used in routine clinical practice at the Regional Hyper-acute Rehabilitation Unit (RHRU), Northwick Park Hospital

The PDOC standardised objectives are a baseline for team discussion on the needs of the individual patient, and are primarily "process focussed" to ensure clinical issues are considered/addressed.
The wordings of the objectives are "broad" to facilitate interpretation as appropriate to individual patient needs.

Specialist rehabilitation units may modify this exemplar or develop their own local tool to support best practice and for data capture.

The PDOC standardised objectives, are used in conjunction with family selected goals (GAS SMART goals) and reviewed alongside them

The PDOC standardised objectives were developed from original objectives initiated by Professor Lynne Turner-Stokes.

Patient name: ……

NHS No:……

Putting patients at the HEART of everything we do

NHS
London North West University Healthcare
NHS Trust

Admission Date: Discharge Date:

Key worker:

STANDARDISED OBJECTIVE SET FOR PDOC PROGRAMME (Version 7) - TO BE ACHIEVED BY DISCHARGE DATE

Level of ability:	**Probability** of achieving (professionals): score,	**Goal attainment score**
If the objective is being set record "S" for "some ability" or "N" for "no ability"	Doubtful = 1 Possible = 2 Probable = 3	+1 = more than expected/overachieved +2 = much more than expected/significantly overachieved

COMMON THERAPEUTIC OBJECTIVES - MINIMUM DATA SET

		DATE SET:			DATE ACHIEVED:				
	Level of ability	Objective NOT SET as		Objective Set	Achieved				
	"Some/ No Ability"	Already Able	N/A	Probability	No	Partial	Achieved	A little +1	A Lot +2
Nutrition:									
To establish suitable feeding regimen (e.g. via gastrostomy)									
To achieve or maintain BMI within range (……to ……)									
To assess feasibility of oral feeding (e.g. tastes for pleasure)									
Respiratory Function:									
O R To establish tracheostomy management programme									
O R To de-cannulate tracheostomy									
Skin Integrity:									
O R Maintain skin integrity									
O R To reduce/heal existing wound(s)									
Continence:									
To manage urinary continence using catheter/convene/pads									
To manage faecal continence (opening bowels with established routine)									
Sleep Hygiene:									
To achieve a minimum block of 3-4 hours sleep at night									
Personal Care									
To maintain oral hygiene									
Postural Management:									
To establish 24 hour postural programme									
To sit in an appropriate seating system for 4 hours/day									
To identify and supply suitable seating/wheelchair									
To increase and/or maintain joint range									
Pain and Mood:									
To assess for evidence of pain behaviour									
To assess for evidence of depression/anxiety									

Patient name: **NHS no:**	**Level of ability**	**Objective NOT SET as**		**Objective Set**	**Achieved**				
Medical Stability:	**"Some/ No Ability"**	**Already Able**	**N/A**	**Probability**	**No**	**Partial**	**Achieved**	**A little +1**	**A Lot +2**
To optimise medical condition/stability									
To reduce pain (from .....[current score] to .....[target score])									
To reduce depression/anxiety (from.....[current score] to. .....[target score])									
Communication:									
To assess communication level									
PDOC Diagnosis:									
To establish PDOC diagnosis using WHIM, CRS-R (and/or SMART)									
To establish sensory stimulation programme (involving family if possible)									
To establish an orientation programme									
Behaviour Management:									
To manage agitated behaviour									
Social Interaction/Quality of Life:									
To improve opportunities for social interaction/quality of life									
Family support:									
To provide information for family regarding condition/prognosis									
To provide counselling/support for family members									
Best Interest Decision:									
To assess and document mental capacity for care and treatment									
To establish resuscitation status									
To hold best interest meetings regarding care and treatment (including ceiling of care where appropriate)									
Financial									
To provide financial advice on work withdrawal/medical retirement									
To advise on financial benefits and assist with applications									
Medicolegal:									
To provide medicolegal assessment/reports as required									
Discharge/care Planning:									
To prepare a care booklet for handover to on-going care team									
O To discharge **Home** with a suitable care package									
R To discharge to **Nursing Home** care									
To discharge to **another unit/back to referrer**									
To provide an **end of life care** programme									

Diagnosis on Discharge: **Continuing VS** ☐ **Permanent VS** ☐ **Continuing MCS** ☐ **Permanent MCS** ☐ **Patient died** ☐ **Emerged** ☐ **Date emerged**_____