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.

ACI NSW Agency for Clinical Innovation

Tips for using SMARTAAR Goal Worksheet

Elements	DETAILED EXPLANATION OF GOAL ELEMENT
Specific	**Is the patient's name included in goal statement?** It should be there to support patient centred goals and rehab
	WHAT does the patient want to achieve? 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
Measurable	**Is it easy to determine when the goal is achieved?** (This is also linked to '**S**pecific' criterion) If you cannot measure whether the goal has been achieved or not, you may need to refine the goal further
	What is the desired standard or quality for achievement? • 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
Achievable	**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?
Relevant	**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?
Time bound	**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
Action Plan	**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
Achievement Rating	**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'
Reporting Goal Outcomes	**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?

Tips for incorporating patient goals into Rehabilitation Plan template

Plan	Prompt questions and considerations
Patient Goal	• 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 • Does the goal appear to reflect patient identified priorities? • Is there information regarding the level of patient engagement? Is it a patient generated or patient focused goal? • How realistic is the goal, given your knowledge of the nature and impact of the patient's injuries and their progress to date?
Patient Steps	• 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 • 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? • How realistic is the step given your knowledge of the nature and impact of the patient's injuries and their progress to date? • 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) • 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? • If too many steps are needed per goal, does the goal need to be broken into more than one goal?
Action Plan	• 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? • 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 • If the actions are extensive (high level type and amount of services), should the step be broken down into more than one step? • Are the actions consistent with the available evidence, clinical practice and guidelines? • Is there evidence that the patient has agreed to / collaborated in developing the action plan? • If too many actions are needed per step, does the step need to be broken into more than one step?
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? • 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? • 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? • 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? • Does the plan describe reasons for variations in the projected action plan and impact on patient progress towards steps and goals? • Consider whether the number of goals and steps in the whole plan reflects a realistic rehabilitation plan for the specified period

DATE of PLAN:	Plan No:	Plan Period:

PATIENT GOAL: 1	Achievement
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.	To what degree has the patient achieved their goal?

PATIENT STEP 1a)	Achievement	PATIENT STEP 1b)	Achievement	PATIENT STEP 1c)	Achievement
• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated • If an impairment level goal is the actual goal, this section may have very little or no information	To what degree has the patient achieved this Step?	• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated • If an impairment level goal is the actual goal, this section may have very little or no information	To what degree has the patient achieved this Step?	• This is generally a list of PATIENT FOCUSED activities or impairment level goals but can also be patient generated • If an impairment level goal is the actual goal, this section may have very little or no information	To what degree has the patient achieved this Step?
ACTION PLAN 1a)	**Achievement**	**ACTION PLAN 1b)**	**Achievement**	**ACTION PLAN 1c)**	**Achievement**
• What intervention is required? • Who from? • How frequently? • This includes any action that the patient and/or their significant others need to take	To what degree has the patient achieved each element of the Action Plan?	• What intervention is required? • Who from? • How frequently? • This includes any action that the patient and/or their significant others need to take	To what degree has the patient achieved each element of the Action Plan?	• What intervention is required? • Who from? • How frequently? • This includes any action that the patient and/or their significant others need to take	To what degree has the patient achieved each element of the Action Plan?

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.

Rehabilitation Plan Template

DATE of PLAN:	Plan No:	Plan Period:			
PATIENT GOAL:					**Achievement**
PATIENT STEP 1a)	**Achievement**	**PATIENT STEP 1b)**	**Achievement**	**PATIENT STEP 1c)**	**Achievement**
ACTION PLAN 1a)	**Achievement**	**ACTION PLAN 1b)**	**Achievement**	**ACTION PLAN 1c)**	**Achievement**
PROGRESS					

SMARTAAR Goal Worksheet

Patient Priorities / Rehab Goal to be Reviewed:			
SMARTAAR goal elements		**Existing Goal Elements**	**SMARTAAR goal**
S	Patient name in goal statement		
	What **patient outcome** is being aimed for? What is the **purpose of any intervention**? ** **CLINICIAN'S ACTIONS/ INTERVENTIONS DO NOT GO HERE****		
	Focus on **Patient's Participation** (Y/N)		
	Where will participation take place – context of goal? e.g. at home, local community (might be implicit)		
M	**How well?** What is the desired **quality of performance** in relation to level of independence, amount / nature of supports		
	How much? Quantity of performance by patient e.g. time taken, frequency, amount, speed, efficiency		
A **R**	**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		
T	**Time bound:** How long do you think it will take the patient to achieve the goal?		
A	**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.		
A	**Achievement rating:** Has the goal been achieved?		
R	**Reporting goal outcomes:** Who needs to know about progress the patient made on this goal?		
Is the goal clear and concise? **Does the goal identify what the patient needs / wants to be able to do?**			
Revised goal:			