Rehabilitation Goal Training

Participant Workbook
Acknowledgements

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# TABLE OF CONTENTS

1. **INTRODUCTION** 1
   1.1 Training Objectives 1
   1.2 Training Structure 2

2. **REHABILITATION MODEL OF CARE** 3

3. **ENABLEMENT APPROACH** 6

4. **DEFINITIONS** 9

5. **THE ROLE OF GOAL SETTING IN REHABILITATION** 12
   5.1 Benefits of Goal Setting on Patient Participation 12
   **Activity 1.** 13
   5.2 Benefits of Goal Setting for Planning within a Team Context 15
      5.2.1 Team Collaboration 16
      5.2.2 Measuring Goal Achievement to Inform Clinical Planning 18
   5.3 Revision Exercise 1 21

6. **FACTORS THAT INFLUENCE GOAL SETTING IN REHABILITATION** 22
   6.1 Patient Factors that Influence Goal Setting in Rehabilitation 22
      6.1.1 Patient centred Goal Setting 22
      6.1.2 Patient Factors that Influence Patient Engagement in Goal Setting 23
      6.1.3 Continuum of Patient Engagement in Goal Setting 26
   6.2 Levels of Patient Goals 29
      6.2.1 The International Classification of Functioning, Disability and Health (ICF) 29
      6.2.2 Levels of Rehabilitation Goals Using ICF Framework 30
   **Activity 2** 34
   6.3 Approaches to Rehabilitation that Influence Goal Setting 36
   6.4 Revision Exercise 2 41

7. **ASSESSING THE QUALITY OF REHABILITATION PATIENT GOALS** 42
   7.1 SMARTAAR Goal Process 42
   7.2 Elements of High Quality SMARTAAR Goals 43
      7.2.1 Elements of SMART Goals 43
   **Activity 3** 48
      7.2.2 The AAR Elements of the SMARTAAR Goal Process 50
      7.2.3 Additional Criteria for High Quality Goals 53

8. **THE SMARTAAR GOAL WORKSHEET** 56
   8.1 Scope and Limitations of the SMARTAAR Goal Worksheet 56
      8.1.1 What type of goals can I use it for? 58
      8.1.2 How SMART does a goal need to be? 58
      8.1.3 How long will I need to use it? 59
   8.2 How to Use the SMARTAAR Goal Worksheet 61
      8.2.1 Using the SMARTAAR Goal Worksheet: Instructions for CLINICIANS 62
List of Tables

Table 1 Relevant Model of Care principles and examples of service checkpoints ........................................ 5
Table 2 The traditional approach and an enablement approach to health care ............................................ 7
Table 3 Factors affecting patient engagement in goal setting ..................................................................... 24
Table 4 Strategies and tools to engage patients in a rehabilitation goal setting process ............................. 25
Table 5 Examples of impairment, activity and participation level goals ..................................................... 31
Table 6 Elements of a goal that could be used to make it measureable ..................................................... 46
Table 7 Examples of goal achievement rating scales .................................................................................. 52
Table 8 Tips for using SMARTAAR Goal Worksheet ................................................................................ 63
Table 9 Application of high quality, goal setting principles in rehabilitation plan template ....................... 78
Table 10 Example of patient rehabilitation plan 1 (first plan) ..................................................................... 79
Table 11 Example of patient rehabilitation plan 2 (second plan) ............................................................... 80
Table 12 Tips for incorporating patient goals into Rehabilitation Plan template ..................................... 81

List of Figures

Figure 1 The guiding principles and defined care settings of the Rehabilitation Model of Care .......... 4
Figure 2 The relationship between patient goal, patient steps and action plans ..................................... 10
Figure 3 An example of how a patient’s goal will direct rehabilitation plans ........................................ 16
Figure 4 The difference between a clinician-driven treatment plan and a patient goal-driven treatment plan .................................................................................................................. 17
Figure 5 Influences on the activities/tasks that people choose ................................................................ 23
Figure 6 The ICF conceptual model (WHO 2001) ..................................................................................... 30
Figure 7 The relationship between goal setting and participation / activity / impairment level goals and assessment results ......................................................................................................... 33
Figure 8 Impact of clinician-driven and client goals-driven treatment plans on team collaboration and planning .................................................................................................................. 37
Figure 9 An example of the contribution of different disciplines to a patient’s participation level goal ................................................................................................................................. 38
Figure 10 The use of patient generated, patient focused and clinician generated goals in rehabilitation plans .......................................................................................................................... 73
Figure 11 An example of a patient generated goal and its relevant patient focused steps ................... 74
Figure 12 An example of a goal setting process within rehabilitation units / teams ............................. 90
Figure 13 An example of a goal setting process for single discipline clinicians / sole workers .......... 92
1. Introduction

The Rehabilitation Goal Training Workshops are an activity of the NSW Agency for Clinical Innovation (ACI). The ACI Rehabilitation Network recognises the need for clinicians to have a greater understanding of the role and use of goals in rehabilitation, and that goal training can facilitate communication between clinical services by providing a common approach to communicating goals.

Although goal setting is an essential part of rehabilitation, it is typically neglected in undergraduate training, and variations in practice may be taught in different professions. This training aims to provide clinicians with increased knowledge and skills to enable them to develop and use high quality rehabilitation goals in practice. Consistent high quality goal setting will reduce the likelihood that inadequacies in goal setting will compromise patient care – such as limiting patient motivation, impeding treatment planning and compromising communication with all stakeholders. The training aims to increase the consistency of goal setting practice and reduce the risk that poor quality goals result in compromised patient outcomes.

The Rehabilitation Network acknowledges the previous work of the ACI Brain Injury Rehabilitation Directorate (BIRD) in developing the resources and training materials that form the basis of these Workshops. The content has been further guided by the ACI Rehabilitation Executive Committee (Appendix A). It reflects the principles outlined in NSW Health’s Rehabilitation Model of Care. The content is consistent with best practice in goal setting as identified in the literature.

1.1 Training Objectives

This Goal Training Workbook addresses the following participant training objectives:

1. To improve understanding of the purposes of goal setting to engage patients in rehabilitation, support patient-centred clinical practice and team coordination, and for communicating with key stakeholders
2. To improve clinician understanding of the factors that affect the development and use of goals in rehabilitation
3. To increase clinician skills in working collaboratively with patients to develop patient centred goals and rehabilitation plans
4. To improve clinician ability to write, review and use patient centred SMART rehabilitation goals that support rehabilitation practice using the SMARTAAR Goal Process
5. To increase knowledge of how to incorporate patient centred goals in rehabilitation plans.

Training on specific tools and strategies for engaging patients in goal setting is beyond the scope of this training. Some strategies will be listed and explained briefly in the training sessions. Training specific to this topic warrants its own training. Many of the skills involved in these strategies are inherent to those working in rehabilitation and revolve around engaging patients in discussions to identify their values, hopes and dreams.

1.2 Training Structure
The first part of this training provides the theories behind goal setting as a rehabilitation tool, and factors that affect the goal setting process. The topics covered are:

- NSW Health’s Rehabilitation Model of Care
- Enablement approach
- Definitions
- The role of high quality goal setting in rehabilitation
- Factors that affect goal setting in rehabilitation:
  - Patient factors, including engaging patients in goal setting
  - Levels of patient goals
  - Approaches to rehabilitation.

The second part of this training covers the use of tools and strategies to facilitate high-quality goal setting. The topics covered are:

- Criteria for high quality rehabilitation goals: the SMARTAAR Goal Process
- Assessing goal quality using the SMARTAAR Goal Worksheet
- Putting it all together: incorporating patient goals in rehabilitation plans.
2. Rehabilitation Model of Care

A ‘model of care’ is a multifaceted concept, which broadly defines the way in which health care is delivered, including the values and principles, the roles and structures, and the care management and referral processes. Where possible, the elements of a model of care should be based on best practice evidence and defined standards, and provide structure for the delivery of health services and a framework for subsequent evaluation of care. The model of care has a facilitating role between the strategic direction for the health system and the delivery of care at local rehabilitation services.

The NSW Rehabilitation Model of Care provides guidance towards achieving equity of access, appropriateness of care and consistency of service quality. The model of care is not prescriptive in terms of work practices and instead allows local services the flexibility to design practices that suite their needs, leaving room for innovation in service delivery.

The Model of Care consists of:
- definition of rehabilitation
- eight guiding principles
- six defined care settings
- elements of a patient journey
- enablers of rehabilitation services.

Eight principles underpin the NSW Rehabilitation Model of Care:

1. **Leadership** – Leadership is displayed at all levels providing a strategic and operational direction, a sense of team and a commitment to the principles of rehabilitation care

2. **Equitable access** – Patients receive equitable access to rehabilitation services in the most appropriate setting and in a timely manner

3. **Multidisciplinary care teams** – Patients have access to a core multidisciplinary team who work collaboratively within an interdisciplinary framework. Access to non-core team specialist services is available as required

4. **Care coordination** – Patient care is communicated and coordinated between the multidisciplinary team and other care providers across the continuum of care. Patients and their carers are encouraged to participate in goal setting and care planning
5. **Patient centred care** – Rehabilitation services are patient centred and delivered to promote an enablement model of care. Patient centred care ensures an ongoing understanding of an individual’s needs and expectations.

6. **Evidence based care** – Processes to promote the implementation of evidence and best practice are in place to support safe and effective care. Evidence based practice is supported through professional development, teaching, quality research and quality assurance activities.

7. **Appropriate care setting** – Patients receive rehabilitation services in the most appropriate setting based on individual patient’s fit with the admission and discharge criteria for the relevant care setting and the potential to achieve rehabilitation goals.

8. **Clinical process and outcome indicators** – Consistent measurement processes across rehabilitation services are in place to monitor and demonstrate patient outcomes that contribute to enhanced functional independence.

Figure 1 illustrates the eight guiding principles and the six defined care settings.

The Rehabilitation Goal Training Workshops are consistent with the principles of Multidisciplinary care teams, Care coordination, Patient centred care, Evidence based care and Clinical process and outcome indicators. Service check points are indicative measures of compliance for each principle that underpins the Model of Care. See Table 1 for examples of check points for each of the principles that this training is consistent with.
Table 1 Relevant Model of Care principles and examples of service checkpoints

<table>
<thead>
<tr>
<th>Principle</th>
<th>Examples of service check points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary care teams</td>
<td>• Evidence of multidisciplinary care planning (ie a single care plan – <strong>no duplication &amp; a common goal</strong>)</td>
</tr>
<tr>
<td>Care coordination</td>
<td>• Evidence of linkages across care settings</td>
</tr>
<tr>
<td></td>
<td>• Evidence of communication between teams</td>
</tr>
<tr>
<td></td>
<td>• Evidence of transfer of care planning</td>
</tr>
<tr>
<td>Patient centred care</td>
<td>• Patient satisfaction with involvement in care planning &amp; delivery</td>
</tr>
<tr>
<td></td>
<td>• Achieved goals (ie short / long term goals, patient centric goals)</td>
</tr>
<tr>
<td>Evidenced based care</td>
<td>• Implementation / adherence to evidenced based guidelines</td>
</tr>
<tr>
<td></td>
<td>• Continuing education for staff</td>
</tr>
<tr>
<td>Clinical process &amp; outcomes indicators</td>
<td>• Clinician: clinical audit, peer review, patient outcome data</td>
</tr>
<tr>
<td></td>
<td>• Clinical team: clinical audit, compare to peer services</td>
</tr>
<tr>
<td></td>
<td>• Organisation: activity (LOS, impairment type), performance (adverse events, patient satisfaction)</td>
</tr>
</tbody>
</table>

**Summary: Rehabilitation Model of Care**

- The NSW Rehabilitation Model of Care provides guidance towards achieving equity of access, appropriateness of care and consistency of service quality.

- It consists of:
  - definition of rehabilitation
  - guiding principles
  - elements of a patient journey
  - six defined care settings
  - enablers of rehabilitation services.

- The Rehabilitation Goal Training Workshops are consistent with the principles of Multidisciplinary care teams, Care coordination, Patient centred care, Evidence based care and Clinical process and outcome indicators.

**Notes**
3. Enablement Approach

Health care is moving away from the traditional approach of the health care provider taking responsibility for the patient’s treatment plan and ‘treating’ the patient, of clinicians being protective of their care planning, with a lack of communication between teams and a duplication of services. Enablement, as an approach, is gaining increasing prominence in the health care sector. The origins of the concept of enablement go back to the concept of ‘empowerment’ (potere: Latin for ‘to be able’, em: ‘cause to be or provide with’).

Studies have shown that interventions supporting the development of individual empowerment are associated with more effective decision making, better handling of the complications of disease and the adoption of healthier behaviours. In 2010, The NSW Department of Family and Community Services (Ageing, Disability and Home Care) began The Better Practice Project. Four projects were funded to implement an enabling approach for people who were eligible for Home and Community Care services. Participants recorded higher average scores for wellbeing and functional ability on exit that they had on entry.

So what is an enablement approach? It is an intervention in which the health care provider recognises, promotes and enhances the patient’s ability to control their health and life.

A concept analysis of enablement in the healthcare context identified six (6) main attributes:

1. Contribution to the therapeutic relationship: active listening, good communication, collaboration, continuity, egalitarian relationship
2. Consideration of the person as a whole: (bio-psycho-social), health condition, psychological condition, life context (eg family, work, finances), knowledge and understanding of the situation (health literacy), opinions, feelings, expectations
3. Facilitation of learning: exchange of information, education, individualised teaching
4. Valorization (give or ascribe value or validity to) of the person’s strengths (expertise): reinforcement of the skills and competence, guidance to the patient in understanding his/her situation
5. Implications and support for decision making
6. Broadening of the possibilities: positive vision of the future, change in the self-image, process of transformation of thoughts, hope, finding a meaning to events/life
An enablement approach aims to achieve the following outcomes:

- patient empowerment
- staff acting as ‘enablers’
- increased teamwork and increased use of clinician skills and experience
- improved continuity of care
- improved communication between teams.

Table 2 compares the traditional approach to health care and an enablement approach.

Table 2 The traditional approach and an enablement approach to health care

<table>
<thead>
<tr>
<th>Traditional Approach</th>
<th>Enablement Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient dependency</strong> - health professional takes responsibility for patient’s treatment plan</td>
<td><strong>Patient empowerment</strong> - aim to maximise self-care at all levels</td>
</tr>
<tr>
<td><strong>Staff as doers/fixers</strong> - work is done when the patient is treated</td>
<td><strong>Staff as enablers</strong> - work is done once the patient is enabled</td>
</tr>
<tr>
<td><strong>Individual assessment / care planning</strong> - protective of discipline / practice</td>
<td><strong>Teamwork</strong> - increased use of skills / experience within teams</td>
</tr>
<tr>
<td><strong>Lack of continuity</strong> - leading to duplication</td>
<td><strong>Continuity of care</strong> - seamless transfer across the service</td>
</tr>
<tr>
<td><strong>Lack of communication</strong> between teams</td>
<td><strong>Improved communication</strong> between teams</td>
</tr>
</tbody>
</table>

What does an enablement approach look like in practice?²⁷

- The focus is on what each patient can do and wants to be able to do, not just on what they are unable to do at present. Understanding an individual’s past abilities is as important as knowing about present disabilities
- Each patient is actively involved in setting and achieving goals that are important and meaningful to them
- Health care providers work collaboratively with each patient, the patient’s carer, social networks and other providers, tapping into both formal and informal supports
- The focus is on the achievement of each patient’s goals
- Each patient’s goals are regularly reviewed
- Health care providers work with patients to reduce unnecessary service use – improving their functional independence in ways defined as important by them.
Summary: Enablement Approach

- An enablement approach is an intervention in which the health care provider recognises, promotes and enhances the patients’ ability to control their health and life.

- It aims to achieve:
  - patient empowerment
  - staff acting as ‘enablers’
  - increased teamwork and increased use of clinician skills and experience
  - improved continuity of care
  - improved communication between teams.

Notes
4. Definitions

Rehabilitation

The term ‘rehabilitation’ will be used in this Workbook to mean the provision of care that aims to:

- restore functional ability for a person who has experienced an illness/injury
- enable regaining of function and self-sufficiency to the level prior to that illness / injury, within the constraints of the medical prognosis for improvement
- develop functional ability to compensate for deficits that cannot be medically reversed.  

Patient

The term ‘patient’ will be used in this Workbook to mean:

- a person of any age, including children, young people and adults, who requires rehabilitation following an injury or injury
- depending on patient capacity, it may also include their family / decision maker

Goal

- ‘The object of one's ambition or effort; a desired end or result’

- The intended outcome of a specific set of interventions (with specific reference to rehabilitation goals).

The goal is what the patient wants to achieve; it can also be seen as why the patient is undertaking the rehabilitation program and why clinicians are providing intervention.

Steps

These are the activities / behaviours the patient needs to be able to do to achieve their overarching goal. Completing all of the steps will lead to the achievement of the overarching goal (assuming no unforeseen circumstances occur and no activities /behaviours have been omitted). Whilst the use of a particular term for this facet of goal setting will be discipline specific (e.g. sub-goals, objectives), the concept remains the same. The term ‘step’ will be used in this Workbook and this is relevant to what you may refer to as sub-goals or objectives.
Each goal will have a number of steps. Steps describe the behaviours/actions that together will enable the patient to achieve their overarching goal. Each step needs to describe one behaviour/activity only. This makes it easier to assess a patient’s progress towards their goal. For example, in order to achieve a goal of resuming studies at TAFE, a patient may need to improve their mobility, improve their computer literacy and be able to manage their anxiety in the local community and while at TAFE. Each of these activities is to be written as separate steps.

**Action Plan**

The action plan outlines the specific plans that describe *how* the patient’s goal will be achieved. In other words, those actions that need to be completed to achieve each of the steps. Each step may comprise a number of actions.

The action plan includes all aspects of required intervention, such as accessing services, obtaining equipment and engaging family assistance, as well as actions for the patient to undertake. Whilst the use of a particular term for this facet of goal setting will be discipline specific (e.g. strategies), the concept remains the same. The term ‘action plan’ will be used in this Workbook and this is relevant to what you may refer to as strategies. Figure 2 illustrates the relationship between a patient goal, patient steps and action plan.

*Figure 2 The relationship between patient goal, patient steps and action plans*
Goal Setting

Goal setting has been described as ‘The formal process whereby a rehabilitation professional or team; together with the patient and/or their family negotiate goals’.\(^4\)\(^5\)

Goal setting includes the actions of:

- identifying a patient’s goals
- establishing steps
- designing an action plan.

This is consistent with the use of the phrase in the literature, although no papers specifically define these inclusions.

Rehabilitation Plan

This refers to the type of documentation frequently used in rehabilitation. The format of rehabilitation (rehab) plans will vary according to individual services. However, the information contained in a plan should have the same elements of a goal, steps and action plan.

Summary: Definitions

- Patient goals are broken down into patient steps. The action plan identifies how the patient will be supported to achieve identified steps and goals.
- Goal setting is the process of:
  - identifying a patient’s goals
  - establishing an action plan
  - monitoring progression towards goal achievement

Notes

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5. The Role of Goal Setting in Rehabilitation

Goals have been described as ‘the essence of rehabilitation’ and essential to facilitate patient centred rehabilitation. Rehabilitation often supports people with complex multifaceted problems to regain independence and reduce the impact of disability. Wade (2009) suggests that a goal setting process can be useful ‘whenever a patient’s problems are sufficiently complex to require the involvement of two or more people from different professions and/or the process is continued for more than a few days’. The principles of goal setting can still be applied for people with less complicated injuries and disabilities, but a simplified and briefer process will be more appropriate.

There are many benefits to setting goals in rehabilitation. High quality goals can be useful to support patient participation as well as planning within a team context. Goal setting helps empower patients and ensures that therapy is targeted to address the priorities identified by the patient. Patient goals are useful for clinicians and services as they can ensure individual team members work towards the same goals, as well as inform treatment planning and communication about patient progress. Conversely, poor quality goals can result in compromised patient care, communication between stakeholders and patient outcomes. The benefits of goal setting for patients, services and communication will now be described in more detail.

5.1 Benefits of Goal Setting on Patient Participation

Goals are most helpful for patients when they address priorities that are important to them. It is widely recognised that the identification of goals that are meaningful to a patient can increase patient motivation and their level of participation in rehabilitation. This is not surprising. Therapy in and of itself is rarely enjoyable, especially in the long-term. Furthermore, the link between therapy activities and functional outcome, while obvious to the therapist, is often not inherently clear to the patient. When goals are relevant and challenging, but still achievable, patients are more likely to change their behaviour to achieve their own goals. Measuring progress towards goal achievement helps to maintain this benefit for the course of a rehabilitation program.

Which of these two patients do you think will have greater motivation? Jill understands that performing the home exercise program prescribed by the physio and attending weekly occupational therapy sessions will assist her to achieve her goal of being able to care for her child independently. Joan only knows that physiotherapy is to help her to improve her balance and occupational therapy is to help her improve her memory.
Jill can see the link between her rehab plan and her goal. Joan has no personal outcome linked to her rehab plan. Working towards a patient’s goals can result in high levels of patient motivation and engagement in activities, including enhanced performance and persistence.

**Goals belong to the patient, not the clinician.** When goals reflect the patient’s priorities, they describe their desired level of achievement and are relevant to their life roles and situation. Goals can be classified by the type of activity or aspect of participation that they relate to, but should not be classified by a particular therapy/discipline.

**Activity 1.**
Choose one or two of the following goals and re-write it so that it becomes a more meaningful and motivating statement for the patient. You will need to make some assumptions about these fictitious patients. Ensure that the wording is written in a positive way i.e. what ‘will’ happen, not what ‘won’t’ happen.

<table>
<thead>
<tr>
<th>Initial Goal Statement</th>
<th>More meaningful and motivating goal statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Jill’s balance will improve</td>
<td>Jill will be able to engage in physical play with her children</td>
</tr>
<tr>
<td>Jack’s anger management will improve</td>
<td></td>
</tr>
<tr>
<td>Jill will complete home and community based OT programme to increase her function</td>
<td></td>
</tr>
<tr>
<td>Jack’s family will be able to manage his care needs at home once he’s discharged from the rehabilitation unit</td>
<td></td>
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</tbody>
</table>

**Reflection:** How did you find the process of making basic / impairment goals more meaningful?
Considerations for Practice:
You can use this component (ie goals being meaningful to the patient) to inform future practice:

- What did you consider when trying to write goals that would motivate a patient to engage in rehab?
- How would you need to change to write more meaningful goals for your patients in future?

Key Tips

**Using Goals to enhance patient participation in rehabilitation:**
- Goals should reflect the patient’s priorities and be meaningful to them
- Patients are more likely to be motivated to participate in therapy if their goals are meaningful!
- Clinicians can consider how they can help patients achieve their goals, rather than focus only on the desired change when they treat underlying problems

Notes
5.2 Benefits of Goal Setting for Planning within a Team Context

The health service providers involved in a patient’s care should be considered a team, even when they may not work for the same organisation. For example, a patient’s health service provider team may compromise a GP, a medical specialist, a psychologist, and an occupational therapist. They need to work together to maximise outcomes for the patient.

An essential feature of any effective team is the existence of a clearly-stated common purpose.\(^3,9,11\) Consider a basic example of a team of three chefs collectively making a meal. Each chef needs to be aware of exactly what the meal is so that their contribution is relevant. It is no good for one chef to prepare a stock assuming the meal they are making is a soup, another to make fresh pasta assuming the meal is lasagne, and the third to cook a steak. Each chef will have produced something (a stock, pasta sheets, a steak) but the end product is not a meal – no meaningful outcome has been achieved.

It is the same in rehabilitation. If we do not know what outcome is being aimed for, how can we plan which services are needed? Consider the example of two patients, John and Jim, with identical impairments and level of function. Figure 3 illustrates how the services each patient requires to assist him achieve a meaningful outcome will be very different. If John and Jim were provided with identical services, it is likely that in a
A couple of months both will have made progress within each therapy, but neither will have achieved their goal.

**Figure 3** An example of how a patient’s goal will direct rehabilitation plans

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### 5.2.1 Team Collaboration

**In rehabilitation, a common goal is the first step** for ensuring team collaboration and an integrated treatment plan.\(^{28}\) The action plan should be developed to support the achievement of the patient’s specific goals. This enables the team to decide which disciplines will be involved and what is needed for the patient’s goals to be achieved. Collaboration with the patient to identify their goals and agree on an action plan supports the delivery of effective patient-centred rehabilitation.

Doig et al state that ‘goals provide structure’ to rehabilitation.\(^{12}\) Ensuring the action plan is targeted towards patient goals can improve the efficiency of service delivery and avoid duplication e.g. the OT and physiotherapist both provide intervention regarding transfer skills. Goal setting can also provide an opportunity for intervention and a tool for case management.\(^{7}\) It enables clinical planning to remain patient focused. It can also be used to structure collaboration with the patient to aid their understanding of the
nature and impact of their injuries, particularly when the patient lacks this understanding.

It is much harder to develop a cohesive rehabilitation program for the patient when goals are formed after the treatment has been decided. This approach is more likely to be used in settings where individual disciplines work separately with the patient. In these cases, the risk is that action plans do not support the achievement of patient goals as directly. Patient motivation may be reduced when the link between actions and their goals is less clear. Figure 4 illustrates the difference between these two approaches to writing goals.

Figure 4  The difference between a clinician-driven treatment plan and a patient goal-driven treatment plan

Individuals and teams can choose to classify or group the type of patient goals recorded by their service by looking at the most frequently patient set goals. The frequency that different types of goals are set, and the frequency that different types of goals are achieved, provides useful information to support service evaluation. A high proportion of goals achieved in those areas of functioning where considerable time is dedicated can provide information on service effectiveness. Areas of functioning where lower numbers of goals are achieved may indicate service gaps and areas for service review e.g. teams can review whether changing current practices could enable more patients to achieve goals related to social relationships. Existing classification systems used to classify and group different types of goals include the ICF\textsuperscript{47} and the Goals Taxonomy\textsuperscript{18}. Alternatively, individuals or teams may develop their own classification system to suit their requirements.
5.2.2 Measuring Goal Achievement to Inform Clinical Planning

Measuring goal achievement is a dynamic process. Once goals are identified, their ongoing review and use by the clinical team can support clinical practice in a number of ways. They can:

- motivate patients by providing evidence of progress made to date
- provide the opportunity to incorporate the patient’s changing status into future plans
- provide teams with information on the effectiveness of the intervention provided to date and indicates ineffective actions that need to be discontinued
- enable reflection of whether the action plan is appropriate or needs to be reviewed
- provide evidence on a service’s effectiveness when data on goal achievement is evaluated.

Considering information obtained from both goal achievement and repeated outcome measures provides more comprehensive information on the patient’s changing needs and progress.

Goals can only assist in clinical planning and service evaluation when they are well written, high quality goals. Measuring progress with well written goals can enable patients and clinicians to understand how intervention is effective. If there is slow or no progress towards goal achievement, the team needs to consider what factors are contributing to this so the plan can be revised to suit the changing needs of the patient. However, when goals are unclear or poorly written, they cannot be used for this purpose. When a goal is vague, failure to achieve the goal may not mean the patient isn’t benefiting from therapy – rather, the goal is unable to reflect this. Goals need to clearly describe the expected change in the patient if they are to be used to measure patient outcomes and the quality of rehabilitation. Measuring goal achievement to assess the quality of care can be supported by evaluating the process of care, and whether the actual services provided match the action plan identified.

When reviewing patient goal achievement and progress, there are several questions the clinical team can ask to support team planning. These include:

- Did the patient agree with the goal and action plan?
  - does the goal reflect the patient’s priorities?
  - is the patient participating in the actions that they agreed to do?
- Is the goal realistic for this patient at this stage?
  - is the goal SMART enough for progress towards goal achievement to be measured?
  - do steps clearly support goal achievement?
  - are there other circumstances that are affecting the patient’s ability to achieve their goal?

- Does the action plan need to be reviewed?
  - is more time required?
  - are additional actions needed?
  - do some actions need to be discontinued as they are no longer beneficial for the patient?

**Key Tips**

**Using goals to enhance team and clinical planning:**

- Goal setting should be the first step completed as this forms the foundation for the development of team treatment plans

- Evaluating a patient’s progress towards their goals is an integral part of the rehabilitation process and can be used to evaluate the patient’s rehabilitation program and ongoing rehabilitation needs

- Goals provide **structure** to rehabilitation by:
  - **Identifying the outcomes desired** by the patient. This enables teams to tailor rehabilitation plans that can motivate a patient to participate in therapy and ensure rehabilitation is relevant to the patient’s life and circumstances
  - **Directing** necessary interventions / assisting with the **planning** of rehabilitation
  - Providing outcomes against which rehabilitation progress can be **monitored**
  - Assisting in the **communication** of care needs to **all stakeholders**
  - **Supporting service evaluation** through the measurement of goal achievement

**For clinicians:**

- What process do you use with your ‘team’ when setting goals with patients?

- How can your team change their processes to be more patient focused?

- How can you work with ‘virtual’ teams, where clinicians work in different organisations, to identify a patient’s goals and develop a cohesive rehabilitation plan? What’s different when everyone works in a single team?
5.3 Revision Exercise 1

**Instructions:** In the figure below, there is space to write one of the following words to reflect what you have learnt about the relationship and role of goals, steps and actions:

<table>
<thead>
<tr>
<th>HOW</th>
<th>STEPS</th>
<th>WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTION PLAN</td>
<td>GOAL</td>
<td></td>
</tr>
</tbody>
</table>

Instructions: Select true or false for the following statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An enablement approach to rehabilitation can result in positive outcomes for patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. An enablement approach focuses only on a patient’s current deficits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Goals don’t motivate patients – only patients can motivate themselves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Goals belong to the patient, not the clinician / discipline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Goals make it harder to monitor change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Goals ensure that important actions are not overlooked</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Goal setting can done as an afterthought once the treatment plan has already been identified by the team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Measuring goal achievement can assist in service evaluation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6. Factors that Influence Goal Setting in Rehabilitation

Setting goals in rehabilitation is a complex task. Many dynamic factors influence the goal setting process. This section will identify a number of key factors that need to be considered when setting goals with patients. These include:

- Patient factors
- Level of patient goals
- Service factors.

6.1 Patient Factors that Influence Goal Setting in Rehabilitation

Collaborative goal setting requires patients to be engaged in the goal setting process. This is an important feature of patient centred care, but patient engagement in the goal setting process can be influenced by pre-morbid and injury-related factors. Clinicians need to consider the impact of these factors on how they work with patients to identify the goals. Describing the level of patient engagement can help understand the context in which goals have been identified.

6.1.1 Patient centred Goal Setting

This training has introduced a number of concepts that place the patient at the centre of the goal setting process. For example, we advocate the need to work collaboratively with patients to identify their goals to ensure they are meaningful to patients and relevant to their life and the context in which they live. This is consistent with a patient centred approach to rehabilitation. In this approach, the patient is at the centre of the rehabilitation process. The patient is empowered to engage as a partner in making decisions about their own rehabilitation and needs. Features of patient centred care include:

- the patient has shared control of the consultation
- the patient is focused on as a whole person
- effort is made to understand the patient’s emotional needs and life issues
- the patient’s motivation is explored
- problems are identified collaboratively
- management is agreed to by the patient and team
- the patient’s concerns and need for information is respected.

It follows that a patient centred goal is one that reflects the desires of the patient (as opposed to the plans of the treatment team).
Patient centred goal setting is important because only the patient knows what activities are relevant to their own life. There are numerous influences on the type of activities and tasks people choose as relevant to their own life (See Figure 5). People make choices to fulfil personal preferences and meet environmental and developmental demands. This is a dynamic process which, when successful, accommodates ongoing changes in a person’s roles and circumstances, and contributes to their overall quality of life. As this process is unique for every individual, it is not possible for clinicians to identify what activities are relevant for each patient. This is something each patient needs to do for themselves.

Figure 5 Influences on the activities/tasks that people choose

6.1.2 Patient Factors that Influence Patient Engagement in Goal Setting

The degree to which the patient can engage in the goal setting process and identify a sufficient range and number of goals to reduce the impact of their injuries is influenced by a number of pre-existing and injury related factors. These are outlined in Table 3.
Table 3 Factors affecting patient engagement in goal setting

<table>
<thead>
<tr>
<th>Pre-existing</th>
<th>Injury related</th>
</tr>
</thead>
<tbody>
<tr>
<td>• personality type</td>
<td>• cognitive impairment</td>
</tr>
<tr>
<td>• lifestyle</td>
<td>• insight into nature of disabilities and impairments</td>
</tr>
<tr>
<td>• health conditions e.g. mental health, level of functioning</td>
<td>• current level of functioning</td>
</tr>
<tr>
<td>• attitude to goal setting and life planning</td>
<td>• knowledge about anticipated recovery</td>
</tr>
<tr>
<td></td>
<td>• adjustment to disability after injury/ illness</td>
</tr>
<tr>
<td></td>
<td>• mood / mental health issues</td>
</tr>
</tbody>
</table>

Goal setting is a complex process and it is unrealistic to expect that all patients will be able to formulate goals without assistance, as not everyone consciously uses a goal framework to manage their daily lives. Some authors advocate the need for patients to receive training in goal setting and the rehabilitation process so they better understand what is required and how the goals will be used in their rehabilitation. Even cognitively intact patients with great self-awareness will require direction from health professionals regarding what is realistic within certain time frames. It is even less realistic to expect patients to express goals with all the elements of a SMART goal (see Section 7).

The impact of injury and any pre-existing conditions can impair a patient’s ability to understand and engage in a goal setting process. Cognitive impairment, lack of insight into the impact of their injuries/illness and low or impaired mood can all reduce the patient’s ability to judge their current status and what goals are reasonable and realistic. Patients may need help in understanding that in order to achieve their long-term goals, other things will need to be achieved first e.g. to achieve their goal of getting back to work, they first need to be able to walk without assistance, be able to sit without pain, and be able to get up and catch bus to their workplace and arrive on time. Collaboration between the patient and clinicians is needed to identify what is and is not achievable, and to resolve discrepancies where possible.42

Sometimes patients identify goals that are unlikely to be achievable in the foreseeable future - balance is needed between the goals identified by the patient and the timeframes for service delivery. Bigger and longer term goals may need to be broken down into several goals and many steps, dependent on the level of therapy and time required to achieve them. Clinicians need to ensure that the patient gains an understanding of the link between current steps and actions and their longer term goals.
When a substantial number of services are required, the patient’s ultimate goal may need to be broken down into several patient focused goals so the link between the action plan and anticipated change in the patient is clear. This is acceptable as both goals and steps describe how the patient will benefit from the recommended action plan.

6.1.2.1 Tools for Engaging Patients in Goal Setting

Given the complexity of engaging patients in goal setting, several informal strategies and formal tools exist for assisting the patient to identify goals. As a starting point, informal strategies can be a useful starting point, especially with those patients with less complex and recoverable injuries. Engaging the patient to identify their rehabilitation goals may be as simple as using the following prompts:

- ‘What can’t you do since your injury that you’re keen to get back to?’
- ‘What are you finding more difficult since your injury that you’d like to be easier?’
- ‘How will you know when you’re ready to stop coming to see me?’

More formal strategies for interviewing the patient and objective goal tools are also available (see Table 4). In essence, these tools are all based around identifying a patient’s values, and what activities they would like to be able to do. They can be useful for those who do not feel confident to engage patients in conversations to identify their rehabilitation goals and for patients who are difficult to engage. Not all tools will be useful for all patients or services. The finer details of these strategies and tools are beyond the scope of this training and further research into them is recommended if you feel they will support your practice.

<table>
<thead>
<tr>
<th>Informal Strategies</th>
<th>Formal Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identity Oriented Goal Setting</td>
<td>Canadian Occupational Performance Measure (COPM)</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>Goal Attainment Scaling (GAS)</td>
</tr>
</tbody>
</table>

23, 40, 41
6.1.3 Continuum of Patient Engagement in Goal Setting

Patient engagement in the goal setting process is variable and can be thought of as falling on a continuum. At the highest level of engagement, the patient will generate their own goals, or some of their own goals. However, sometimes rehabilitation needs to support patients to achieve other goals, even when they have not been explicitly identified by the patient themselves. For example, when patients have identified a long term goal but are unable to identify shorter term goals that will enable them to achieve their longer term goal. Similarly, a patient may not be able to identify all of the steps that will be needed to achieve their goal. At the other end of the continuum are goals identified by clinicians but these tend not to describe how the patient will benefit. The impact of patient factors on patient engagement is dynamic, and an individual patient may be able to identify some but not all goals, so their level of engagement in identifying goals will vary from goal to goal.

We have identified three levels on this continuum of patient engagement:

- Patient generated goals
- Patient focused goals
- Clinician goals.

Both patient generated and patient focused goals describe an expected outcome i.e. how the patient will change / benefit at end of the proposed rehabilitation. However, patient generated goals describe the patient’s own priorities. Patient generated and patient focused goals both involve a level of collaboration with the patient and support patient centred rehabilitation.

A patient generated goal is one that the patient identifies - it reflects their priorities. The goal may or may not be as stated verbatim by the patient. It may have been formulated or re-worded by a health professional to maximise the usefulness of the goal statement but it directly relates to the anticipated level of change desired by the patient. Ideally, a patient generated goal can be reported verbatim in the patient’s own words but, in most rehabilitation situations, the health professional will need to assist in the formulation of the goal statement. The health professional makes improvements to the goal in order to generate a statement that is useful for directing intervention, communicating the rehabilitation plan with all stakeholders and measuring progress towards the goal. When the patient’s own words need to be changed to fulfil the needs for the goal, the patient should be involved as much as possible in translating their
priorities into a SMART rehabilitation goal. It should still be something the patient understands and agrees to.

A patient focused goal is one that still relates to how the patient will benefit from the therapy, but may not be an explicit priority identified by that patient. These can often be steps that help the patient achieve their patient generated goal. Patient focused goals can be set by the clinician but still describe how the patient will benefit from therapy. They can be useful to identify additional changes in activity or function that are required for the patient to achieve their own goal e.g. encouraging the patient to shower daily as a strategy to support their ultimate goal of ‘getting a girlfriend’. In this example, the patient may not be able to identify what a realistic goal is for their particular situation, or may fail to understand the link between shorter term goals and their ultimate goal of ‘a girlfriend’. Many factors, including insight, adjustment to disability and time since injury, affect a patient’s ability to set a realistic goal. When patients identify goals that are unrealistic, or cannot be achieved in the foreseeable future, patient focused goals may need to be set to support rehabilitation planning. As patients gain insight and understanding, the patient may become able to identify the importance of these goals.

Clinician goals are on the other end of the continuum and usually describe what needs to be done and by when. They often describe what the patient will be doing in therapy e.g. ‘Jack will complete his home exercise program’, ‘Jill will complete 6 sessions of physiotherapy’, ‘Jack will achieve 5 point change on assessment scale’. They often describe what the clinician wants the patient to do, but are distinguished from patient focused and patient generated goals which focus on how the patient will benefit from therapy. Clinician focused goals can be appropriately reworded in the action plan, as these typically describe actions to support the patient achieve their own goal. They can also provide opportunities for monitoring progress against the patient’s goals e.g. if the patient achieves the clinician generated goal of being able to ‘sit for 30 minutes without pain’, they are likely to be closer towards being able to achieve their own goal of managing their office work. The patient’s progress towards goal achievement can be monitored by using a standardised assessment at regular intervals. Clinician goals are less likely to reflect the patient’s own priorities and may / may not describe the anticipated change in a patient.
### Key Tips

- **Patients know their priorities better than you do!!** Identifying patient goals involves engaging the patient in conversations to identify what they value.

- Each patient needs to identify their own activities and priorities relevant to their lifestyle and quality of life. This cannot be done by the clinician.

- The first step in identifying patient goals requires the patient to be asked what they want to achieve or change by participating in therapy.

- Patients will vary in their ability to identify issues relevant and realistic to address in rehabilitation.

- Assessments that help patients identify their priorities and preferences can be useful to support patients to identify relevant and meaningful rehabilitation goals.

- Work with the patient to identify their priorities so that as many goals as possible are patient generated i.e. reflect the patient’s own priorities.

- Including the patient’s name in the goal statement does not make it patient focused.

### Summary: Continuum of patient engagement in goal setting

- **A patient generated goal** is one that the patient identifies - it reflects their priorities. The goal may or may not be as stated verbatim by the patient. It may have been formulated or re-worded by a health professional, to maximise the usefulness of the goal statement but it directly relates to the anticipated level of change desired by the patient.

- **A patient focused goal** is one that one that still relates to how the patient will benefit from the therapy, but may not be an explicit priority identified by that patient. These can often be steps that help the patient achieve their patient generated goal.

- Patient generated and patient focused goals both describe how the patient will benefit from therapy, and are preferable to clinician goals that describe what needs to be done and by when.
6.2 Levels of Patient Goals

There are many factors that influence the nature and size of goals that are written to support rehabilitation. The primary approach used in this training to describe different levels of goals is the World Health Organisation (WHO) International Classification of Functioning, Disability and Health (ICF). This provides a useful framework for describing and understanding the primary focus of rehabilitation goals.

6.2.1 The International Classification of Functioning, Disability and Health (ICF)

The International Classification of Functioning, Disability and Health (ICF) (2001) and classifies the consequences of health conditions on functioning. The components of the ICF model include:

**Body function and structures:** refers to physiological functions of body systems (including psychological functions) and anatomical parts of the body (including organs, limbs). **Impairments** occur when people experience problems at the level of body function and structures.

**Activity:** describes the execution of a task or action by an individual. Problems with activities are described as **activity limitation.**

**Participation:** describes involvement in a life situation. At the level of participation, the activities and behaviours people engage in are performed in relation to their roles and the context in which they live. Problems with participation are described as **participation restrictions.** People can experience participation restrictions due to the impact of impairments, activity limitations or contextual factors e.g. prejudicial attitudes, lack of services, inaccessible environments.

**Disability** is an overarching term that describes a problem at any of the three levels.

**Contextual factors:** describe aspects of the environment in which a person lives that can be thought of as facilitators and barriers to functioning and participation. Contextual factors include **environmental factors** (e.g. social attitudes, architectural characteristics, legal and social structures, climate, terrain) and internal **personal factors** (including gender, age, coping styles, social background, education, profession, past and current experience, overall behaviour pattern, character).

The ICF is a biopsychosocial model that acknowledges that the experience of health is dynamic, where change in one component can impact others. In rehabilitation, intervention can target each aspect of the model, including the context / environment in which people live. Figure 6 illustrates the ICF Conceptual Model.
6.2.2 Levels of Rehabilitation Goals Using ICF Framework

The ICF provides a useful framework for articulating the desired and different levels of rehabilitation goals. Using ICF terminology, rehabilitation goals can be set at three levels that describe the desired change in the person’s:

1. level of **impairment**
2. level of **activity**
3. level of **participation**.

This concept is most easily explained through examples. See Table 5.
Using the examples in Table 5, Steven’s physiotherapist will be interested to measure improvement in his hip extensor strength to check that Steven is responding to therapy as planned and to guide when an attempt at independent transfer might be appropriate. Similarly, Joanne’s psychologist might measure anxiety using the Depression, Anxiety and Stress Scales (DASS) scores over time to determine the effectiveness of the psychology sessions and guide when it might be appropriate for Joanne to expose herself to different challenges. However, the more meaningful outcome for Joanne will be whether she is able to attend and enjoy her daughter’s ballet recital – her main priority.
Participation level goals are considered best practice in rehabilitation. The ICF concept of participation is consistent with the aim of rehabilitation to reduce disability and ‘make life worth living’. In Australia, ‘the rehabilitation process is different for everyone and rehabilitation programs should be individualised, catering to each person’s unique needs’. Participation anchors activity performance in the context in which the person lives. Participation level goals are more likely to motivate patients as they demonstrate how rehabilitation can help them achieve meaningful outcomes. For example, telling a patient that physiotherapy for 8 weeks will enable them to commence a trial to return to driving is likely to be much more motivating than the potential to improve their neck rotation by 30°.

While participation level goals are advocated as best practice, and are most likely to reflect the longer term priorities of patients, at times impairment goals can also be appropriate. This is particularly the case in the early stages of recovery and when level of disability remains severe. The focus of a large proportion of therapy in these situations often addresses impairments. The level of engagement of patients in the rehab process is often lower when the patient’s level of disability is more severe, so setting participation level goals is more difficult, are less likely to be achievable in the short term, and rely on family members’ views of what’s important to the patient. However, even during the early stages, it is important to engage patients as much as possible in identifying their priorities for meaningful activity and participation level goals. This does not mean that impairment level goals need not be identified and addressed. Ideally, they will support the patient to achieve activity and participation level goals, or provide mechanisms to measure progress.

For example, an elderly patient may not have regained the last 20° of shoulder range of motion, but if he is satisfied with his ability to perform all desired activities, this impairment becomes irrelevant in guiding treatment. Conversely, a patient who wishes to return to playing tennis may have only lost 10° of shoulder range of motion, but the restoration of full range may be vital for the achievement of her goal of return to tennis.

Impairment level goals are generally more useful for directing and assessing discipline specific interventions. This may be accompanied by impairment level objective assessments to provide detailed clinical information on current status and treatment needs. Impairment goals may be reported as steps or in the action plan where therapy and assessments to address impairments are described. Figure 7 illustrates this relationship.
While contextual factors can often be addressed as part of rehabilitation, they should usually be described in action plans that support the achievement of patient change at the level of activity or participation, as appropriate e.g. provision of equipment and therapy is a contextual factor in the ICF and an action that supports the patient to achieve their goal.
**Activity 2**

**Clinicians:** Think of an impairment level goal that you would frequently identify in your clinical work. Write this in the first column. Then fill in the next two columns with possible activity and participation level goals that relate to your chosen impairment level goal.

<table>
<thead>
<tr>
<th>Impairment</th>
<th>Activity</th>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Considerations for Practice:**

After completing the above activity, consider the following questions:

- How did you find the process of describing the combination of impairment goals, activity and participation level goals?
- What would the difference be if you started with participation level goals or patient priorities?
- Which level of goal tells you the most about the patient and what they want to achieve?
Summary: Levels of Goal Setting

- It is recognised best practice to set rehabilitation goals at activity and participation levels. This means identifying functional goals that are meaningful for that patient and relevant for their lifestyle. Activity and participation level goals often describe a patient’s return or progress towards an important life role.

- Impairment level goals describe an improvement in a body function, but not necessarily a functional ability. Impairment level goals are useful steps, and should only be used as a main goal statement when activity or participation level goals are not realistic (this generally only occurs in early recovery or in the context of very severe persistent disability).

- Clinicians should engage patients as early as possible in identifying meaningful activities and roles relevant to their lifestyle to support identification of activity and participation goals.

- When patients, or clinicians, have trouble moving beyond impairment focused goals, ask ‘What is it you will be able to do if we address this (impairment) e.g. will being able to run mean you can resume coaching your son’s soccer team?’

Notes
6.3 Approaches to Rehabilitation that Influence Goal Setting

From a team perspective, there are three approaches to goal setting in the rehabilitation setting:

1. **Multidisciplinary**, in which each different clinical discipline sets discipline specific goals without collaboration with other therapists.
2. **Interdisciplinary**, in which health professionals from different disciplines share a common patient population, common patient care goals and have responsibility for complementary tasks. The team is actively interdependent.
3. **Transdisciplinary**, in which a team of professionals work together to share knowledge and skills across disciplines. Transdisciplinary teamwork improves communication and cooperation, and provides integrated care to the clinic's patients. The aspect of transdisciplinary care that distinguishes it from all other team models is its emphasis on cross-training.

Collaborative goal setting is an essential and central part of an interdisciplinary process and is considered best practice. The benefits include:

- an emphasis on the involvement of the patient in goal setting:
  - not including the patient in the goal setting process increases their dependence on the therapist, which is contrary to the purpose of rehabilitation.
  - a positive relationship between the level of patient involvement in goal setting and rehabilitation outcomes has been demonstrated.
  - non-collaboration with the patient in regards to goal setting has been cited as a reason for neuro-rehabilitation failure.

- prevention of the duplication of roles.

- facilitation of a focus on participation level goals, which are recognised as best practice in rehabilitation.

While the overarching approach to rehabilitation may be influenced by service and organisational drivers, clinicians are encouraged to facilitate a collaborative approach to goal setting as much as possible. This differs from a more traditional approach where clinicians drive the treatment plan, and team and patient communication is directed by discipline specific goals and interventions. Using an interdisciplinary collaborative approach, patient goals direct the action plan rather than individual disciplines identifying goals for the patient specific to their role. Communication is structured around the patient’s rehabilitation goals and each discipline identifies if and how they
can contribute to each goal e.g. instead of discussing OT goals, the OT will ask ‘does the patient have any goals that require OT input?’ Figure 8 compares the impact of clinician-driven and client goals-driven treatment plans on team collaboration and planning.

Figure 8 Impact of clinician-driven and client goals-driven treatment plans on team collaboration and planning

Clinic-driven treatment plan

Client goals-driven treatment plan
A collaborative approach that enables the patient’s goals to drive the treatment plan is particularly important when the patient identifies participation level goals. Participation level goals can be more complex and often require the input of several disciplines concurrently. Input from multiple therapists is often required from the beginning to ensure a participation level goal is realistic. For example, a patient whose goal is to return to work following multi-trauma from a car accident may realistically have the physical ability to do so within three months, but not the psychological well-being. If there is no liaison between the physiotherapist and psychologist, it is possible that the physiotherapist may be setting the patient up to fail. It is largely because of the importance of participation level goals that an interdisciplinary approach is considered best practice (see Figure 9).

Figure 9  An example of the contribution of different disciplines to a patient’s participation level goal

The impact of introducing a more interdisciplinary collaborative approach on time demands will depend on the current approach to service delivery and how meetings and communication about patients are organised. A common response to the suggestion that goal setting be a collaborative approach is that patient meetings already take too long and that this will take even more time. Discussions about goals should not be separate to other discussions about patients. All discussions about patients should be relevant to their goals and how these are going to be achieved. **Goals offer structure and focus to the patient discussions that are already occurring.**
Within a multidisciplinary unit, changing to a collaborative goal setting approach does not always increase the time demands, but can make meetings and reporting more streamlined. Rather than case conference meetings being structured by headings of each discipline involved - so that that each therapist speaks once to provide feedback regarding progress in their sessions - it is more useful to structure case conferences by headings of the patient’s goals, with each therapist then reporting on progress and outstanding needs relevant to that goal. This ensures that all are aware of the current goals being worked towards and provides the opportunity for each therapist to provide input, relevant to that goal, which other therapists may not have considered. In some settings, additional meetings with patients may be needed. In others, the focus of existing contact with patients and clinicians is more goal directed but able to be implemented within current schedules.

The suggestion that case conferences be structured in terms of current goals is sometimes met with comments that this structure is too restrictive and doesn’t allow for important information that doesn’t relate to a goal to be discussed. Everything that is discussed in a formal case conference should relate to a patient’s goal. If it doesn’t, it is very likely that there is a goal that has not been formally identified. This is often a big change from how people are used to working.

A collaborative goal setting approach is not confined to use within multidisciplinary health units. It is just as relevant when the patient is receiving care from multiple private providers. Regular joint meetings may not always be practical, but all health professionals involved should be aware of the patient’s goals and everyone’s role in assisting the achievement of these. When individual clinicians work collaboratively with others, increased time may be required. Further information on this point is provided in Section 9.7.
Summary: Approaches to Goal Setting

- An interdisciplinary collaborative approach to rehabilitation and goal setting is recognised as best practice. Using this approach a group of health professionals from different disciplines work towards common goals that are set in collaboration with the patient. This approach has the following benefits:
  - it facilitates a focus on participation level goals
  - it emphasises the involvement of the patient in goal-setting
  - it facilitates an efficient approach to goal achievement by ensuring that necessary input from multiple disciplines is provided concurrently, without duplication of roles.

- A collaborative approach is just as important when multiple therapists do not work at the same unit / organisation. Clinicians can promote professional collaboration by instigating liaison with the other clinicians in the patient’s rehabilitation team.

Notes
6.4 Revision Exercise 2

**Instructions:** Select true or false for the following statements

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An interdisciplinary approach is recognised as best practice</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Participation level goals are broader and more complex than impairment level goals</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The patient is central to all planning and decision making about treatment, rehabilitation and care</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. A patient generated goal reflects a patient’s priorities and may be reworded by a health professional</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. A patient focused goal is one that may not be an explicit priority identified by that patient</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. All patients can identify all their own rehabilitation goals</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Patients may benefit from training or education about goal setting in rehabilitation</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. A collaborative approach to goal setting can streamline existing meetings about patients</td>
<td>True</td>
<td>False</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. Assessing the Quality of Rehabilitation Patient Goals

Goal quality can be assessed using a number of approaches. This training aims to increase skills in writing, revising and using high quality rehabilitation goals in practice using several criteria to evaluate goal quality. The approach builds on existing literature regarding the application and limitations of SMART goals, and provides additional criteria to evaluate goal quality and guides how goals can be used in clinical practice.

Implementation of this approach is supported by the SMARTAAR Goal Worksheet, which is a quick and practical tool to support people to write and improve rehabilitation goals. Other approaches exist and clinicians can use their own approach, or modify this approach to suit their role and purpose. Additional approaches include seeking patient and stakeholder feedback on the goals and other published goal quality methods.23

7.1 SMARTAAR Goal Process

The SMARTAAR Goal Process refers to the development of SMART goals that reflect the patient’s desired change in participation that are USED in rehabilitation. The key steps of a SMARTAAR goal writing process include:

I. Writing a SMART Goal
II. Reviewing the goal quality and making refinements if necessary
III. Using goals to support clinical practice.

I. Writing a SMART Goal

The first step is to write the goal incorporating as many elements and details as is necessary to describe what the patient needs or wants to be able to do. This is done as succinctly as possible, but with sufficient detail so that it is as clear as possible at what point the goal has been achieved. The SMARTAAR Goal Worksheet describes how SMART criteria and other elements can be incorporated into the goal statement. These will be described in detail in the following section.

II. Reviewing goal quality and making refinements if necessary

For existing goals, the SMARTAAR Goal Worksheet can indicate components of the goal statement that may need review. This may involve adding more detail to ensure descriptors are measureable enough and easily understood by the patient and others. It is important to check that the goal pertains to how the patient will benefit, and that any actions regarding how this will be achieved are recorded separately (in the lower part of the SMARTAAR Goal Worksheet). Specific instructions for using the SMARTAAR Worksheet are found in Section 8.2.
III. Using goal setting in clinical practice

Once the goal has been written, it can be used to support clinical practice. The action plan (to support the patient achieve their goal) can then be developed, and progress towards goal achievement evaluated and reported.

This process supports goals that:
- reflect principles identified as SMART goals
- are patient centred i.e. reflect the patient’s priorities
- are useful for rehabilitation i.e. support the use of goals to motivate the patient, enhance patient participation and team planning
- direct what action is provided
- supports clinicians to use their high quality SMART goals to:
  - inform and support clinical practice
  - evaluate the degree to which the rehabilitation provided is patient centred
  - measure the effectiveness of rehabilitation for each patient (goal achievement)
  - support team coordination, clinical decision-making and communication
  - support service evaluation through monitoring service-wide goal achievement
  - promote goals that reflect rehabilitation models of care e.g. patient centred, goal focused, interdisciplinary.

Using this approach, goals should be SMART and must also be clear and concise and succinctly tell you what the patient needs and wants to be able to do. It is an approach that is flexible enough to apply to different levels of goals, including steps, commonly included in rehabilitation plans. In the following sections, the separate elements addressed in the SMARTAAR Goal Process will be described, followed by the instructions and activities to demonstrate how clinicians can use practical tools to apply these principles when using patient goals in practice.

7.2 Elements of High Quality SMARTAAR Goals

7.2.1 Elements of SMART Goals

The first element of the SMARTAAR Goal Process is to develop goals that are SMART. SMART is an acronym for the elements that should be included when formulating goals. The theory behind the SMART acronym is based on the work of Dr Edwin Locke, a psychologist who developed a goal setting theory to explain human actions in specific
Numerous definitions have been applied to each aspect of the acronym.

For the purposes of this training, SMART stands for:

- **Specific**
- **Measureable**
- **Achievable**
- **Relevant**
- **Time-bound**

It should be remembered that the SMART formula was developed as a management tool, not a clinical tool. As such, a goal may be perfectly written in SMART format but not necessarily constitute a useful rehabilitation goal. Most importantly, it is possible for a goal to be SMART but not be a participation goal. The SMARTAAR Goal process identifies additional elements to address the limitations of SMART criteria.

**Specific**

This criterion refers to both particular aspects and overall goal statement. In the SMARTAAR Goal Worksheet, Specific starts with using the patient’s name in the goal statement. Having the patient’s name in the goal statement requires the goal to be related to the desired outcome for the patient, whether or not the goal is patient focused or patient generated. Having the patient name in the goal statement isn’t enough by itself to make the goal patient centred – it still needs to specify what the patient wants to achieve. One of the primary benefits of starting with the patient’s name is that it makes it harder to write goals related to clinician / team plans for completing the action.

The goal must also specify the outcome the patient is aiming for. When goals are specific, the patient knows exactly what to aim for, when, and how much. The goal should include specific terms so it is easy to measure or know when it has been achieved (as much as possible). Specific goals should describe concrete outcomes rather than abstract or vague outcomes. For example, ‘John will join his friends on a fishing trip’ is specific, ‘John will increase his social interactions’ is not. Telling a patient to ‘Try hard’ or ‘Do your best’ is less effective than ‘Try to get more than 80% correct’ or ‘Concentrate on beating your best time’. Goals must be unambiguous and clear.
Sometimes, wordy and lengthy goals can contain so much information the change desired by the patient is lost in extraneous detail. Often, simplifying a goal by removing extraneous elements can make it a more effective goal. Consider the patient’s expressed priorities, impact of injuries, level of functioning and stage in the rehab process.

The context and conditions that are required may need to be included to improve a goal’s specificity.\textsuperscript{23} Context generally refers to where the activity will take place e.g. ‘Jack will return to his pre-injury employment as a mechanic with Ford’ is more specific than ‘Jack will return to work’. Context may be implicit. For example, if Jan’s goal is to cook the family’s evening meal, we do not need to specify ‘in her home kitchen’. Conditions generally refer to the level of assistance and equipment required. These elements can also be thought of as increasing a goal’s measurability and are described further in the following section.

**Measureable**

It must be possible to identify when the goal has been achieved. The goal needs to describe the desired level of performance around which clinical interventions are designed, and still make sense to the patient. The degree or specificity of ‘measureable’ will often be informed by the patient’s own expectations, or based on their previous level of participation. Table 6 describes elements of a goal that could be used to make it measureable.
Table 6 Elements of a goal that could be used to make it measureable

<table>
<thead>
<tr>
<th>Element</th>
<th>Examples of Measureable Goals</th>
</tr>
</thead>
</table>
| **How much**                           | Jill will return to work *20 hours per week over 4 days* by end March 2013  
Jack will host a dinner party including cooking a *two course meal* for *himself and three friends* at his home within 12 weeks  
John’s satisfaction with his ability as a father will increase from *self-reported score from 2/10 – 8/10* |
| **How often**                          | Karen will perform the family grocery shop *every week*  
Karen will increase her work days from *2-3 days/week*  
Jack will make his bed *every day*  
Jill will make contact with a friend *twice a week* via phone or face to face |
| **How well**                           | Linda will be able to complete her morning hygiene routine *within one hour*  
Linda will be able to follow a *5-step* written instruction |
| **With what level of independence/assistance** | Peter will cook the evening meal with *assistance only to cut the vegetables*  
Jack will walk from home to the bus stop with *a walking stick and stand-by assistance* |

A goal may only require one of the elements above, or it may require multiple elements. A goal does not need to include numbers to be measureable. It is measureable so long as there is no ambiguity about what constitutes achievement of that goal. For example, ‘Melissa will be able to independently brush her teeth’ is measureable - either she can or she can’t. A meaningful measureable goal can help a patient to stay motivated to complete their goals when they have a milestone to indicate their progress. It also provides the rehab team with the ability to assess the effectiveness of the rehab plan. Specificity and measurability are related – a non-specific goal generally cannot be measured.
In the SMARTAAR Goal Process, any numbers used to quantify or describe when a goal is achieved must also be meaningful. A compromise may be needed between the degree to which a goal is measureable and meaningful. To support patient centred practice, it is most important that goals are meaningful, and measureable enough to support their use in practice. Steps can often include more ‘measureable’ elements than goals, as these are more clearly linked to service provision, as long as the goal itself is clearly linked to the patient’s desired level of change.

The level of measurement needs to be balanced with ensuring the goal remains clear and is easily understood. While numbers can provide clear indicators for goal attainment, they do not always help make a goal measureable and can reduce the meaning of the goal for a patient e.g. ‘74% community integration’, ‘change on assessment from 50 to 65 points’. Referring to change in scores on objective measures is rarely relevant to the patient, although it may be useful tool for the clinician to monitor the patient’s progress. For example, ‘Jack’s anxiety while playing golf will improve by 5 points on the anxiety scale’ may be changed to ‘Jack will enjoy playing golf once a week’. Another limitation of using scores is that, even for clinicians, the measurement is only useful when they understand the scope and limitations of the measurement tool being used.

The quality of performance can sometimes be implicit. To use the previous tooth brushing example, we do not need to specify ‘using the correct amount of toothpaste, not missing any teeth and remembering to spit out rather than swallow the toothpaste’, even though these are elements we would consider when determining goal achievement. However, these nitty-gritty elements of a goal become relevant when a goal has already been worked towards and has been almost achieved. For example, if Jason’s goal is to return to his pre-injury job as a motor mechanic and he achieves this in every aspect other than the fact that he is consistently late to work, the next goal would be ‘Jason will be on time to work each day.’
**Activity 3**

Choose one of the following statements and re-word it to make it more specific and measureable. You will need to make some assumptions about these fictitious patients. Ensure that the wording is written in a positive way i.e. what ‘will’ happen, not what ‘won’t’ happen. Then identify whether your re-written goal is an impairment level, activity level or participation level goal.

<table>
<thead>
<tr>
<th>Original goal statement</th>
<th>Specific and measureable goal</th>
<th>Goal Level (impairment, activity or participation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack will increase his contribution to family life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill will improve her balance and mobility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack will experience improved mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill's comprehension will improve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack will increase his community participation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Achievable**

Is it realistic that the goal will be achieved given the nature of the patient's impairments and the available resources (e.g. skills, money, equipment, time)? What is achievable for the patient will depend on many factors e.g. the nature and impact of their injury, previous functional status, stage in rehab, social situation and age. In order for a goal to be achievable, it needs to be realistic. A goal is not achievable if the necessary resources are not available.

Ideally, goals should be achievable but challenging. There is a balance that needs to be aimed for when setting a goal so that it is sufficiently achievable so as not to be intimidating, yet challenging enough to be motivating. However, in some situations you may want to document the patient's goal, even when it is unrealistic. The 'gap' between the current action plan and the patient's goal can inform ongoing discussions with patients to support the development of insight, particularly if progress towards goal achievement is much slower than the patient anticipated. It can also be useful to document unrealistic goals to highlight service gaps where services are unavailable or inadequate.

Playford suggests that goals set to be achieved within a shorter timeframe, say 3-6 months or less, should be 'probably attainable', whilst longer term and life goals will be 'possibly attainable'. The degree to which a patient generated goal is achievable will vary. When patients are unrealistic, the clinician may need to identify patient focused (not patient generated) goals that are useful for that stage of the rehabilitation program. Incorporating patient generated goals as well can be useful to indicate the 'gap' between what the patient and clinician are aiming for in the foreseeable future. It also serves to describe potentially longer term patient priorities.

**Relevant**

It is of primary importance that the goal is relevant to the patient. The patient needs to be able to answer 'yes' when asked, 'Is this goal something you want to work towards?', 'Is this goal important to you?', 'Does this goal matter to you?' This aspect of writing a goal is consistent with a patient centred approach. A goal that describes how the patient wants to change will usually be relevant to them. Patient focused goals need to be linked to broader patient generated goals as much as possible and it is important to assist the patient to understand the link between them. This ensures patient focused goals are relevant to the patient.
The likelihood of goal achievement is increased when the patient goal is relevant to the service provider. It is useful to identify whether the service can provide the required intervention to achieve the goal. However, not every patient goal will be relevant to specific services. This needs to be documented and actions may be limited to making referrals or seeking alternative treatment options e.g. where the goal is complicated by a pre-existing condition. At times, it can also be useful to record goals that cannot be achieved due to such constraints to highlight service gaps.

**Time-bound**

When will the goal be realistically achieved? Without a time frame, there is less urgency to start taking action towards achieving the goal. This is best specified by a date, rather than by a length of time e.g. ‘by February 2013’, rather than ‘in 3 months’ time’. This prevents the need for constant referral back to when the goal was written and makes it clearer as to whether or not patient progress is on track.

The time-frame for a rehabilitation plan should be guided by how long it is likely to take to achieve the identified goals, rather than formulating goals to fit in with a pre-determined period. The individual circumstances of each patient will impact on the time needed to achieve a goal. It will still be necessary, of course, to specify an approximate time frame with the patient when engaging them in conversations about what their goals are i.e. whether you are asking them to identify a goal for the next 3 - 6 weeks or the next 3 - 6 months. Note that a patient may have several goals with different expected timeframes for achievement.

7.2.2 The AAR Elements of the SMARTAAR Goal Process

The AAR elements of SMARTAAR Goal process identify three additional elements and address how SMART patient centred goals are USED in rehabilitation. The many benefits of writing rehabilitation goals are only realised when they are used in practice and engage patients and the families, the clinical team and stakeholders. The AAR elements describe:
**Action Plan**

The action plan specifies each activity / behaviour that will contribute to achieving the steps. These activities may need to be performed by the patient, clinician, family member or carer. The action plan is intentionally separate from the patient goal statement to differentiate that what the patient wants to achieve is not the same as the intervention the clinician wants to provide. The action plan describes what needs to be done to enable the patient to achieve their goal – these are related but separate elements of the rehabilitation plan.

One of the key drivers for the development of the SMARTAAR Goal Worksheet was to separate the patient’s goal (their reason for undertaking the intervention) from the plans of the clinician or team (what needs to be done and by when). Previously, clinicians frequently wrote their interventions as the goal. Differentiating these two elements supports the provision of patient centred rehabilitation by ensuring treatment plans match patient priorities. The distinction is important: patient priorities are driven by their own needs, lifestyle and the context in which they live; the rehabilitation program, while important, is only a means to help them achieve this.

**Achievement Rating**

Goal achievement needs to be measured if goals are to fulfil their purpose to guide further rehabilitation.\(^7\), \(^25\), \(^40\), \(^41\) Progress towards the achievement of both goals and steps, and the delivery of the action plan should be measured (and then reported / shared). Assessing the patient’s progress in this way enables the goal to be used as an outcome measure. This also allows reporting of the reasons for not achieving the goal or step, as well as the identification of any issues that affected patient progress and the implementation of the action plan.

There are multiple methods of scoring attainment, some more complex than others. Rating scales can include achieved, partially achieved, not achieved, over achieved and discontinued. The key is that some method of measuring goal achievement is used to ensure that the purpose of the goals is met. Some examples of achievement rating scales are provided in Table 7.
When using the GAS, the specific outcome that would constitute each score is determined at the time the goal is set. The GAS is recognised as being very effective as a measure of rehabilitation outcomes, but can be very time consuming.

Measuring goal achievement is only useful when the goal describes how the patient will benefit. Goals that describe when clinicians aim to complete an intervention provide a measure of process of care, but not patient outcome. Goals need to be high quality patient centred goals if the aim of measuring goal achievement is to support patient centred rehabilitation.
**Reporting Goal Outcomes**

The time and effort involved in collaborative goal setting can be wasted if no-one knows about how the patient has progressed, including the central stakeholder: the patient! Who and how progress needs to be reported will depend on the purpose and stakeholders involved. Consider who needs to know this information - the patient and their family, rehab team, other agencies?

- Patients and families may want informal verbal feedback, but sometimes written feedback can be powerful
- Team members will need timely feedback on patient progress and the patient’s views on their feedback. Team processes will influence how communication between clinicians is realised (see also Section 9.7 for further information on developing team processes to support this approach).

### 7.2.3 Additional Criteria for High Quality Goals

SMART criteria provides useful information to direct goal development, but it does not consider the level of patient engagement in the goal setting process, or benefits and reasons for writing goals in a rehabilitation context. For this reason, the SMARTAAR Goal Process identifies additional criteria considered important for high quality useful goals.

**Patient centred:** In addition to SMART criteria, the SMARTAAR Goal Process identifies that goals must be patient centred i.e. reflect the patient’s preferences, or at least describe how the patient will change as a desired outcome of intervention. Goals are ideally patient generated but may be patient focused. Steps are more often patient focused but can also relate to priorities identified, or at least agreed to, by the patient.

**Relate to patient’s participation as identified in ICF:** The need to focus on participation level change is also advocated as ideal in rehabilitation.

**Useful in rehabilitation:** Goals should be useful for rehabilitation – they ideally will realise two primary benefits of writing goals: to engage the patient in rehabilitation planning and to support team planning and clinical decision making.
Summary: SMARTAAR Goal Process

- The SMARTAAR Goal process supports the development and use of high quality, patient centred rehabilitation goals in practice.

- There are 3 steps involved in a SMARTAAR Goal process:
  1. Writing a SMART goal
  2. Reviewing the goal quality and making refinements if necessary
  3. Using goals to support in clinical practice.

- SMARTAAR goal criteria can be used to identify patient centred goals that support rehabilitation. It includes elements of SMART goals and includes additional criteria for quality goals:

- High quality useful goals should be:
  1. **Specific**
  2. **Patient centred** – describe what the patient wants / needs to achieve
  3. **Participation focused** (ideally)
  4. **Useful for rehabilitation**: be clear, concise and tell you want the patient wants or needs to be able to do. They can be used in clinical practice to describe:

  **Action Plan**: The action plan is separate from the goal and describes what needs to be done to support the patient to achieve their goal. The action plan is separate to the patient goal – it describes what activities / behaviours clinicians, the team, other services and the patient / their family need to do to achieve the patient’s goal. The patient goal should inform what intervention is required

  **Achievement rating**: It is important to measure each patient’s progress with goal achievement. Ensuring that progress is monitored is more important than which measuring scale is used

  **Reporting**: Progress towards goal achievement needs to be reported to ensure that the goals fulfil their functions of motivating patients and informing planning.

- Using SMART criteria alone does not guarantee that it is a useful rehabilitation goal. It is possible for a goal to be SMART but not be a patient centred or participation level goal that supports clinical reasoning in rehabilitation.
8. The SMARTAAR Goal Worksheet

The SMARTAAR Goal Worksheet was developed by Helen Badge, Outcomes Manager with the ACI Brain Injury Rehabilitation Directorate (2012). The SMARTAAR Goal Worksheet was designed as a quick approach to writing and reviewing high quality, patient centred, SMART goals. The worksheet provides a practical approach to consider the elements in a goal statement that reflect criteria for high quality goals identified in the SMARTAAR Goal Process.

The SMARTAAR Goal Worksheet can be used to develop, review and refine SMART goals that are focused on patient participation and to support clinical reasoning in rehabilitation. It evaluates the separate elements and overall meaning of a single goal statement and highlights areas for improvement. Clinicians can use the Worksheet to improve the quality of the goals they formulate with patients and to guide them when documenting these goals.

Although the concept of SMART goals is not new, clinicians have struggled with writing high quality, SMART goals in clinical practice. The goal setting process is complex and we have already identified a number of factors that influence the goal setting process. The Worksheet was informed by a review of a range of goals in Brain Injury Rehabilitation Program services. This review indicated a number of inconsistencies in goal writing practice as well as variation in the use of goals in clinical practice. In addition to patient factors, variations in service structure and practice, including how goals were developed and whether they were used in practice, existed.

The SMARTAAR Goal Worksheet has not been formally validated but clinicians have reported it is a useful tool and fit for purpose. It draws on existing approaches to writing goals but has tailored them to suit clinical and rehabilitation service needs identified by clinicians and the literature. It has been found to be flexible enough to be used by clinicians from various disciplines.

8.1 Scope and Limitations of the SMARTAAR Goal Worksheet

The SMARTAAR Goal Worksheet is a tool to develop and use goals consistent with criteria described in the SMARTAAR Goal Process. Essentially, the SMARTAAR Worksheet is a checklist of the important elements of a rehabilitation goal and how goals can be used in practice. It addresses the development and review of a single
goal statement. The Worksheet indicates the need to use the goal in practice, but this is not addressed by the Worksheet itself.

The SMARTAAR Goal criteria include:

- the goal is SMART but still meaningful to the patient
- the goal is patient centred and ideally describes patient generated goals (or at least patient focused goals). It describes how the patient will benefit from rehabilitation
- the goal is focused on patient participation (this criteria sits within the Specific element)
- the action plan is not included in the patient goal statement
- the focus of the SMARTAAR Goal Worksheet is that the patient is at the centre of the goal - the goal should be about what the patient is going to achieve, not what the clinician plans on doing. Ideally, goals should focus on the patient's participation, but there may be instances where this isn't possible or desired. The patient’s name is the starting point of the SMARTAAR Goal Worksheet
- clinicians and teams need to use the patient’s progress towards their goals and goal achievement in clinical decision making and reporting. This is essential if goals are to fulfil their primary aims (motivate patients and support team planning). This highlights that writing the patient goal is only the first step - they then need to be USED in clinical practice.

The first part of the Worksheet describes the key elements of high quality goals, enabling each of these elements to be reviewed. Missing or incomplete elements may indicate areas where a goal could be improved. However, just adding more information is not always a solution – the goal still needs to make sense and reflect the patient’s priorities. Clinicians can use the Worksheet to review which parts of a goal statement can be reviewed and improved.

The second part of the Worksheet focuses on using goals in clinical practice. Goals can be used as a measure of outcome by reviewing progress towards goal achievement and to guide clinical reasoning and communication. Monitoring goal achievement is an integral component of the goal setting process. Without monitoring, patient goals can continue to provide a direction for further therapy but won’t indicate whether the previous action plan has been effective. The Worksheet itself primarily focuses on improving the content of each goal statement rather than how and when the goal is used in practice. The person writing or reviewing a goal needs to also consider the goal in relation to other aspects of the patient’s situation and rehabilitation requirements.
However, these are beyond the scope and purpose of the SMARTAAR Worksheet. Section 9 describes how goals can be incorporated into Rehabilitation Plans.

While actual use of the SMARTAAR Worksheet focuses primarily on the first two steps in the SMARTAAR Goal Process, it does highlight that further work to use the goal in clinical practice is also needed (although this is unlikely to involve using the Worksheet but will involve using the goal statement generated from the Worksheet).

8.1.1 What type of goals can I use it for?
The SMARTAAR Goal Worksheet assesses a single goal statement. It is flexible enough to be used for a range of goal statements at different levels. The goal statement can describe a goal or step; it can be either patient generated or patient focused. It can be used when the goal statement in question needs to be SMART and support rehabilitation practice. The need for rigour in the quality of goal statements, that is, the degree to which it includes SMART elements, needs to be decided by each clinician. Not all goal statements will need to be as SMART as others e.g. patient life goals or long term goals may be more general than shorter term rehabilitation goals. SMARTAAR goals can be used with any type of patient regardless of age, diagnosis or gender, and with any classification system of goal organisation.

8.1.2 How SMART does a goal need to be?
When deciding how SMART a goal needs to be, goal writers need to consider the degree to which the goal statement reflects the patient’s priorities, and balance these against SMART criteria and the needs of clinicians. The elements in the SMARTAAR Goal Worksheet describe different components that can be included in goals. However, not all will be needed for every goal statement.

In some cases, including all elements described on the SMARTAAR Goal Worksheet can be useful, but simply adding more information does not always improve goal quality, and sometimes reduces the clarity and utility of the goal. In other cases, the more elements included can make a goal wordy and lose sight of the intent of the patient’s priorities. Sometimes, more elements can reduce the meaningfulness of a goal:

The goal needs to be SMART enough, but not too SMART!
The goal needs to be flexible enough for clinicians to use to support rehabilitation but still be meaningful to the patient and remain true to the patient’s priorities. For goal statements, it is most important that the goal clearly states what the patient wants to be able to do.

Different types of goals can influence the ease in which a goal statement balances being SMART and measureable on the one hand, and still be meaningful to the patient on the other. This can be particularly true for goals regarding people’s relationships and more psychosocial aspects of functioning – they are often difficult to make measureable while still being meaningful to patients. Just adding numbers to measure change doesn’t always provide meaningful measurement of progress. While the use of objective scores in goal statements can provide a monitoring tool, this should be part of the action plan as this is unlikely to be meaningful to a patient – not many patients will be motivated to work towards a goal involving changing 15 points on a scale they don’t understand.

Similarly, when objective outcome measures (change in scores on assessment tools) are used in practice, they need to be precise enough to give a reliable indicator of change but still be manageable so they can be readily completed by patients and clinicians – and sometimes this means reduced sensitivity. All measures (goals and objective assessments) will vary in the degree to which they are specific and will have some degree of error. This is balanced by their utility in practice – very specific assessments are useless if they take so long there’s no time to provide treatment. It is more critical that patient goals describe what the patient wants and needs to be able to do than meet SMART criteria to the letter.

8.1.3 How long will I need to use it?
The SMARTAAR Goal Worksheet is particularly useful in the early stages of goal writing skill development but may not be needed routinely in the longer term. In this case, it may only be needed for very complex goals, on an as-needed basis. Once you are familiar with the concepts, you may be able to go through the same process without using the physical structure of the worksheet. At times, it can be useful when goals and clinical needs are very complex, and for scheduled team based discussions where variation in goal writing skills exists.
### SMARTAAR GOAL WORKSHEET

#### Patient Priorities / Rehab Goal to be Reviewed:

<table>
<thead>
<tr>
<th>SMARTAAR goal elements</th>
<th>Existing Goal Elements</th>
<th>SMARTAAR goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong> Patient name in goal statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong> How well? What is the desired quality of performance in relation to level of independence, amount / nature of supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>H</strong> How much? Quantity of performance by patient e.g. time taken, frequency, amount, speed, efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A</strong> Achievable and Relevant: You must know the patient to decide whether any goal is achievable for that patient, given the availability of current resources. In some cases, recording a goal that is not achievable may be clinically useful. Ensuring goals refer to the desired outcome for each patient rather than describing an action plan with timeframes helps keep the goal relevant to the patient, not clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T</strong> Time bound: How long do you think it will take the patient to achieve the goal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A</strong> Action Plan: What does the multidisciplinary team, patient, family NEED TO DO to achieve this goal? All treatment plans go here: who does each action, frequency/ duration and by when. Actions pertaining to reducing impairments / managing environmental factors (e.g. train carers, equipment) can go here: list as patient steps towards goal if desired.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A</strong> Achievement rating: Has the goal been achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>R</strong> Reporting goal outcomes: Who needs to know about progress the patient made on this goal?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is the goal clear and concise?**
Does the goal identify what the patient needs / wants to be able to do?

**Revised goal:**

---
8.2 How to Use the SMARTAAR Goal Worksheet

The SMARTAAR Goal Worksheet is flexible and can be used for different purposes. It helps identify elements that may be useful to explain what the patient wants and needs to be able to do to support rehabilitation.

Using the Worksheet supports clinical reasoning. However, the clinician still needs to make judgements about whether the goal is appropriate for this patient. It is not a stand-alone solution but provides a process to write and review goals and highlight how they can be used to support rehabilitation.

Guidelines on using the Worksheet have been provided for WRITING GOALS, and REVIEWING GOALS. These can be adapted to suit clinical need, the clinician’s level of skill and team and service processes. Table 8 outlines some tips for using the SMARTAAR Goal Worksheet.
8.2.1 Using the SMARTAAR Goal Worksheet: Instructions for CLINICIANS

1. Start at the top of the Worksheet in ‘Rehab goal to be reviewed’.
   - If you are **WRITING A NEW GOAL**, record the patient’s words or their main priorities for treatment e.g. ‘I want to be earning money’, ‘I want to get back to work by the end of the year’
   - If you are **REVIEWING AN EXISTING GOAL**, record the current goal statement.

2. Use the Worksheet boxes under the ‘Existing goal elements’ column to record elements that will help develop a SMART goal statement that the patient identified they want to achieved. For new goals, more than one goal may be necessary to reflect the patient’s priorities to support rehabilitation.
   - What is the patient’s desired outcome? The ‘level’ or amount they want to achieve in a given period may need to be narrowed down to fit within service requirements
   - When writing the rehabilitation goal, start with the patient’s name
   - Is it a participation goal? If not, consider whether it could be
   - Add elements you can think of using SMART criteria. The patient may be able to identify some details of what goal achievement would look like for them
   - Sometimes it’s easier to initially record ideas for the action plan to support goal achievement, as most clinicians will have early ideas on this. This can help identify the details to be included in the goal statement and ensures the action plan doesn’t sneak into the goal statement.

3. If the goal statement appears to tell only part of the story, use the ‘SMARTAAR goal’ column to add and change the goal statement to make it a clearer better goal.
   - Start by reviewing which SMART boxes are blank – what elements are missing from the goal according to SMARTAAR criteria? What extra information is needed?
   - Does existing information need to be reworded for greater clarity?
   - Are any numbers meaningful and make sense in real life? The patient’s satisfaction may be a better indicator than any change on an assessment. For some goals, particularly psychosocial issues, there may be no relevant metric. If one is used, the criterion of success should be understood by the patient.

4. Sometimes goals can be improved by adding more detail. All or most of the boxes need information. However, on other occasions, the goal is improved by simplifying it and taking extraneous information out of the goal, particularly where information is explicit. For example, the context may be obvious and not need repeating in the goal statement e.g. driving … on roads, playing golf … at the golf club. Consider the purpose of this goal – for the patient and team planning – and balance SMART criteria with the intent of goal.

5. Once the goal is documented, review the goal statement.
   - **Does it tell you succinctly what it is the patient needs and wants to do as an outcome of the action plan?** Does the goal statement reflect the patient’s priorities effectively?
     You need to determine the balance required between remaining true to the patient’s priorities and writing a SMART, measurable goal that fulfils the purpose of writing the goal. The goal needs to be SMART ENOUGH, but not too SMART. Sometimes, simple goals are best.
   - **Does the goal fulfil its purpose** e.g. motivating patients and contribute to rehabilitation planning?

6. Review steps 3 and 4 if required. Then, after any revisions, repeat step 5 to help make sure the goal is SMART enough, but still useful and meaningful.

7. Record the revised goal statement that will be used to guide rehabilitation in the box at the bottom of the sheet.
### Table 8 Tips for using SMARTAAR Goal Worksheet

<table>
<thead>
<tr>
<th>Elements</th>
<th>DETAILED EXPLANATION OF GOAL ELEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific</strong></td>
<td>Is the patient’s name included in goal statement?  It should be there to support patient centred goals and rehab</td>
</tr>
<tr>
<td></td>
<td><strong>WHAT does the patient want to achieve?</strong>  What is the point of doing the intervention?  Is the goal focused on participation (or activity)?  Ensure the goal is clear and well defined.  It provides reason for providing and evaluating the efficacy of the intervention</td>
</tr>
<tr>
<td><strong>Measureable</strong></td>
<td>Is it easy to determine when the goal is achieved? (This is also linked to ‘Specific’ criterion)  If you cannot measure whether the goal has been achieved or not, you may need to refine the goal further</td>
</tr>
<tr>
<td></td>
<td><strong>What is the desired standard or quality for achievement?</strong>  Specify what the desired standard / quality is needed to be met for the goal to be achieved e.g. frequency, level of independence, speed, number of errors, location, quantity  How will you measure whether goal has been achieved?  If this question is hard to answer, you may need to refine goal further</td>
</tr>
<tr>
<td><strong>Achievable</strong></td>
<td>Is the goal realistic for this patient at this time?  Consider the patient’s injury, age, supports, lifestyle, stage of rehab  Is the goal achievable given current resources?  Is the goal is within the capacity of your service / role?</td>
</tr>
<tr>
<td><strong>Relevant</strong></td>
<td>Has the patient said that they want to achieve this goal?  The goal needs to have meaning for the patient  Is the goal relevant for the services being requested?  Is the goal within the scope of the service?</td>
</tr>
<tr>
<td><strong>Time bound</strong></td>
<td>How long do you think it will take for the patient to achieve the goal?  Include a specific time period  Ensure that there is enough time to achieve the goal  If it will take too long, smaller goals may need to be written</td>
</tr>
<tr>
<td><strong>Action Plan</strong></td>
<td>What does the multidisciplinary team, patient, family and other agencies need TO DO to achieve this goal?  Who does each action?  When is it due to be completed?  Clinician actions with a timeframe for completion should be recorded in this section (not the goal itself) e.g. ‘complete neuropsych assessment by .....’  Impairment goals can often be reworded as steps to monitor progress e.g. use of DASS to monitor changes in mood, 6 minute walk test</td>
</tr>
<tr>
<td><strong>Achievement Rating</strong></td>
<td>A good goal should be measured.  Use a rating scale to describe the degree to which the patient has achieved their goal  Services may have their own goal achievement scale  Reporting reasons for not achieving a goal can enable goals to be used as an outcome measure, to communicate with the patient, and to support ongoing clinical reasoning and service evaluation e.g. ‘Poorly written goal / Patient moved / Patient changed mind re goal / No appropriate service available’</td>
</tr>
<tr>
<td><strong>Reporting Goal Outcomes</strong></td>
<td>Who needs to know about the progress the patient has made to date?  Providing the patient with feedback ensures that rehab remains patient centred and can maintain motivation  How many goals were fully / partially achieved?  What factors affected progress towards the goals?  What are the implications for ongoing rehab?  Does the action plan need to be amended?</td>
</tr>
</tbody>
</table>
Using the SMARTAAR Worksheet with an example can illustrate how these instructions work in practice. Take the example of the following goal:

Increase patient motivation to participate in physiotherapy to improve patient range of movement in the upper and lower limbs and have increased safety with all mobility.

When reviewing this goal, consider the following questions:

- Do you think this goal is patient generated, patient focused or clinician generated?
- What meaning does this goal have for the patient?
- Does it succinctly tell you what the patient wants and needs to be able to do?

It is more likely this is a clinician generated goal to describe what the clinician wants the therapist to do. It doesn’t describe what the patient wants to be able to do when he does complete his physio.

Given the existing goal, the phrases and elements of this goal can be broken down, and recorded in the blue Existing Goal column:

- Patient name: not stated (referred to as patient)
- Patient outcome: not described
- Focus on patient participation: no, focused on the completion of the action plan
- Where: not described
- How well and how much: not described
- Time-bound: not described
- Is it clear and concise: not really – what do ‘improve’ and ‘increase’ mean?
- Does it tell us what the patient wants and needs to be able to do? NO

The SMARTAAR Goal column on the right side of the Worksheet can be used to improve the goal statement. Other information about the patient’s priorities is then needed to ‘fill the gaps’ to generate a patient centred goal that describes the desired level of change in their participation. In this case, the patient may want to be able to walk his dog.

Consider:

- What is the patient’s main participation goal? He has said he wants to be able ‘to walk his dog’. Add this to the Patient Outcome box.
- How will we know when he is walking his dog enough to be happy he’s achieved his goal? In conjunction with the physio, they have decided that walking his dog for 20 minutes 3 times a week is a good starting goal. He attends physio sessions on Tuesdays and Fridays so extra walking on these days may be too much at this time. These details can be added into the How Much box.
- Other details go into action plan. Motivating Jack is a purpose for writing a patient centred goal, not a goal in itself.

This example has been illustrated in the using the form of the SMARTAAR Goal Worksheet on the next page.
SMARTAAR GOAL WORKSHEET

Patient Priorities / Rehab Goal to be Reviewed:

Increase patient motivation to participate in physiotherapy to improve patient range of movement in the upper and lower limbs and have increased safety with all mobility

<table>
<thead>
<tr>
<th>SMARTAAR goal elements</th>
<th>Existing Goal Elements</th>
<th>SMARTAAR goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name in goal statement</td>
<td>patient</td>
<td>Jack</td>
</tr>
<tr>
<td>What patient outcome is being aimed for? What is the purpose of any intervention? <strong>CLINICIAN’S ACTIONS/INTERVENTIONS DO NOT GO HERE</strong></td>
<td></td>
<td>Will be able to walk his dog</td>
</tr>
<tr>
<td>Focus on Patient’s Participation (Y/N)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Where will participation take place – context of goal? e.g. at home, local community (might be implicit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How well? What is the desired quality of performance in relation to level of independence, amount / nature of supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much? Quantity of performance by patient e.g. time taken, frequency, amount, speed, efficiency</td>
<td></td>
<td>For 20 minutes three times a week</td>
</tr>
<tr>
<td>Achievable and Relevant: You must know the patient to decide whether any goal is achievable for that patient, given the availability of current resources. In some cases, recording a goal that is not achievable may be clinically useful. Ensuring goals refer to the desired outcome for each patient rather than describing an action plan with timeframes helps keep the goal relevant to the patient, not clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time bound: How long do you think it will take the patient to achieve the goal?</td>
<td></td>
<td>By Easter (18th April 2014)</td>
</tr>
<tr>
<td>Action Plan: What does the multidisciplinary team, patient, family NEED TO DO to achieve this goal? All treatment plans go here: who does each action, frequency/ duration and by when. Actions pertaining to reducing impairments / managing environmental factors (e.g. train carers, equipment) can go here: list as patient steps towards goal if desired.</td>
<td>‘participate in physiotherapy’</td>
<td>• Physiotherapy sessions</td>
</tr>
<tr>
<td></td>
<td>‘Improved range of movement in the upper and lower limbs’</td>
<td>• Jack will complete ‘home’ exercise program</td>
</tr>
<tr>
<td></td>
<td>‘increased safety with all mobility’</td>
<td></td>
</tr>
<tr>
<td>Achievement rating: Has the goal been achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting goal outcomes: Who needs to know about progress the patient made on this goal?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is the goal clear and concise? Does the goal identify what the patient needs / wants to be able to do?

Revised goal: Jack will be able to walk his dog for 20 minutes three times a week by Easter, 18th April 2014.
Summary: Assessing Goal Quality

- The SMARTAAR Goal Worksheet was designed as a quick approach to writing and reviewing high quality patient centred SMART goals. It provides a checklist of the important elements of a rehabilitation goal and how goals can be used in practice.

- SMARTAAR goals:
  - need to be patient centred, SMART goals that address desired change in the patient’s participation
  - must be clear and concise and succinctly tell you what the patient needs and wants to be able to do.

- It is an approach that is flexible enough to apply to different levels of goals, and steps commonly included in rehabilitation plans.

- You can use the SMARTAAR Goal Worksheet to:
  - write SMART goals that can be used in clinical practice
  - review goal quality
  - identify how goal quality can be improved.

- Use the ‘Tips for Using SMARTAAR Goal Worksheet’ handout to help you make decisions when writing and revising goals.

Notes
8.3 PRACTICAL ACTIVITY 1

8.3.1 Instructions

Use the SMARTAAR Worksheet TO REVIEW AND IMPROVE the goal provided on the following page:

1. Use the SMARTAAR Worksheet on the following page to record each 'element' of the goal according to the boxes.

2. Identify the gaps in the goal. What is missing? Can the goal be improved? If yes, add detail to improve the goal. You need to develop your own ideas about the patient, their rehab needs and situation.
### SMARTAAR WORKSHEET for PRACTICAL ACTIVITY 1

#### Patient Priorities / Rehab Goal to be Reviewed:

Penny will independently access her 'her own backyard' (with its rugged terrain) and her local community allowing her to engage fully in family activities on weekends and holidays by October 2013.

<table>
<thead>
<tr>
<th>SMARTAAR goal elements</th>
<th>Existing Goal Elements</th>
<th>SMARTAAR goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient name in goal statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What <strong>patient outcome</strong> is being aimed for? What is the <strong>purpose of any intervention?</strong> <strong>CLINICIAN'S ACTIONS/INTERVENTIONS DO NOT GO HERE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on Patient’s Participation (Y/N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where will participation take place – context of goal? e.g. at home, local community (might be implicit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How well?</strong> What is the desired <strong>quality of performance</strong> in relation to level of independence, amount / nature of supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How much?</strong> Quantity of performance by patient e.g. time taken, frequency, amount, speed, efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achievable and Relevant:</strong> You must know the patient to decide whether any goal is achievable for that patient, given the availability of current resources. In some cases, recording a goal that is not achievable may be clinically useful. Ensuring goals refer to the desired outcome for each patient rather than describing an action plan with timeframes helps keep the goal relevant to the patient, not clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time bound:</strong> How long do you think it will take the patient to achieve the goal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action Plan:</strong> What does the multidisciplinary team, patient, family NEED TO DO to achieve this goal? All treatment plans go here: who does each action, frequency/ duration and by when. Actions pertaining to reducing impairments / managing environmental factors (e.g. train carers, equipment) can go here: list as patient steps towards goal if desired.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achievement rating:</strong> Has the goal been achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting goal outcomes:</strong> Who needs to know about progress the patient made on this goal?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is the goal clear and concise?**

Does the goal identify what the patient needs / wants to be able to do?

**Revised goal:**
8.4 PRACTICAL ACTIVITY 2

8.4.1 Instructions

Using a patient goal that you have brought to training, use the SMARTAAR Worksheet TO REVIEW AND IMPROVE that goal.

1. Use the SMARTAAR Worksheet elements to record each 'element' of the goal according to the boxes.

2. Using your knowledge of the patient identify the gaps in the goal. What is missing? Can the goal be improved? If yes, Add detail to improve the goal. You need to develop your own ideas about the patient, their rehab needs and situation.
### 8.4.2 SMARTAAR GOAL WORKSHEET – PRACTICAL ACTIVITY 2

**Patient Priorities / Rehab Goal to be Reviewed:**

<table>
<thead>
<tr>
<th>SMARTAAR goal elements</th>
<th>Existing Goal Elements</th>
<th>SMARTAAR goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>S</strong> What <strong>patient outcome</strong> is being aimed for? What is the <strong>purpose of any intervention?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong> <strong>Focus on Patient’s Participation (Y/N)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Where</strong> will participation take place – context of goal? e.g. at home, local community (might be implicit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How well?</strong> What is the desired <strong>quality of performance</strong> in relation to level of independence, amount / nature of supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How much?</strong> Quantity of performance by patient e.g. time taken, frequency, amount, speed, efficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achievable and Relevant:</strong> You must know the patient to decide whether any goal is achievable for that patient, given the availability of current resources. In some cases, recording a goal that is not achievable may be clinically useful. Ensuring goals refer to the desired outcome for each patient rather than describing an action plan with timeframes helps keep the goal relevant to the patient, not clinician</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time bound:</strong> How long do you think it will take the patient to achieve the goal?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action Plan:</strong> What does the multidisciplinary team, patient, family NEED TO DO to achieve this goal? All treatment plans go here: who does each action, frequency/duration and by when. Actions pertaining to reducing impairments / managing environmental factors (e.g. train carers, equipment) can go here: list as patient steps towards goal if desired.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Achievement rating:</strong> Has the goal been achieved?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting goal outcomes:</strong> Who needs to know about progress the patient made on this goal?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is the goal clear and concise?**

*Does the goal identify what the patient needs / wants to be able to do?*

**Revised goal:**

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
9. Putting it All Together

This training has provided you with information and skills to write, review and use rehabilitation goals in the context of your role. This section provides information to synthesise the information and skills you have learnt during this training program. We have provided an example of a template for writing rehabilitation plans. The aim of the template is to illustrate how concepts addressed in this training work together. It provides an example of how the final stage of the SMARTAAR Goal Process using goals in clinical practice. Specifically, incorporating SMARTAAR Goals into a rehabilitation plan will demonstrate how:

- goals form the basis for developing steps and action plans to guide patient centred rehabilitation
- goals can fulfil the purposes of working with the patient and in team collaboration
- steps and action plans are developed to demonstrate how the patient’s goals can be achieved
- goal achievement can be used to inform clinical reasoning, as well as communication with the patient and other stakeholders.

9.1 Structuring Rehabilitation Plans

Goals are frequently documented in written rehabilitation plans that communicate the patient’s goals, rehabilitation treatment plans and progress in a single document.

Rehabilitation plans are, ideally, a document that conveys to all stakeholders:

- the goals being aimed for
- the strategies for goal achievement (i.e. steps and action plans)
- progress being made.

Documenting this information (goals, strategies and progress) should be an essential step in the rehabilitation of all patients. An effective rehabilitation plan is in effect fulfilling the AAR of the SMARTAAR goal process – it links Action plans to SMART goals, Achievement is assessed and Reported on to key stakeholders. It enables goals to be used in clinical practice and maximise their utility for the patient, clinicians and others.

How a rehabilitation plan is structured i.e. what information goes where, can make a big difference to how effectively it meets the purposes outlined above.
9.1.1 Patient generated and Patient focused Goals in Rehabilitation Plans

A rehab plan may include a mixture of patient generated and patient focused goals. The number and type of goals identified by patients will vary. While many patients will identify participation and activity goals, they may also identify some impairment level goals. For example, a patient may identify a few goals at different levels: (1) ‘I want to get back to work by Easter’, and (2) ‘I want to be able to sit at my desk without pain’. Some patients will identify several goals, some only one or two, and others may need support to identify even one goal. Some patients need education in what goals are and how to set them. Negotiating realistic and appropriate goals can be an important part of the rehabilitation process, as individuals adjust to their level of impairment and disability.

Clinicians often find it is easier to use the SMART goal format to describe impairment level goals, as these can reflect the results of assessments that are frequently completed as part of the assessment process e.g. ‘Jill’s DASS score will improve by 5 points’, ‘Jack’s knee range of motion will improve by 60°’. In a rehabilitation plan, these are more appropriately described as actions to monitor a patient’s progress towards their own goal, rather than goals in themselves e.g. an action will include ‘to monitor changes in Jill’s anxiety using DASS’. Additionally, more discrete activity goals may also be reported as steps supporting the patient achieve their bigger goal.

Figure 10 illustrates the use of patient generated and patient focused goals in rehabilitation plans.
**Example 1:** Jill expresses that she wants her ‘life back’. For her, this means she wants to live independently. However, based on assessments, it is considered unrealistic that this goal can be achieved within the next 3 - 6 months. Jill is assisted to identify and agree to shorter-term goals that are still relevant to her long-term goals, but more useful in supporting the immediate phase of her rehabilitation. The more realistic goals described in the rehabilitation plan include being able to independently perform all aspects of her personal hygiene and to competently prepare her breakfast. Whilst Jill may not have initially identified these specific goals, they are still patient focused and still relevant to her stated goal of returning to independent living. Jill was able to agree to these goals as part of her rehabilitation program.

Figure 11 illustrates the relationship between Jill’s patient generated goal and the two patient focused goals that will help her achieve this.
Figure 11 An example of a patient generated goal and its relevant patient focused steps

It is important that the goal statement actually reflects an outcome that is meaningful to the patient. Including the patient’s name in the goal helps ensure the goal relates to the desired change in the patient. It makes it harder to write goals that relate to the action plans or objectives of the clinician. A goal statement that reflects Jack’s main priority could be ‘Jack will return to his pre-injury employment as a shelf-stacker’. However, including the patient’s name in the goal statement is not enough by itself to make it patient focused. For example, ‘Jack will learn safe lifting technique’ describes a strategy and is not a patient focused goal.

9.2 Template for Rehabilitation Plan Reporting

A rehabilitation plan template has been developed to illustrate key messages addressed in this training. It demonstrates how information can be structured to best apply the principles of high quality goal setting identified in this training. The information in the template relates to the section describing the patient goal, steps and action plan. It also documents the relationship between patient progress and the need for different types of services over time, whilst still working towards the patient’s main goal.
The information is not intended to replace existing forms, but may be used to inform a review of rehabilitation plan forms by rehabilitation services. This section aims to illustrate key lessons learnt during the training. These can be translated when you need to use other rehab plan templates when document a patient’s rehabilitation needs and progress. Experience using different templates assists in skill development of writing goals, steps and action plans.

9.3 Elements of the Rehabilitation Plan Template

The template we have used in this training demonstrates the link between the key elements of the plan: the patient goal, steps and the associated action plans.

The patient’s goal is the starting point when devising a rehab plan. The next step is to identify what the patient will need to do to achieve that goal. Finally, the actions that the patient, significant others and rehab team need to undertake to achieve the step are listed.

When appropriate, assess the patient’s progress towards their goal. Achievement is reported on ALL ELEMENTS SEPARATELY - it is recorded in the ‘Achievement’ column next to the goal, each step and each aspect of the action plan. Comments are recorded in the ‘Progress’ box.

Whilst it may appear cumbersome to assess each aspect of the rehab plan, doing this provides useful information about the reasons why a goal or step has not been achieved. Did an event occur that was not accounted for? Was an important element omitted from the plan? These aspects can then be addressed in subsequent rehab plans.

As each impairment often affects multiple aspects of functioning, it is common for the same steps to be part of the achievement process of multiple goals. Therefore, elements of the action plan may need to be repeated throughout the rehabilitation plan. This only emphasises the importance of those interventions to all involved.

If it is necessary to use an impairment level goal as the main goal statement, the reason for this should be stated in the plan. Ideally, all stakeholders (patients, their significant others, carers, clinicians, employers etc) should have a copy of the rehabilitation plan so that they are aware of their role, and others’, in assisting the patient towards their goals. There generally needs to be different versions for different stakeholders so that the patient’s privacy is respected. Of course, patient permission must be obtained to provide stakeholders with this information.
In the following rehab plan examples, progress towards the achievement of the goal, steps and action plan is reported using the following scale:

<table>
<thead>
<tr>
<th>Achievement rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not achieved</td>
</tr>
<tr>
<td>2</td>
<td>Partially achieved</td>
</tr>
<tr>
<td>3</td>
<td>Achieved</td>
</tr>
</tbody>
</table>
9.4 Instructions for Using Template

The following template has been used to provide an example of how to record a patient’s rehabilitation plan. See Table 9 for information about each component of the template. See Table 12 for a sheet on tips for using the template.

When reading the templates, please note:

1) each patient goal is numbered e.g. Patient Goal 1
2) each step corresponding to a particular patient goal is numbered in relation to that goal e.g. 1a), 1b)
3) each action plan corresponding to a particular step is numbered in relation to the step e.g. 1a), 1b).

On subsequent pages two sample plans using the template have been provided. The first includes a progress report on a previous plan. The second presents the next stage of rehabilitation.

- Table 10 documents the patient’s goal and his progress over the plan period towards the achievement of his goal, each of the steps and whether each element of the action plan was completed. Note in Step 1a), even though Jack has only partially achieved his home exercise program, he has still been able to achieve his step of safely ascending and descending a flight of 16 stairs independently. In contrast to this, even though Jack has achieved all of the elements of his action plan 1c), he has only partially achieved step 1c) - performing all aspects of his personal hygiene independently. This discrepancy between the two indicates that something unaccounted for has prevented him achieving the step. Discussion with Jack revealed that his mother has been helping him shower at home; he is also fearful of falling in the shower. New steps and action plans were written to accommodate those issues that were identified since the previous plan.

- Table 11 documents the follow-on plan, which lists subsequent steps and the action plans to achieve them.
Table 9 Application of high quality, goal setting principles in rehabilitation plan template

<table>
<thead>
<tr>
<th>DATE of PLAN:</th>
<th>Plan No:</th>
<th>Plan Period:</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT GOAL: 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ideally, it is a patient generated goal but may be patient focused. This should ideally be a participation level goal, or at least an activity level goal.

In some situations, an impairment level goal may be appropriate, particularly early after injury/illness or for very low functioning patients when it is unrealistic for participation or activity level goals to be set. However, very broad participation goals may also be appropriate e.g. remain living in community, return to live at home.

The SMARTAAR Goal Worksheet can be used to ensure that the goal is a high quality, patient centred participation goal.

<table>
<thead>
<tr>
<th><strong>PATIENT STEP 1a)</strong></th>
<th>Achievement</th>
<th><strong>PATIENT STEP 1b)</strong></th>
<th>Achievement</th>
<th><strong>PATIENT STEP 1c)</strong></th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated</td>
<td>To what degree has the patient achieved this Step?</td>
<td>• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated</td>
<td>To what degree has the patient achieved this Step?</td>
<td>• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated</td>
<td>To what degree has the patient achieved this Step?</td>
</tr>
<tr>
<td>• If an impairment level goal is the actual goal, this section may have very little or no information</td>
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<td>• If an impairment level goal is the actual goal, this section may have very little or no information</td>
<td>• If an impairment level goal is the actual goal, this section may have very little or no information</td>
<td>To what degree has the patient achieved this Step?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ACTION PLAN 1a)</strong></th>
<th>Achievement</th>
<th><strong>ACTION PLAN 1b)</strong></th>
<th>Achievement</th>
<th><strong>ACTION PLAN 1c)</strong></th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• What intervention is required?</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
<td>• What intervention is required?</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
<td>• What intervention is required?</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
</tr>
<tr>
<td>• Who from?</td>
<td>• Who from?</td>
<td>• Who from?</td>
<td>• Who from?</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
<td></td>
</tr>
<tr>
<td>• How frequently?</td>
<td>• How frequently?</td>
<td>• How frequently?</td>
<td>• How frequently?</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
<td></td>
</tr>
<tr>
<td>• This includes any action that the patient and/or their significant others need to take</td>
<td>• This includes any action that the patient and/or their significant others need to take</td>
<td>• This includes any action that the patient and/or their significant others need to take</td>
<td>• This includes any action that the patient and/or their significant others need to take</td>
<td>To what degree has the patient achieved each element of the Action Plan?</td>
<td></td>
</tr>
</tbody>
</table>

**PROGRESS**

This section should comment on both the progress towards the goal and on the steps. Issues affecting progress, including potential barriers, should be described. It should also include details of any parts of the action plan that have not been fully implemented, the effectiveness of services already provided and describe the rationale when new / additional services are required.
Table 10 Example of patient rehabilitation plan 1 (first plan)

<table>
<thead>
<tr>
<th>DATE of PLAN: 30/6/13</th>
<th>Plan No: 1</th>
<th>Plan Period: 30/6/2013 - 31/9/2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT GOAL: 1</td>
<td>Achievement</td>
<td></td>
</tr>
<tr>
<td>Jack will be ready to return to living independently in his own home by September 2013</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT STEP 1a)</th>
<th>Achievement</th>
<th>PATIENT STEP 1b)</th>
<th>Achievement</th>
<th>PATIENT STEP 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack will be able to safely ascend and descend a flight of 16 stairs independently by 30/9/13</td>
<td>3</td>
<td>Jack will be able to independently perform the weekly shop using online ordering of home-delivery</td>
<td>3</td>
<td>Jack will be able to perform all aspects of his personal hygiene independently</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN 1a)</th>
<th>Achievement</th>
<th>ACTION PLAN 1b)</th>
<th>Achievement</th>
<th>ACTION PLAN 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly physiotherapy for weeks 1-6 to address deficits in balance and mobility - includes the prescription of a home-based exercise program</td>
<td>3</td>
<td>Weekly occupational therapy to improve memory and planning skills/ strategies</td>
<td>3</td>
<td>Weekly physiotherapy for weeks 1-6 weeks, to address balance issues that are currently impacting on ability to safely negotiate Jack’s home bathroom</td>
<td>3</td>
</tr>
<tr>
<td>Fortnightly physiotherapy for weeks 7-12 weeks to address deficits in balance and mobility - includes the prescription of a home-based exercise program</td>
<td>3</td>
<td>Fortnightly speech therapy to improve computer literacy</td>
<td>3</td>
<td>Fortnightly physiotherapy for weeks 6-12 weeks to address balance issues</td>
<td>3</td>
</tr>
<tr>
<td>Performance of home exercise program 4 days/week</td>
<td>2</td>
<td></td>
<td></td>
<td>Installation of a grab rail within the shower recess in both his mother’s home and his home</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Purchase of a shower chair</td>
<td>3</td>
</tr>
</tbody>
</table>

PROGRESS: Jack has achieved the steps regarding negotiation of stairs and performance of online grocery shopping but not the step of independent showering. Jack has diligently attended all of therapy sessions and completed his home exercise program. His balance has improved to a level to enable him to safely shower independently and this has been confirmed by occupational therapy shower assessment. Unfortunately, this ability has not transferred to the home setting. Jack remains fearful of falling, despite having demonstrated the ability to shower safely without assistance. His mother continues to provide assistance in the shower.
Table 11 Example of patient rehabilitation plan 2 (second plan)

<table>
<thead>
<tr>
<th>DATE of PLAN:</th>
<th>Plan No: 2</th>
<th>Plan Period: 1/10/13 – 31/12/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT GOAL: 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jack will be ready to return to living independently in his own home by January 2014.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENT STEP 1a)</td>
<td>Achievement</td>
<td>PATIENT STEP 1b)</td>
</tr>
<tr>
<td>Jack’s mother will only provide assistance to Jack that has been assessed as necessary by the OT</td>
<td></td>
<td>Jack will be able to shower independently at home</td>
</tr>
<tr>
<td>ACTION PLAN 1a)</td>
<td>Achievement</td>
<td>ACTION PLAN 1b)</td>
</tr>
<tr>
<td>Jack’s mother will receive further education weekly from the OT regarding level of assistance for weeks 1-3</td>
<td></td>
<td>Fortnightly psychology sessions to help overcome the fear of falling</td>
</tr>
<tr>
<td>Jack’s mother will receive further education weekly from the OT regarding level of assistance at week 7</td>
<td></td>
<td>Practice of independent showering with standby assistance from the occupational therapist to reinforce ability</td>
</tr>
<tr>
<td>Jack’s mother will receive counselling weekly for weeks 1-4 from the social worker to assist her to understand the need to let Jack practice his independent living skills</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PROGRESS
<table>
<thead>
<tr>
<th>Plan</th>
<th>Prompt questions and considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Goal</strong></td>
<td>• Is the goal SMART, patient centred and useful for rehabilitation? Does it clearly describe how the patient will benefit from recommended action plan? If you are unsure, use the SMARTAAR Goal Worksheet to revise goal statement&lt;br&gt;• Does the goal appear to reflect patient identified priorities?&lt;br&gt;• Is there information regarding the level of patient engagement? Is it a patient generated or patient focused goal?&lt;br&gt;• How realistic is the goal, given your knowledge of the nature and impact of the patient’s injuries and their progress to date?</td>
</tr>
<tr>
<td><strong>Patient Steps</strong></td>
<td>• Is the step (a goal statement) SMART, patient centred and useful for rehabilitation? Does it clearly describe how the patient will benefit from the recommended action plan? If you are unsure, use the SMARTAAR Goal Worksheet to revise goal statement in relevant step&lt;br&gt;• Does the step appear to reflect patient identified priorities / needs? Steps may often be patient focused rather than patient generated – has the level of patient engagement been reported?&lt;br&gt;• Consider, if the patient can perform all the steps, will they successfully achieve their goal? Are there additional steps needed? Ensure all steps contribute to achievement of this goal (and each goal they are described for)&lt;br&gt;• Do steps describe what the patient will be able to do as a consequence of the action plan? If no, should it be an action?&lt;br&gt;• If too many steps are needed per goal, does the goal need to be broken into more than one goal?</td>
</tr>
<tr>
<td><strong>Action Plan</strong></td>
<td>• Are ALL recommended actions you think are necessary for the patient to achieve their steps and goal included? Ensure actions are related to each step. Are all necessary? Do others need to be added?&lt;br&gt;• Are the level of services and level of steps and goal well matched? Consider appropriateness of service/equipment (cost, clinical consensus, evidence based), appropriateness of provider (relevance, availability), expected degree of benefit to patient. Have alternatives been considered but discounted - explain&lt;br&gt;• If the actions are extensive (high level type and amount of services), should the step be broken down into more than one step?&lt;br&gt;• Are the actions consistent with the available evidence, clinical practice and guidelines?&lt;br&gt;• Is there evidence that the patient has agreed to / collaborated in developing the action plan?&lt;br&gt;• If too many actions are needed per step, does the step need to be broken into more than one step?</td>
</tr>
</tbody>
</table>
| **Rehab Plan as a whole**                | • Does the overall plan tell a cohesive story about how the recommended actions will address clinical needs and support the patient to achieve steps and goals?<br>• Is the level of patient engagement in the report described? If goal and step are patient focused and different from patient generated priorities e.g. because patient lacks insight and the goal is not realistic in given timeframe, is this recorded in the report somewhere?<br>• Is the type and intensity of services required in line with the desired level of change in the patient in the specified timeframe as described in steps and goals?<br>• Does the plan describe the patient’s progress with actions, steps and goals to date, including issues affecting progress and how these will be addressed?<br>• Does the plan describe reasons for variations in the projected action plan and impact on patient progress towards steps and goals?<br>• Consider whether the number of goals and steps in the whole plan reflects a realistic rehabilitation plan for the specified period
In the example above, the patient’s progress towards his primary goal (living independently) remains the same, but the steps and action plan (and timeframe) for achieving this have changed. The change indicates different steps were needed to address Jack’s lack of progress in the initial plan.

As impairment can often affect multiple aspects of functioning, it is common for the same strategies to be part of an action plan to address more than one step, and possibly more than one goal. Therefore, some strategies in the action plan will be repeated throughout the rehabilitation plan. This emphasises the importance of those interventions to all involved.

Summary: Putting it all together

- The main goal statement is ideally an activity or participation level goal
- Impairment level goals can be steps to the main goal statement
- Action plans are written for each step
- The same step and action plans will often be listed under multiple goals
- It is often necessary for multiple therapists to contribute towards achieving the same goal
- Assessing patient achievement on each element of the rehab plan can provide useful information about the reasons why a goal or step has not been achieved

Notes
9.5 PRACTICAL ACTIVITY 3

9.5.1 Instructions

Using the information in the following case study, formulate two (2) goals that reflect Jack’s desires. Document these (in SMART format) on the separate worksheets (1 rehab plan worksheet per goal) on the following pages, along with any steps and action plans that will be needed for goal achievement.

You can make up any details that you feel relevant that have not been provided.

9.5.2 Case study

- Jack is a 29 year old father of two boys aged 6 and 8. Jack is one year post stroke. Pre-stroke, he worked as a motor mechanic.
- Jack has just expressed to his occupational therapist that he feels he is letting his family down. Further questioning revealed that these feelings primarily stem from not providing for the family financially and not being able to take his sons out on the weekend, as he is not yet cleared to drive. In particular, he is upset that his sons will not be able to play soccer in the upcoming season as they are reliant on him to take them to soccer (his wife works on the weekend).
- The physio has identified that Jack will need to improve his neck range of motion, or have his car fitted with wide-angle mirrors, before he can trial return to driving. His mobility is adequate for walking over the uneven ground to access the soccer fields, but he is too slow to be able to keep up with his boys if they ran away. His physical endurance will need to be further improved to ready him for the physical demands of his work. As well as general strength and fitness, Jack needs increased hand strength so as to manipulate spanners etc.
- The neuropsychologist has cleared Jack as suitable for undertaking an OT driving assessment.
- The occupational therapist has identified that Jack will need improved time management skills to be able to get his boys to soccer on time, to get himself to work on time and to work effectively.
- The psychologist has identified that Jack’s engagement in rehabilitation is currently being compromised by Jack’s depression and low motivation. Low mood is also impacting on his interactions with his sons and wife.
- The speech therapist has identified that further improvements in receptive language of written material would be needed for Jack to be able to read job requests.
### 9.5.3 Worksheets for PRACTICAL ACTIVITY 3

<table>
<thead>
<tr>
<th>DATE of PLAN:</th>
<th>Plan No:</th>
<th>Plan Period:</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PATIENT GOAL:** 1

<table>
<thead>
<tr>
<th>PATIENT STEP 1a)</th>
<th>Achievement</th>
<th>PATIENT STEP 1b)</th>
<th>Achievement</th>
<th>PATIENT STEP 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN 1a)</th>
<th>Achievement</th>
<th>ACTION PLAN 1b)</th>
<th>Achievement</th>
<th>ACTION PLAN 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PROGRESS**
## Worksheet for PRACTICAL ACTIVITY 3

<table>
<thead>
<tr>
<th>DATE of PLAN:</th>
<th>Plan No:</th>
<th>Plan Period:</th>
<th>PATIENT GOAL:</th>
<th>2</th>
<th>Achievement</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PATIENT STEP 2a)</th>
<th>Achievement</th>
<th>PATIENT STEP 2b)</th>
<th>Achievement</th>
<th>PATIENT STEP 2c)</th>
<th>Achievement</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN 2a)</th>
<th>Achievement</th>
<th>ACTION PLAN 2b)</th>
<th>Achievement</th>
<th>ACTION PLAN 2c)</th>
<th>Achievement</th>
</tr>
</thead>
</table>

**PROGRESS**
9.6 **PRACTICAL ACTIVITY 4**

The aim of this exercise is to critique an example rehabilitation plan using the training template based on what you have learnt today regarding:

- engaging patient’s in goal setting
- factors affecting patient centred goal setting
- SMARTAAR Goal Process and WORKSHEET
- rehabilitation planning and reporting.

You have been given the 3rd Rehab Plan reporting Jill’s progress in rehabilitation. You know Jill sustained moderate TBI and orthopaedic injuries in MVA on way home from work 5 months ago.

9.6.1 **Instructions**

Review the rehabilitation plan on the following page. The plan is intentionally weak in some areas. Based on the information provided, what additional information would you like to know to understand the patient’s clinical needs and progress to date?

Consider:

- What issues can you see?
- Do you want additional information on the patient, goal, steps or action plans?
- Does the plan tell a ‘story’ that describes what the patient wants and needs to be able to do (goal), the steps of achievement that will help them realise their goal, and actions needed to support achievement of steps and goal?
- Is the ‘size’ or level of the steps clearly related to the action plan for that step?
- Do you think the patient will achieve their goal if they achieve their steps?
- Do you think the patient goal and steps are patient centred, realistic and helpful for rehabilitation?
REHABILITATION PLAN FOR PRACTICAL ACTIVITY 4:

**DATE of PLAN:** 15th March 2013  
**Plan No:** 3  
**Plan Period:**

**PATIENT GOAL:** 1

Jill will return to work as waitress in city restaurant

<table>
<thead>
<tr>
<th>PATIENT STEP 1a)</th>
<th>Achievement</th>
<th>PATIENT STEP 1b)</th>
<th>Achievement</th>
<th>PATIENT STEP 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jill will be able to tolerate standing for 30 minutes</td>
<td>2</td>
<td>Jill will be able to take accurate notes of verbal information</td>
<td>2</td>
<td>Jill will be able to drive to and from work 5 times a week</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTION PLAN 1a)</th>
<th>Achievement</th>
<th>ACTION PLAN 1b)</th>
<th>Achievement</th>
<th>ACTION PLAN 1c)</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 25 sessions physio</td>
<td>2</td>
<td>- 6 x Speech therapy</td>
<td></td>
<td>- OT &amp; driving assessment</td>
<td></td>
</tr>
<tr>
<td>- Gym program</td>
<td>1</td>
<td>- Back cushion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Counselling for parents</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Progress:** Patient’s cognitive, physical and psychological problems continue to interfere with her ability to resume work.
9.7 Developing Team Processes to Facilitate High Quality Goal Setting

This training provides individuals with skills and knowledge in writing SMART goals and how they can be used to support patient centred practice in rehabilitation. However, to implement these skills, the whole team you work with may need to be aware of these skills and be involved in negotiating what changes may be needed to current processes. While this is beyond the scope of this training, we have provided some information to help you consider what may be required in the context or service in which you work.

What this section aims to do is provide some suggestions for the elements of processes to facilitate high-quality goal-setting. The specific processes that best facilitate high-quality goal setting within each setting will vary, as these will be influenced by internal policies and practices. Clinicians and teams can use this section to revise or develop their own processes, if desired. Changing processes to improve goal-setting is a worthwhile quality improvement project as effective goals can be used to motivate patients, guide clinical practice and evaluate patient and service outcomes (e.g. monitor the number of participation level goals that are achieved; audit level of patient engagement in goal setting).10

9.8 Goal Setting Processes within Rehabilitation Units / Teams

This section describes an example of an interdisciplinary, patient centred goal setting process that would suit a team of clinicians who primarily work together in a single service.

The aim is to provide structure to conversations and meetings that frequently occur and to ensure that patient priorities drive the development of a cohesive rehabilitation plan. It is easier to write high quality, participation level patient centred goals when an interdisciplinary approach is used. The order and elements may need to be adjusted to suit different environments and services.

The key features of an interdisciplinary goal setting process include:

- All clinicians discuss goals with the patient, although one person may take the lead
- The patient’s goals direct the action plan
- More than one meeting with the patient may be needed to identify their goal – dependent on patient age, nature and severity of injury and adjustment to injury
- Clinicians complete necessary assessments to inform the development of an action plan and to provide an understanding of the patient’s current level of functioning and needs
Team meetings or case conferences are needed to review patient goals and assessment results as well as develop an action plan. The patient’s long term goals and SMART rehabilitation goals and steps need to be defined and reported. Team meetings / case conferences are required regularly to support ongoing rehabilitation planning and reporting.

Patients can be engaged in determining and agreeing to goals, steps and action plans in collaboration with clinicians throughout their rehabilitation program. Accommodating patient preferences is consistent with current definitions of evidence based practice.

The process is cyclical – steps are repeated as the patient makes progress and new goals are set.

New goals may be identified during plan periods and these need to be communicated to all involved. This can be done via email or a further meeting may be needed.

An example of how these principles can inform a team, process is outlined in Figure12.
Figure 12 An example of a goal setting process within rehabilitation units / teams

<table>
<thead>
<tr>
<th>Step</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversations between patient &amp; clinicians to identify patient goals</td>
<td>May occur over several sessions</td>
</tr>
<tr>
<td>Clinician case conference</td>
<td></td>
</tr>
<tr>
<td>Document patient's ultimate long term goals, SMART goals for the</td>
<td>Immediate plan period plus associated steps for each goal and action plans for each steps</td>
</tr>
<tr>
<td>immediate plan period</td>
<td></td>
</tr>
<tr>
<td>Collaboration with patient (&amp; family) to agree goals, steps and</td>
<td>Action plan for the current plan period. Amendments made as needed. This can be done in a family meeting with clinical team or with patient.</td>
</tr>
<tr>
<td>action plan for the current plan period</td>
<td></td>
</tr>
<tr>
<td>Any new patient goals are recorded on rehab plan by relevant</td>
<td>Clinician who informs other clinicians</td>
</tr>
<tr>
<td>clinician</td>
<td></td>
</tr>
<tr>
<td>Case conference to discuss goal progress held at regular intervals</td>
<td>During each plan period. Conversations / meetings with patient regarding progress occur during plan period as needed.</td>
</tr>
<tr>
<td>At end of plan period</td>
<td>Patient progress towards goals and steps is reviewed. Submit further rehab plan as required to reflect changes in goals, report progress and ongoing service needs</td>
</tr>
<tr>
<td>Use goals in clinical practice to measure and evaluate patient</td>
<td>Progress, provide feedback to patient and their family regarding their process, review appropriateness of treatment and in reporting as required.</td>
</tr>
<tr>
<td>progress, provide feedback to patient and their family regarding</td>
<td></td>
</tr>
<tr>
<td>their process, review appropriateness of treatment and in reporting</td>
<td></td>
</tr>
</tbody>
</table>
9.9 Goal Setting Processes for Single Discipline / Sole Workers

It can be harder to negotiate a ‘team’ based approach when you work as a sole provider or discipline working with clinicians from different services to meet the needs of patients. There tends to be less face to face meetings with all the clinicians involved.

The process is very similar to that for those in rehabilitation units / teams but the information obtained in the case conference may be completed over time and managed without a face to face meeting. The key features include:

- All clinicians have conversations with the patient about the patient’s goals. They need to communicate information about the patient’s preferences to the lead clinician.
- The lead clinician needs to collaborate with the patient and clinicians to agree the goals, steps and action plan for the plan period.
- The lead clinician should document the patient’s long-term and current goals, the therapy-specific steps and action plans that have been agreed to by all clinicians and seek feedback regarding whether they:
  - have any comment to make about the achievability of the goal from their particular professional perspective
  - consider that they need to play a role towards any of the goals. If they do, request that they share with you their steps and action plans and the degree to which the patient is aware of these.
- Progress should be discussed between involved therapists as frequently as seems clinically relevant.
- The lead clinician completes the rehabilitation plan to cover services required by all providers. Additional discipline specific reports may be needed to support the rehabilitation plan. Progress from each discipline should be provided in relation to the identified goals and steps.
- When a lead clinician is not involved, each involved clinician should consider it their responsibility to initiate and maintain a collaborative approach between clinicians to ensure patient centred practice.

An example of this process is outlined in Figure 13.
Figure 13 An example of a goal setting process for single discipline clinicians / sole workers

Conversations between patient & clinicians to identify patient goals may occur over several sessions

Patient & clinicians formulate steps & action plans for each goal for the current plan period and provide information to lead clinician

Lead clinician documents all of the patient’s long-term & current goals, steps & discipline specific action plans. This is communicated to all other involved clinicians, who are asked for their feedback

Feedback provided by other clinicians re: the achievability of the goal; describe the actions to assist the patient achieve any of the goals / steps; identify new steps they can work towards to enhance goal achievement

When a lead clinician is not involved, each involved clinician should consider it their responsibility to initiate a collaborative approach between clinicians

Patient agrees to rehab plan or patient requests change

Patient progress should be discussed between involved therapists as frequently as clinically relevant. Discipline specific assessments and reports may also be shared during plan period

Case conference / family meeting may be needed to discuss goal progress during each plan period

Clinicians maintain conversations with patient re progress during plan period

Use goals in clinical practice to measure and evaluate patient progress, provide feedback to patient and their family regarding their process, review appropriateness of treatment and in reporting as required
For further information about a collaborative interdisciplinary approach to patient centred participation level goals, see NSW Health’s Rehabilitation Redesign Project Model of Care.29

Summary: Developing Team Processes to Facilitate High Quality Goal Setting

- Internal policies and practices will influence the processes required in each setting to facilitate high-quality goal setting

- Similarities in these processes between rehabilitation units and single discipline practices include:
  - Discussion between patient and clinicians to identify patient goals, and related steps and action plans
  - Patient agrees to rehabilitation plan which is documented by clinician
  - Clinicians document any new patient goals and inform other clinicians
  - Amendments to goals/step/action plans are made as needed
  - Discussions continue between clinicians
  - Goals are used in clinical practice.

Notes
10. **Workbook Summary**

1. Effective goal setting is a vital part of rehabilitation as it can engage and motivate the patient and support team planning.

2. **ASK** the patient what they want to achieve or change by participating in therapy - goals need to reflect the patient’s priorities and be meaningful to them.

3. **IDENTIFY** the patient’s functional goals (i.e. activity or participation level goals) wherever possible.

4. Write SMART goals that describe what the patient needs and wants to be able to do that fulfil the purposes of goal setting – be cautious about making the goal overly measurable.

5. The SMARTAAR Goal Worksheet can be used to write and assess the quality of goals – use the instructions and tip sheets when writing and reviewing goals.

6. Patient goals are broken down into steps:
   a. steps describe the smaller components of achievement that will contribute to goal attainment.
   b. the action plan details those actions that need to be completed to achieve each of the steps and goal.

7. **MEASURE** patient progress on goal achievement, **EVALUATE** issues impacting on progress, and **REPORT** to all relevant stakeholders.

8. A collaborative approach to rehabilitation and goal setting is recognised as best practice.

9. Rehab Plans should describe the relationship between (i) the patient’s goals, (ii) the steps of patient progress that will enable the goal to be achieved and (iii) what actions are required to support achievement of steps and goals and reduce the impact of injuries. Use the tips sheet on ‘Writing Rehab Plans’ when writing reports to communicate patient progress.

10. **REVIEWING** team processes may be necessary to incorporate SMART patient centred goal setting / or to use the SMARTAAR Goal process.
11. References


# Appendix A: ACI Rehabilitation Executive Committee

## Members

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Position and Organisation / Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chris Shipway</td>
<td>Director Primary Care and Chronic Services, Agency for Clinical Innovation</td>
</tr>
<tr>
<td>2</td>
<td>Chris Poulos</td>
<td>Hammond Chair of Positive Ageing, University of NSW</td>
</tr>
<tr>
<td>3</td>
<td>Claire O’Connor</td>
<td>Rehabilitation Network Manager, Agency for Clinical Innovation</td>
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<tr>
<td>4</td>
<td>Elizabeth Huppatz</td>
<td>Clinical Nurse Consultant, Aged Care &amp; Rehabilitation, Southern NSW Local</td>
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<td>Health District</td>
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<tr>
<td>5</td>
<td>Jennifer Mann</td>
<td>Rehabilitation Physician, Concord Hospital</td>
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<tr>
<td>6</td>
<td>Kate Mitchell</td>
<td>Occupational Therapist, Prince of Wales Hospital</td>
</tr>
<tr>
<td>7</td>
<td>Kathleen McCarthy</td>
<td>Consultant in Rehabilitation Medicine, Westmead Brain Injury Rehabilitation</td>
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<td>Service</td>
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<tr>
<td>8</td>
<td>Linda Glanfield</td>
<td>Divisional Manager, Rehabilitation, Hornsby Kuring-gai Hospital</td>
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<td>9</td>
<td>Louis Baggio</td>
<td>Rehabilitation Medicine, Wagga Wagga Base Hospital</td>
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<tr>
<td>10</td>
<td>Marianne Lackner</td>
<td>Manager, Aged and Extended Care, Murrumbidgee Local Health District</td>
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<td>11</td>
<td>Maria (Mi) Weekes</td>
<td>Project Officer, Rehabilitation Network, Agency for Clinical Innovation</td>
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<tr>
<td>12</td>
<td>Michael Pollack</td>
<td>Director, Hunter Stroke Service</td>
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<tr>
<td>13</td>
<td>Michelle Sharkey</td>
<td>Executive Officer, Stroke Recovery Association</td>
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<tr>
<td>14</td>
<td>Nicky Sygall</td>
<td>Clinical Psychologist, St Vincent’s Health Network</td>
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<td>15</td>
<td>Stephanie Ho</td>
<td>Consumer</td>
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<tr>
<td>16</td>
<td>Stephen Wilson</td>
<td>Head of Department of Rehabilitation, Royal North Shore Hospital</td>
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<tr>
<td>17</td>
<td>Steven Wood</td>
<td>Council of Australian Governments (COAG) Subacute Programs Project Officer,</td>
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<tr>
<td></td>
<td></td>
<td>South Eastern Sydney Local Health District</td>
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