November 28, 2025

Research Centre

We RPN
Registered Practical Nurses Association of Ontario

Co-designed tools for data-informed, goal-oriented care planning with older adults in transitional care

WeRPN Symposium

Presenters: Margaret Saari RN, PhD & Lisa Herron, RPN

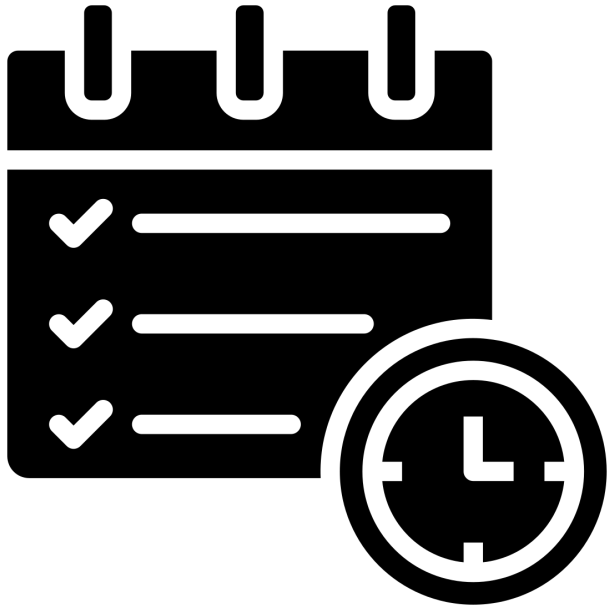
Research Team: Celina Carter RN, PhD, Valentina Cardozo MSc, Justine Giosa PhD, Alzahra Hudani PhD, Lisa Herron RPN, Margaret Saari RN, PhD

Agenda for Today

Objectives:

- ✓ **Learn** about two tools co-designed with clients, caregivers and care providers to support data-informed, person-centered transitional care for older adults
- ✓ **Apply** these tools through interactive activities and provide feedback on their usability and relevance

TIME	TOPIC
5 min	Project Background
15 min	Overview and interaction with the co-designed tools • Tool 1: What Matters Most to You? • Tool 2: the Life Care Goal Agreement
5 min	Next steps & Wrap Up



Project Overview

Purpose: To co-design point-of-care tool(s) to support goal-oriented, data-informed, person-centred care planning in community-based transitional care programs in Ontario.

Set Up
Jul-Sep

Establish a **Learning Community** of experts-by-experience to guide:

- project direction
- diverse community engagement
- review of study materials
- knowledge mobilization

Learn
Oct - Mar

Explore RPNs' perceptions of **successes and challenges** related to conducting the interRAI HC assessment and **using assessment data at point-of-care**

8 interviews with RPNs

Design
Apr - May

Develop **prototype tool(s)** to better equip RPNs to engage in **goal-oriented data-informed, person-centred care planning** at point-of-care.

2 Workshops with transitional care providers, clients and caregivers

Learn: Why Focus on Goal Setting?

- There is considerable variation in how RPNs approach goal setting, and many were **looking for support to confidently lead these goal-setting conversations.**

- RPNs could benefit from support with:
  - ✓ Engaging in goal setting conversations to drive care planning
  - ✓ Setting realistic expectations of clients and families
  - ✓ Using goals to prioritize care needs
  - ✓ Encouraging client engagement in care

Themes

RPNs engage in data-informed care planning drawing on interRAI HC assessment data

Successes

interRAI assessment outputs support development of goal-oriented holistic care plans; and the interRAI HC assessment and outputs support dynamic care planning over the course of the @Home Program.

Challenges

Obstacles to engaging in conversational goal setting to drive care plan development; difficulty combining clinical judgement with interRAI assessment outputs in care planning process; and individual and system barriers can impede needs-based care planning.

Goal Setting: A Three-Step Process

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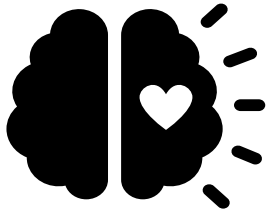
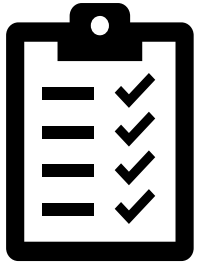
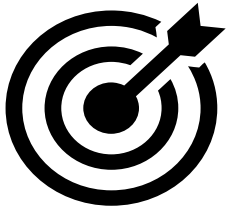
- A **collaborative process** of agreement on health- or life-related goals between a care provider and a client.
- Should focus on **forming clear and realistic goals that help the person live the life they want**, in a way that makes sense for their needs, values and daily life.



1. Exploration:
understanding "what matters most" to the client as individual



2. Sharing Information:
clear, open communication with the client about their health and social care needs centered on what matters most to them



3. Setting Goals:
where the client and care provider work together to set goals through supportive conversations

Lenzen et al, 2018

Life Care: A Holistic Definition of Health

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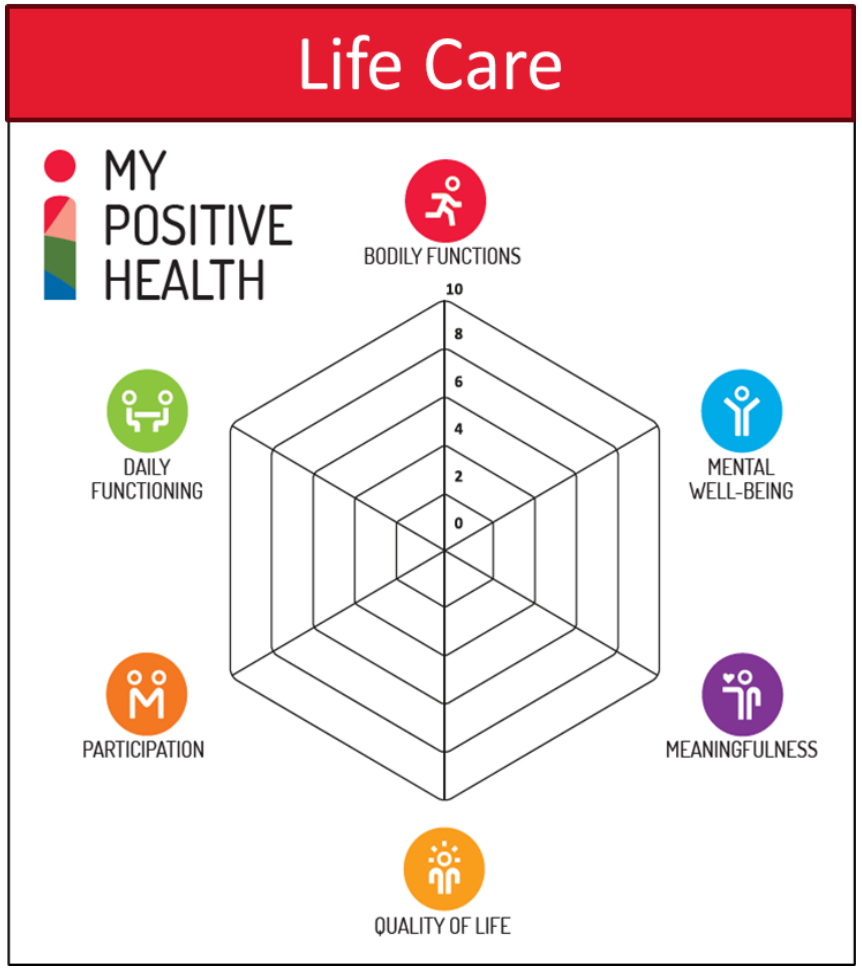
Frames assessment and care planning holistically, not just as a clinical task but as a **core value** and **practice expectation**

My Positive Health includes dimensions typically associated with “health” but also considers social participation, quality of life and meaningfulness

Life Care Asks:

- What matters to you?
- What supports your ability to live well?
- How do we plan care in a way that reflects that?



Design: Co-design Workshop Participants

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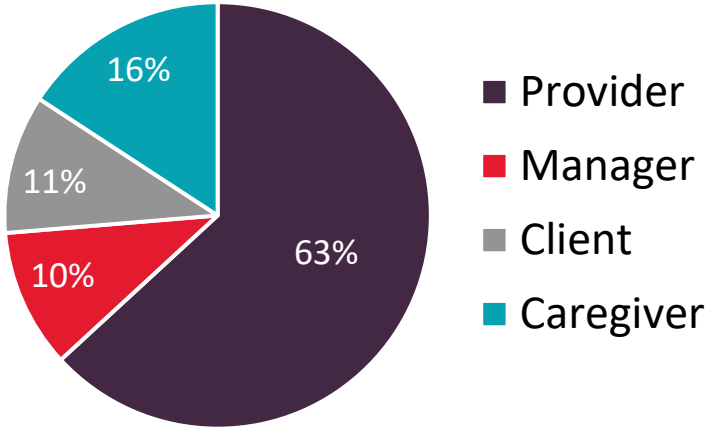
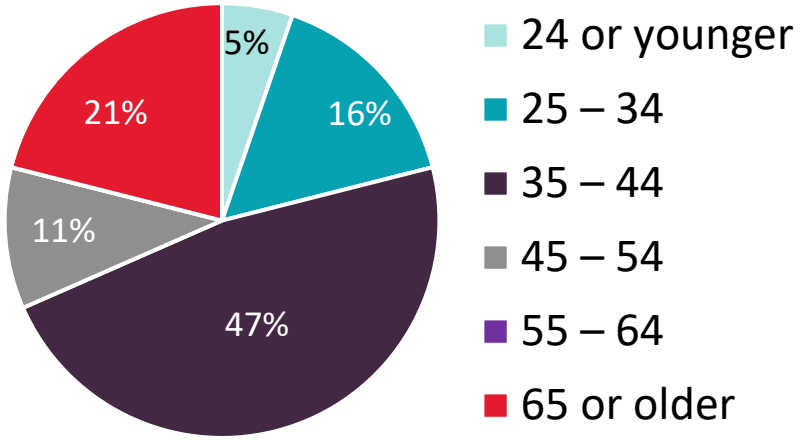
19 participants (Workshop 1 n= 13, Workshop 2, n=14)

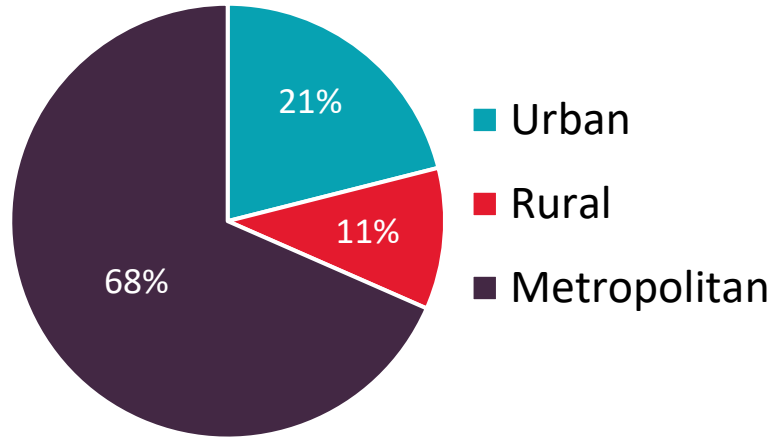
Perspectives



Age Group



Location



7 RPNs, 4 RNs, 1 PT, 1 PSW, 1 OT with representation across 6 @Home Programs

- **53% identified as a visible minority**
- **11% identified as 2SLGBTQ+**
- **84% identified as a women**

Design: Workshop Activities

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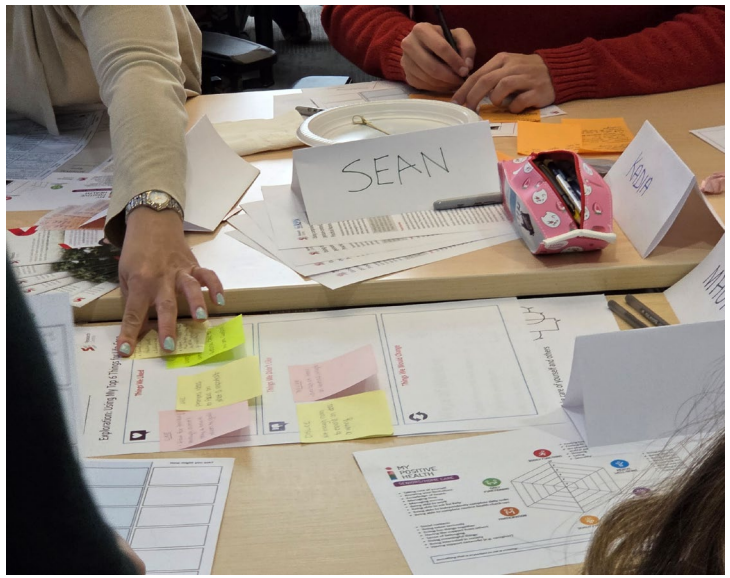
WORKSHOP 1

- **Activity 1**. My Top 6 things for Life Care: Setting the Stage for Shared Goals
- **Activity 2.** The Life Care Goal Agreement: Moving from Values to Goals

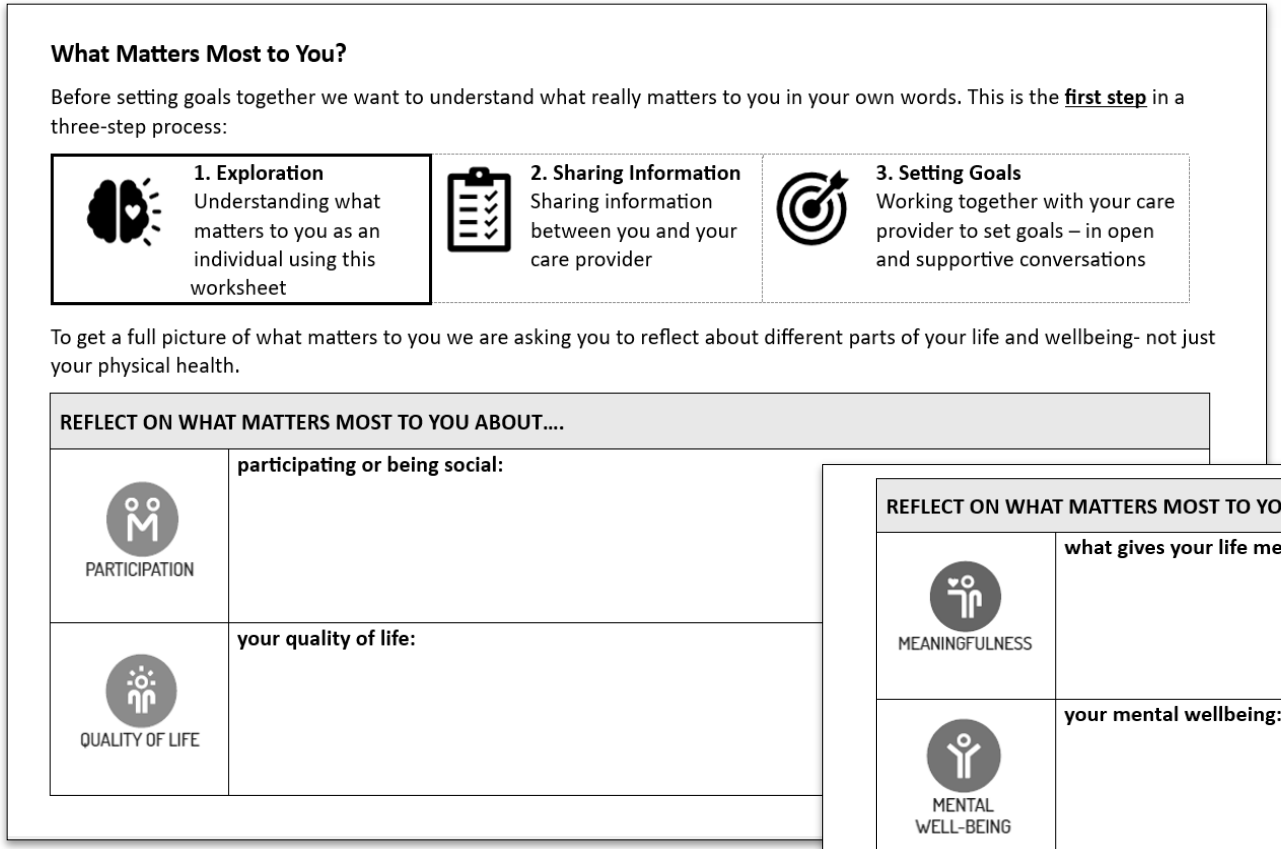


WORKSHOP 2

- **Activity 3.** From Ideas to Action: Integrating the Tools Into Practice

Overview of Tool 1: What Matters Most to You?

- Supports **Exploration** step of goal setting by guiding structured reflection on what matters to the client as an individual (i.e., **elicit client values**)
- Organized based on **My Positive Health dimensions,** taking a holistic approach care planning
- Serves as a **foundation for goal-setting** with clients



What Matters Most to You?

Before setting goals together we want to understand what really matters to you in your own words. This is the **first step** in a three-step process:

1. Exploration	2. Sharing Information	3. Setting Goals
Understanding what matters to you as an individual using this worksheet	Sharing information between you and your care provider	Working together with your care provider to set goals – in open and supportive conversations

To get a full picture of what matters to you we are asking you to reflect about different parts of your life and wellbeing- not just your physical health.

REFLECT ON WHAT MATTERS MOST TO YOU ABOUT….	
PARTICIPATION	**participating or being social:**
QUALITY OF LIFE	**your quality of life:**

REFLECT ON WHAT MATTERS MOST TO YOU ABOUT….	
MEANINGFULNESS	**what gives your life meaning/purpose:**
MENTAL WELL-BEING	**your mental wellbeing:**
DAILY FUNCTIONING	**what you need or want to do daily:**
BODILY FUNCTIONS	**your body and how you live in it:**

Tool 1 Activity Instructions: What Matters Most to You?

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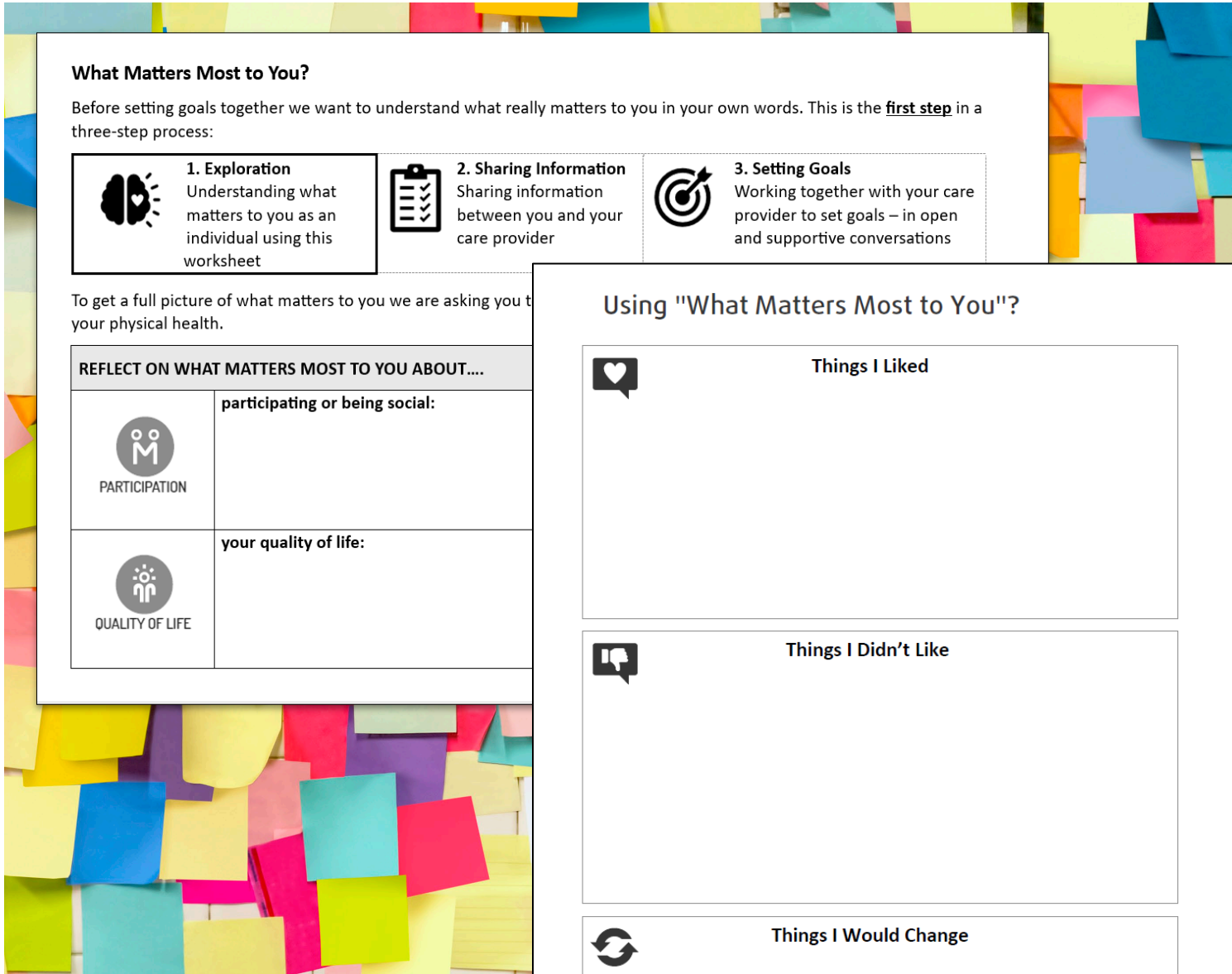
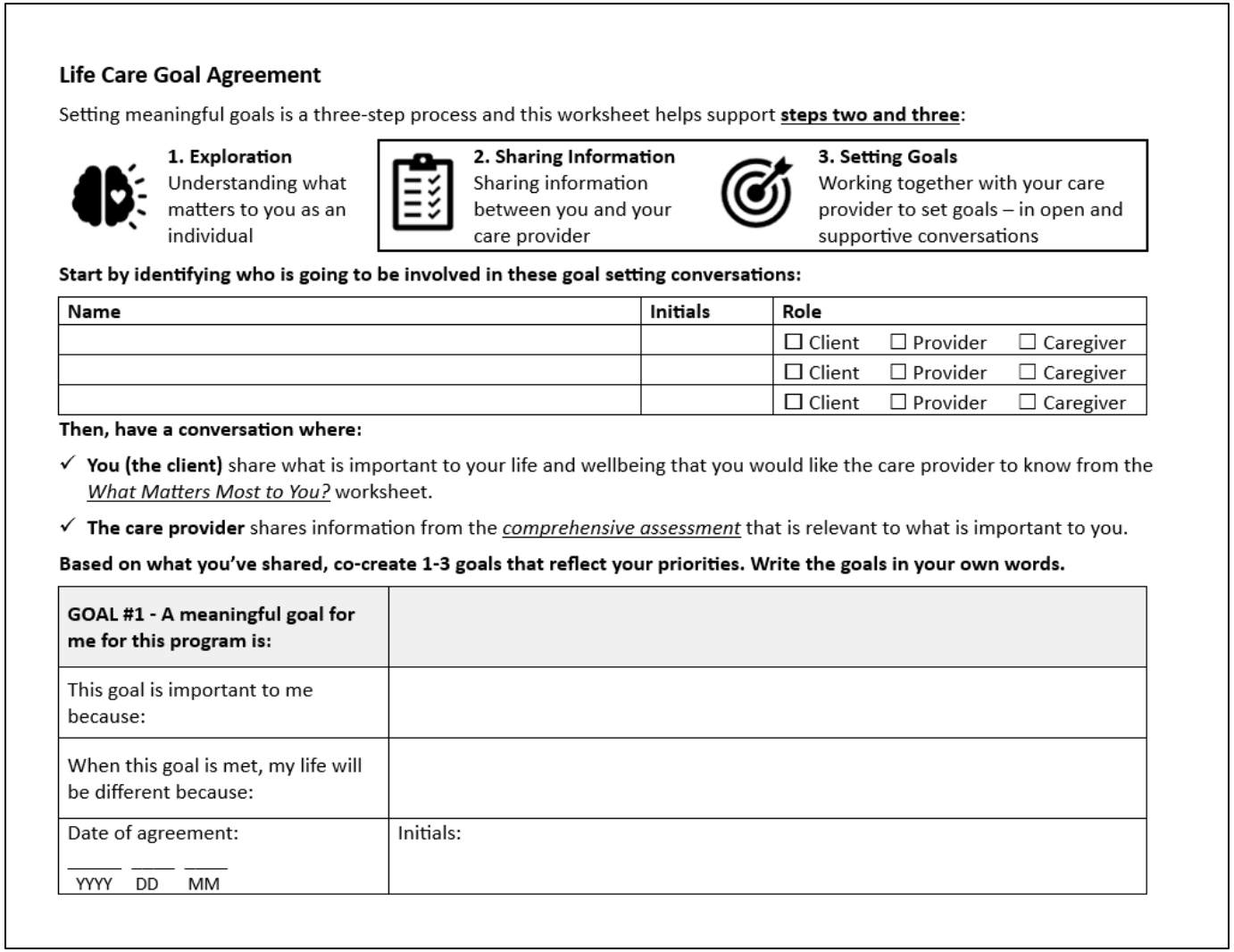
1. Imagine that you were using this tool to explore what matters most to you as an individual
2. Use the sticky notes on your table to note what you liked, disliked and would change if you were using this tool



Overview of Tool 2: the Life Care Goal Agreement

- Structure for leading goal setting conversation guided by information from “What Matters Most to You?” (client values) and the InterRAI assessment (client needs).
- Ensures that the client and provider are involved in goal setting and share a mutual understanding/ accountability for meaningful client goals.



Life Care Goal Agreement

Setting meaningful goals is a three-step process and this worksheet helps support **steps two and three**:

1. Exploration
Understanding what matters to you as an individual

2. Sharing Information
Sharing information between you and your care provider

3. Setting Goals
Working together with your care provider to set goals – in open and supportive conversations

Start by identifying who is going to be involved in these goal setting conversations:

Name	Initials	Role
		☐ Client ☐ Provider ☐ Caregiver
		☐ Client ☐ Provider ☐ Caregiver
		☐ Client ☐ Provider ☐ Caregiver

Then, have a conversation where:

✓ **You (the client)** share what is important to your life and wellbeing that you would like the care provider to know from the *What Matters Most to You?* worksheet.

✓ **The care provider** shares information from the *comprehensive assessment* that is relevant to what is important to you.

Based on what you’ve shared, co-create 1-3 goals that reflect your priorities. Write the goals in your own words.

GOAL #1 - A meaningful goal for me for this program is:	
This goal is important to me because:	
When this goal is met, my life will be different because:	
Date of agreement: ____ ____ ____ YYYY DD MM	Initials:

Tool 2 Activity Instructions: the Life Care Goal Agreement

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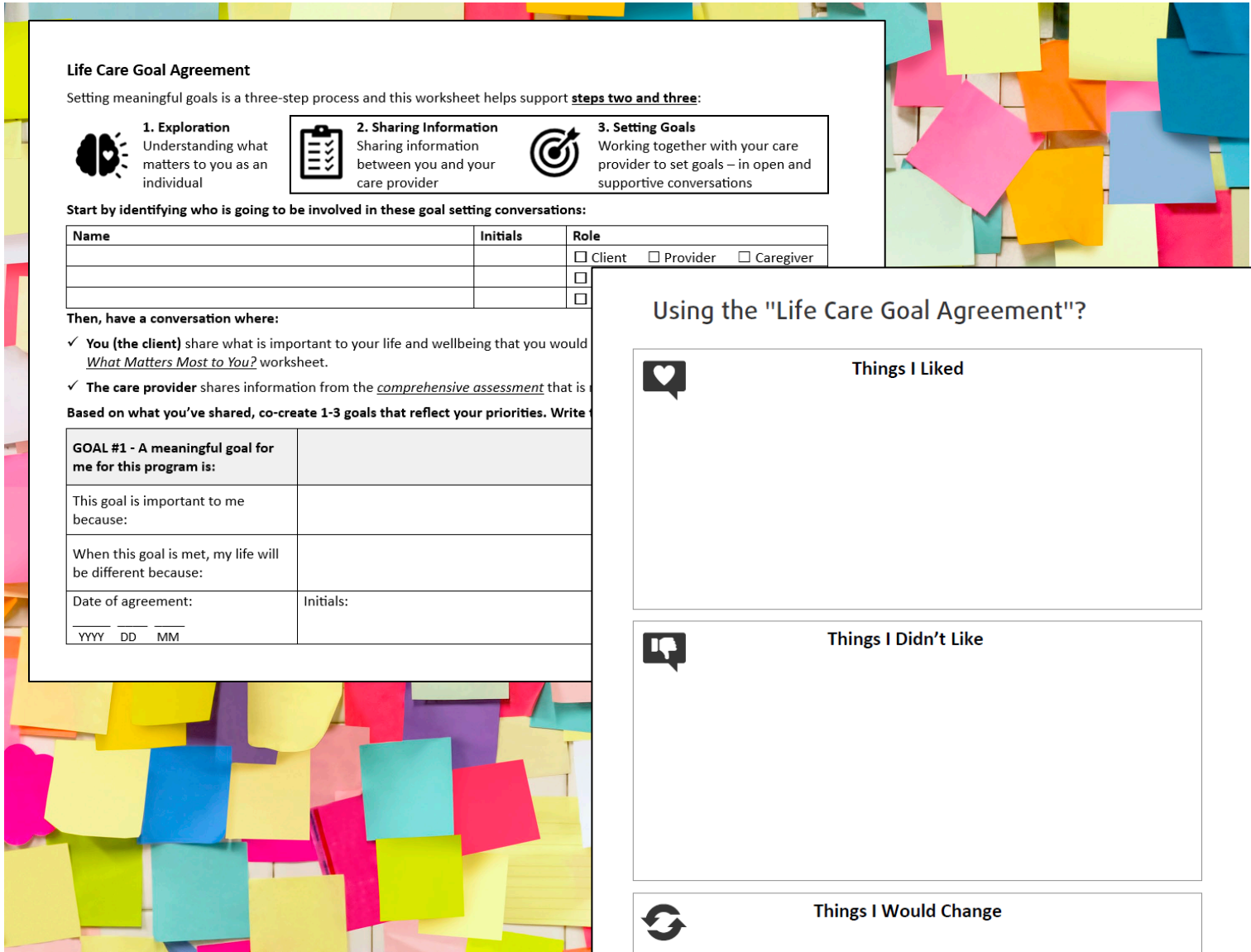
1. Imagine that you were using this tool to set meaningful goals with a client.
2. Use the sticky notes on your table to note what you like, dislike and would change if you were using this tool.



Life Care Goal Agreement

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		☐
		☐

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✓ **The care provider** shares information from the *comprehensive assessment* that is

Based on what you've shared, co-create 1-3 goals that reflect your priorities. Write

GOAL #1 - A meaningful goal for me for this program is:	
This goal is important to me because:	
When this goal is met, my life will be different because:	
Date of agreement: ____ ____ ____ YYYY DD MM	Initials:

Using the "Life Care Goal Agreement"?

Things I Liked

Things I Didn't Like

Things I Would Change

Next Steps

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Assess the feasibility of integrating the co-designed tools to support data informed, person-centred care planning by nurses in community-based transitional care programs.

Do you have other ideas on where to test these tools?

Please connect with us after the session or email research@sehc.com

Take Aways

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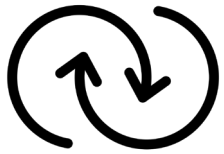
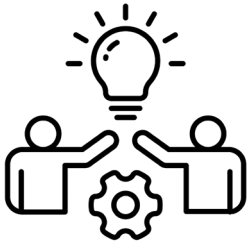


Integrating client's values with data from standardized assessments is critical for setting meaningful, data-informed, person-centred goals with clients.

"What Matters Most to You?" sets a foundation for goal setting by taking a holistic approach to elicit client values.



"The Life Care Goal Agreement" integrates client values with assessment data to support collaborative, conversational goal setting with shared accountability.

Together the co-designed tools aim to support goal setting, minimize assessment duplication and enhance effective, person-centred care planning.

SUPPLEMENTARY

interRAI Data to Support Goal Setting

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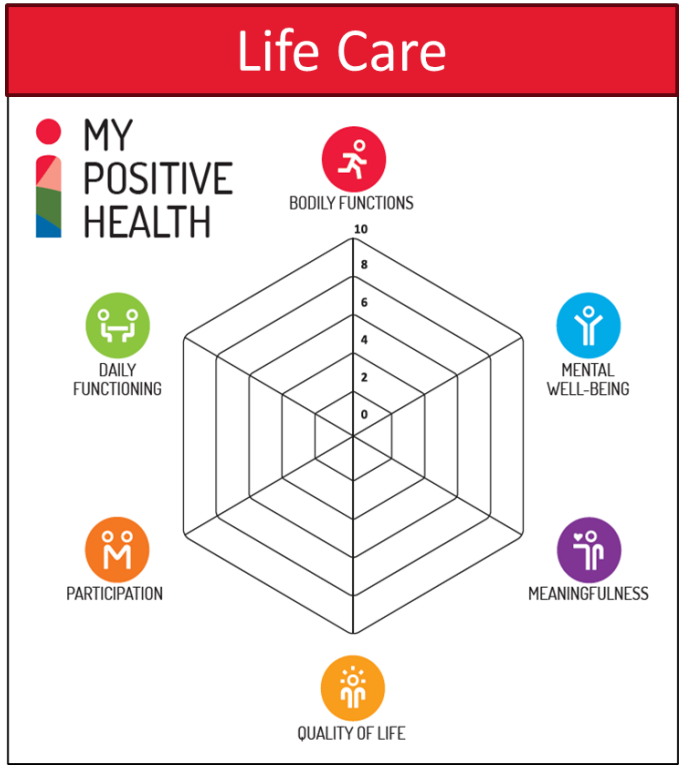

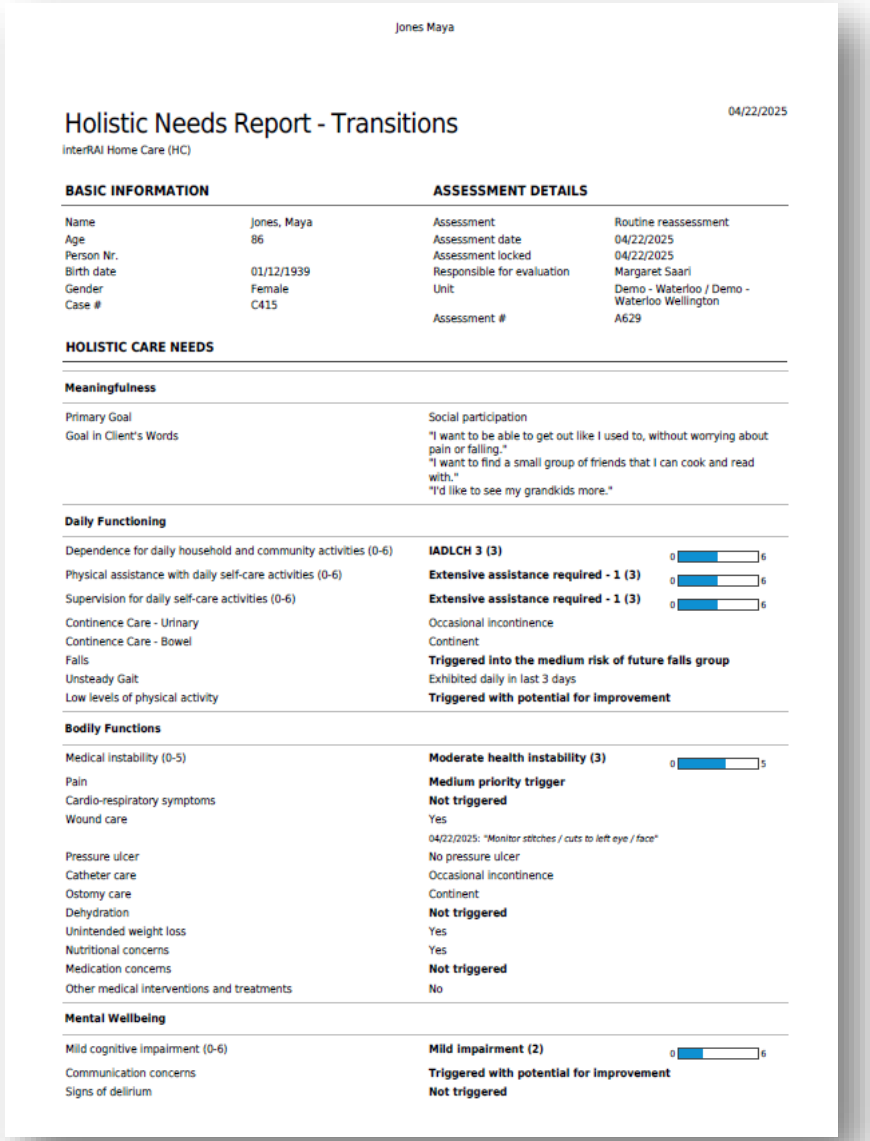

Jones Maya

Holistic Needs Report - Transitions

04/22/2025

interRAI Home Care (HC)

BASIC INFORMATION

Name	Jones, Maya
Age	86
Person Nr.	
Birth date	01/12/1939
Gender	Female
Case #	C415

ASSESSMENT DETAILS

Assessment	Routine reassessment
Assessment date	04/22/2025
Assessment locked	04/22/2025
Responsible for evaluation	Margaret Saari
Unit	Demo - Waterloo / Demo - Waterloo Wellington
Assessment #	A629

HOLISTIC CARE NEEDS

Meaningfulness

Primary Goal	Social participation
Goal in Client's Words	"I want to be able to get out like I used to, without worrying about pain or falling." "I want to find a small group of friends that I can cook and read with." "I'd like to see my grandkids more."

Daily Functioning

Dependence for daily household and community activities (0-6)	**IADLCH 3 (3)**
Physical assistance with daily self-care activities (0-6)	**Extensive assistance required - 1 (3)**
Supervision for daily self-care activities (0-6)	**Extensive assistance required - 1 (3)**
Continence Care - Urinary	Occasional incontinence
Continence Care - Bowel	Continent
Falls	**Triggered into the medium risk of future falls group**
Unsteady Gait	Exhibited daily in last 3 days
Low levels of physical activity	**Triggered with potential for improvement**

Bodily Functions

Medical instability (0-5)	**Moderate health instability (3)**
Pain	**Medium priority trigger**
Cardio-respiratory symptoms	**Not triggered**
Wound care	Yes 04/22/2025: *"Monitor stitches / cuts to left eye / face"*
Pressure ulcer	No pressure ulcer
Catheter care	Occasional incontinence
Ostomy care	Continent
Dehydration	**Not triggered**
Unintended weight loss	Yes
Nutritional concerns	Yes
Medication concerns	**Not triggered**
Other medical interventions and treatments	No

Mental Wellbeing

Mild cognitive impairment (0-6)	**Mild impairment (2)**
Communication concerns	**Triggered with potential for improvement**
Signs of delirium	**Not triggered**

- **Summary report** of client care needs based on interRAI Home Care assessment data
- Based on research on **care needs in home care** populations
- Organized based on **My Positive Health dimensions**
- Includes **client goal(s)** in their own words

Interviews with RPNs

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	Training RPNs to complete interRAI HC assessments in @Home Programs according to assessment standards	interRAI HC assessment processes within @Home Programs	RPNs engage in data-informed care planning drawing on interRAI HC assessment data	The integration of interRAI HC data supports interprofessional collaboration in @Home Programs
Themes				
Successes	Having a culture of mentorship and continuous learning supports RPNs in conducting interRAI HC assessments.	RPNs follow assessment standards when completing interRAI HC assessments.	interRAI assessment outputs support development of goal-oriented holistic care plans; and the interRAI HC assessment and outputs support dynamic care planning over the course of the @Home Program.	interRAI outputs support decision-making about interdisciplinary team member involvement to support deliver of holistic care; and frequent and consistent team communication supports better care planning and delivery
Challenges	RPNs desire additional training in how to conduct interRAI HC assessments based on assessment standards.	Uncertainty about the priority of the interRAI assessment within existing care tasks; Individual and infrastructure barriers complicate the assessment process; and Practice-knowledge gaps in steps required to accurately capture assessment information.	Obstacles to engaging in conversational goal setting to drive care plan development; difficulty combining clinical judgement with interRAI assessment outputs in care planning process; and individual and system barriers can impede needs-based care planning.	Missed opportunities for team-based care planning limits team members' ability to meet client's needs