Setting goals and evaluating meaningful outcomes for people living with dementia who are participating in reablement programs

Practitioner Guide

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Contents

A guide to setting goals and evaluating meaningful outcomes for people living with dementia who are participating in reablement programs

This guide presents a practical dementia-specific model of using Goal Attainment Scaling (GAS) to measure meaningful outcomes from reablement programs.

The model involves using a novel, combined, stepped approach to assessment, through:

1. Choosing therapy goals with clients using newly developed Reablement Goal Lists;
2. Defining these goals using a new dementia-specific adaptation of the SMART (specific, measurable, achievable, relevant and time-bound) Framework; and
3. Scoring using the Gas-Light adaptation of Goal Attainment Scaling to record and evaluate program outcomes.

Background

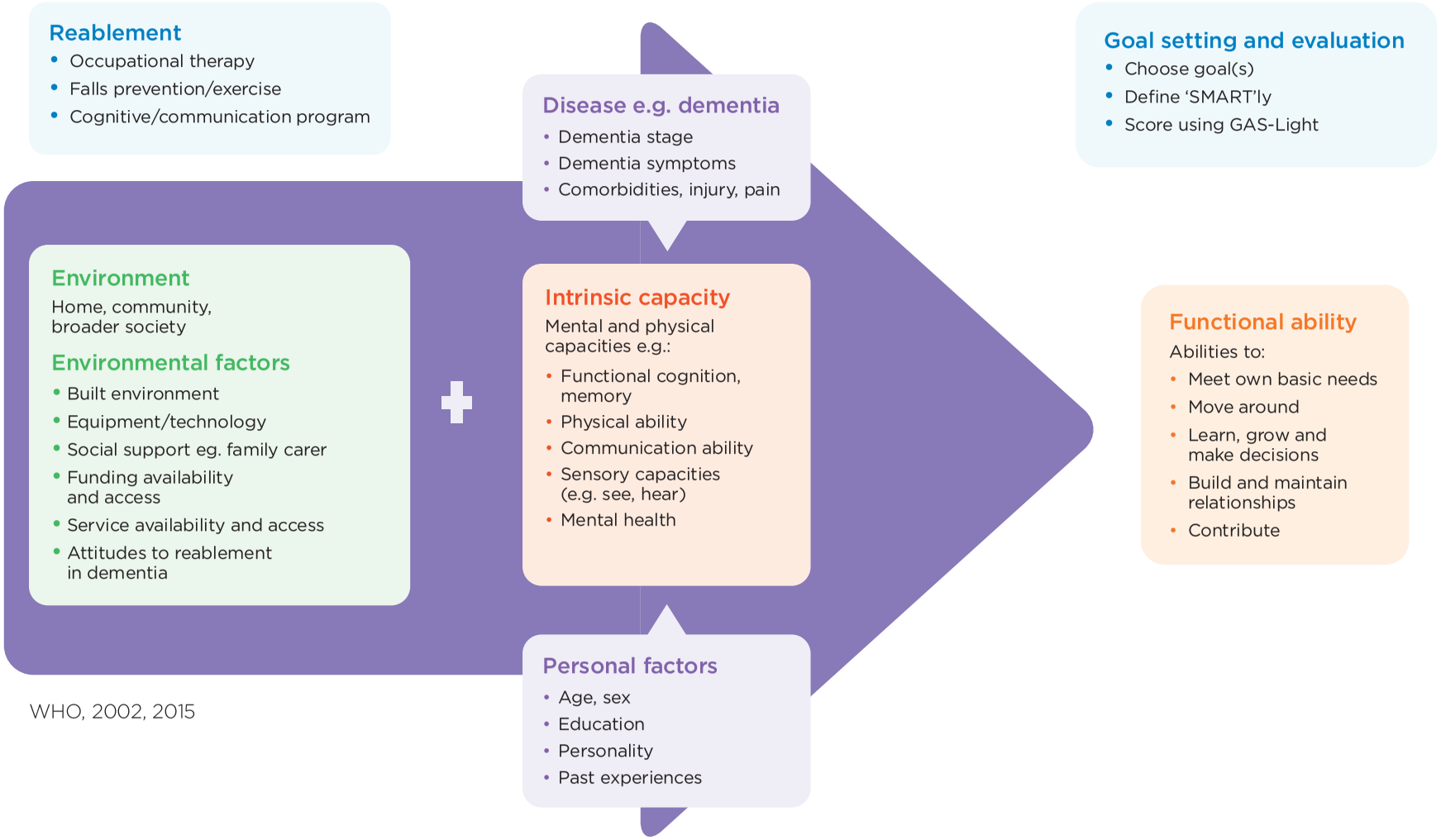
Reablement is an intervention that promotes the regaining or maintenance of functional performance in older people.[1] For people with dementia, reablement is about maintaining function for as long as possible, regaining lost function, or even improving everyday function.[2]

But when people participate in a reablement intervention, how do we measure whether meaningful outcomes for the person with dementia have been attained? If a person has an MMSE that has increased from 20 to 22 at the end of their reablement program, what does that mean in terms of their ability to remain engaged with their weekly game of bowls or continue to cook a Sunday roast for their spouse?

The International Classification of Functioning, Disability and Health (ICF) provides a broad biopsychosocial framework to describe health and functioning within the context of a disability, such as that resulting from dementia.[3] Figure 1 illustrates how the range of interconnected individual factors for an individual with dementia can be mapped out using the ICF.

Goal Attainment Scaling (GAS) is a person-centred approach to evaluation that aligns with the ICF and provides a measure of functional outcomes.[3, 4] Allied health practitioners have reported that GAS in its original form is time consuming and that determining each of the different possible attainment levels at the beginning of each client's program is challenging.[5, 6] GAS-Light[6] provides an alternative approach that is relatively rapid to use in clinical practice and facilitates individualised goal setting to capture personal client preferences and needs. In order to apply GAS-Light, it is necessary to first identify goals in partnership with the client, and second, define identified goals using a SMART framework.

Figure 1: Factors to be considered in establishing realistic goals and designing holistic reablement programs using an ICF framework



WHO, 2002, 2015

Reablement in dementia is about supporting functional ability to maintain wellbeing. This figure provides an overview of the determinant factors that make up functional ability (ICF activity & participation): an individual's intrinsic capacity (ICF body functions & structure) and their environment (ICF contextual). Practitioners should consider each potentially contributory factor to a person's functional ability, including any disease (ICF health condition) or personal factors (ICF contextual) and these should be addressed when setting goals and planning the reablement intervention.

Process of assessing meaningful outcomes for people with dementia engaged in a reablement program

This guide includes the novel amalgamation of the following three concepts into a single framework to guide the use of GAS to evaluate meaningful outcomes for people living with dementia who are participating in reablement programs:

1. Choose – From the Reablement Goal Lists

Identify personally meaningful and desired goal(s) in partnership with the client

2. Define – SMART Goals using the Framework

Define identified goal(s) as Specific, Measureable, Achievable, Relevant, and Time-bound (SMART)

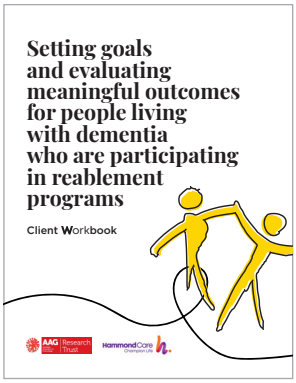
3. Score – using GAS-Light

a) Prior to beginning the reablement program, rate the client's current level of functioning towards their SMART goal

b) At the end of the program (or another pre-specified time), rate the client's level of attainment towards that goal

The associated client workbook provides an individualised workbook that can be used with each client when implementing this process.

1. Practitioners and clients may view, discuss and highlight selected goals on the appropriate goal lists;
2. Practitioners may then use the book 'in the field' to 'SMART'ly define the identified goal(s);
3. Finally, GAS-Light scoring can be recorded.



People with dementia and goal setting

It is important that each client with dementia is supported to make decisions around the goals they hope to achieve when participating in a reablement program, through a process of supported decision making.[7] Support for decision-making involves practical steps that can be applied to help the person make an informed decision about what goals they might prioritise as personally important. Sinclair et al. (2018) suggest some specific supported decision-making strategies[7]:

- Allowing extra time
- Providing information about the program and what goals might be possible
- Using short sentences, addressing one idea at a time, and pausing between sentences to give the person plenty of time to process the information
- Repeating and reinforcing information; waiting for acknowledgement to ensure person has understood
- Communicating transparently using multiple sensory modalities (auditory, visual)
- Relating new information to familiar concepts that the person already understands; translating jargon and simplifying abstract concepts
- Presenting options one at a time, and breaking decisions down into stages
- Demonstrating curiosity and interest in understanding the person's wishes through body language
- Taking breaks as needed

Development of this guide

Development of the Reablement Goal Lists

People living with dementia may need support in identifying personalised goals in a therapeutic context. The Reablement Goal Lists (Programs 1-3) were generated through focus group consultations with people impacted by dementia as well as with allied health practitioners. They are intended to guide goal setting with people living with dementia who are participating in a reablement program.

Dementia-specific adaptation of the SMART Framework

Once client goals have been identified, they need to be formulated into SMART goals in order to apply GAS-Light evaluation. SMART goals are Specific, Measurable, Attainable, Relevant, and Time-bound.[8] The framework presented here (Figure 2) provides a novel dementia-specific structured framework to assist practitioners in rapidly setting SMART goals and identifying varying potential attainment levels for clients engaged in a reablement program.

Applying GAS-Light to reablement programs for people living with dementia

GAS-Light involves clearly defining the expected outcome (achievement level 0) prior to beginning the program (baseline). At the end of the program, it is determined whether this goal was achieved as expected (0), a little more than expected (1), a lot more than expected (2), or if it was not achieved, whether it was partially achieved or no change (-1) or if it got worse (-2).[6, 9] GAS-Light was originally designed for use in brain injury rehabilitation; we have adapted this GAS-Light method to fit within the delivery of reablement programs to support functioning in people living with dementia (Table 2).

Putting it into practice

1. Choose – from the Reablement Goal Lists

Identifying personally meaningful and desired goal(s) in partnership with your client

Use the Reablement Goal Lists below (Programs 1-3) to guide a discussion with your client to identify personally meaningful and desired goals. Through this process, the person (and/or their family) should be prompted to consider a range of potential goals that they may identify as personally meaningful/important. Practitioners should consider applying the tenets of supported decision making to support clients in identifying their goals (see page 7).[7]

Figure 1 presents an ICF-mapped holistic overview of the range of factors to be considered for every client to ensure realistic goals are established. For example, a person's goal might be to regain their ability to manage the garden. This will depend on their personal characteristics or 'intrinsic capacity' (e.g. physical and cognitive health and what is possible to achieve through therapy), as well as what social support they have and the environmental context of their backyard garden.[10]

Practitioners have highlighted the importance of goals from reablement programs to be functional i.e. relate to something that contributes to the individual's meaningful participation and engagement in everyday life. Once goal priorities have been identified, where possible, client goals should be developed into overall functional goals that allied health teams may work collaboratively to achieve (see case examples pages 15-17).

Reablement Goal Lists are arranged by reablement program:

Program 1: Occupational therapy for everyday living

Outlines potential goals that might be identified for an occupational therapy program to support functioning in everyday living activities. The limitations addressed by these programs will be primarily cognitive based and/or secondary to symptoms of dementia.

Program 2: Falls prevention/reduction

Outlines potential goals that might be identified for a falls prevention program or a program aimed at reducing falls or reducing risk for falls.

Program 3: Mobility and physical function

Outlines potential goals that might be identified for an exercise-based program to support mobility and physical functioning in general or towards functional outcomes. The limitations addressed by these programs will be primarily physically based but may also be attributed to dementia.

Program 1: Reablement Goal List – Occupational therapy for everyday living

Leisure

- Community and social life e.g.
  - Recreation and leisure e.g. playing an instrument, dancing, singing, playing sport
  - Community life e.g. outings, visiting the café
- Maintaining relationships e.g.
  - Social e.g. socialising, meeting with friends
  - Family e.g. 'visiting' grandchildren using the iPad

Thinking, planning, and coping

- Thinking about and planning activities e.g.
  - Organising activities e.g. plan and remember to attend an appointment, plan the shopping
  - Undertake a task e.g. making a cup of tea
- Coping e.g.
  - Manage fatigue e.g. manage own activity level
  - Reduce carer frustration e.g. strategies to cope with stress or pressure associated with caring role

Everyday activities

- Activities at home e.g.
  - Preparing meals
  - Doing housework
  - Taking care of plants
- Mobility e.g.
  - Lifting and carrying objects e.g. laundry, shopping, vacuum
  - Fine hand use e.g. writing, making a cup of tea
  - Hand and arm use e.g. making the bed, gardening
  - Indoor mobility in the home e.g. in the kitchen to make a meal, in the bathroom
  - Outdoor mobility e.g. in the garden, in the community to do the shopping
  - Using transportation e.g. catching a bus, train
  - Driving
- Self-care activities e.g.
  - Washing self e.g. showering, bathing
  - Caring for body e.g. doing hair, shaving
  - Dressing e.g. managing buttons, putting on shoes
  - Transferring yourself e.g. on/off the toilet

Program 2: Reablement Goal List – Falls prevention/reduction

Person with dementia-focused goals

- Strengthening
- Balance, stability
- Ability to walk
- Ability to use equipment to move around e.g. walking frame
- Changing body position e.g. unpacking the dishwasher
- Maintaining a body position e.g. standing at the bathroom sink to brush teeth
- Ability to transfer yourself e.g. into the car, in/out of the shower, on/off toilet
- Confidence e.g. to walk outdoors
- Nutrition

Carer-focused goals

- Assisting your family member/friend with dementia
- Communicating effectively with your family member/friend with dementia
- Education on support strategies and using technology and aids

Environment

- Design, modification, equipment
- Screening for falls risk
- Risk reduction

Program 3: Reablement Goal List – Mobility and physical function

Activity or task focused goals

- Indoor mobility in the home
- Outdoor mobility in the garden and community
- Push things/pick things up, carrying objects e.g. carrying shopping, putting washing away
- Ability to do daily activities e.g. shopping, cooking, laundry, cleaning
- Managing self-care needs e.g. showering, dressing
- Using your hands e.g. knitting, opening a packet, writing
- Hand and arm use e.g. opening a jar, brushing hair, hanging washing out

Other

- Managing diet and nutrition
- Pain management
- Arthritis management

Physically focused goals

- Strengthening (legs, arms, hands)
- Balance
- Maintaining or developing fitness
- Range of motion/flexibility
- Ability to walk
- Changing body position e.g. turning over in bed
- Maintaining a body position e.g. standing in the kitchen to wash the dishes
- Ability to transfer yourself e.g. into the car, in/out of the shower, on/off toilet

2. Define – SMART goals using the dementia-specific Framework

Define identified goal(s) as Specific, Measurable, Achievable, Relevant, and Time-Bound (SMART).

Once the goal has been identified in partnership with the client, the practitioner needs to define it as a SMART goal (see Table 1). The SMART Framework outlined in Figure 2 provides practitioners with a range of examples to help in defining the goal explicitly using two broad domains:

1. Support needed: practitioners should first consider the level of support needed in completing the goal activity i.e. how much assistance is needed from another person and is any equipment or change to the environment required;
2. Quantifiers: the quantifiers around the client's participation in the goal activity should then be defined. How will attainment of the goal be measured i.e. what percentage of engagement/ participation is expected, or what will the unit of measurement be?

The examples outlined in the Framework provide a set of variables and levels of attainment that may assist in setting comprehensive SMART goals and consistently quantifying varying attainment levels. This is not an exhaustive list and should be used as a 'prompt sheet' to help practitioners with rapidly considering a range of options that may apply to reablement program goals for their clients with dementia.

Table 1: SMART goal features

Specific	The goal needs to be defined as explicitly and clearly as possible. • What – what goal does the client hope to achieve? e.g. walk to their mailbox to check the mail daily, continue meeting their friend for coffee at the café every Tuesday • Who – who will be involved in attaining this goal? e.g. will the person's family member or carer play an important role in working towards this goal? • How – how will this goal be attained? e.g. engaging in a falls prevention program, learning to use new equipment or strategies to compensate for a limitation secondary to their dementia • Where – where will the goal be attained or the program be conducted?
Measurable	How will the outcome be measured? e.g. level of assistance required to complete an activity, distance walked to reach the shops, length of time able to stand to do the washing up
Attainable	In the context of the person's intrinsic capacity and their environment (refer to Figure 1), is the identified goal attainable?
Relevant	Step 1 of this process is about supporting the client to identify meaningful goals that they wish to achieve
Time-bound	What is a realistic timeframe for this goal to be attained? e.g. at the end of the reablement program, within 4 weeks

(Bovend'Eerdt et al. 2009; Bowman et al. 2015, Schut et al. 1994)

Figure 2: Dementia-specific SMART Framework – example domains and scaling for setting SMART reablement goals and defining attainment levels

Examples of support needed

People

ASSISTANCE

Completely dependent

2-person assist

1-person assist

Stand-by assistance

Prompting

Supervision

Independent

INITIATION

Activity set up and physical prompting

Activity set up and verbal prompting

Activity set up and visual prompt (e.g. white board)

Verbal prompting, sets up own activity

Visual prompt, sets up own activity

Manages own prompting system e.g. diary

Initiates independently

COMMUNICATION

Single word instructions and physical cueing

Single word instructions and visual cueing

Single word instructions

Use of communication technology e.g. iPad

Reduced item choice when asked questions (e.g. 2 or 3)

Time needed to process questions and respond

Equipment

MOBILITY/TRANSFERS

Hoist/lifter, wheelchair, slide board, walking frame, walking stick

COMPLEX ADLs

Raised garden bed

Timer

BASIC ADLs

Shower chair, over toilet aid, long handled reacher, adapted items

COGNITION/QOL

Diary/calendar, white board/orientation, timer, iPad (e.g. Zoom, Skype)

FALLS PREVENTION

Monitors/alarms, shower chair, over toilet aid, walking frame, walking stick, home modifications e.g. ramp, rails

Environment

PHYSICAL

Reduce distraction (visual, noise)

Enhance lighting

ACTIVITY

Reduce activity materials

Reduce activity steps

Modify activity

SOCIAL

Limit number of people in an interaction

Support in maintaining social contacts (scheduling, attending, participating)

Examples of quantifiers

Quantifiers

ENGAGEMENT/ PARTICIPATION

Passive

Active observation

≤ 25% participation

26-50% participation

51-75% participation

76-99% participation

100% participation

MEASUREMENT

Activity length (mins) e.g. time taken to complete online shopping order, time spent engaging with grandchildren

Activity regularity e.g. times/week cooking a meal

Time of day

Distance e.g. walk to the letter box

Amount e.g. folding a full basket of laundry; number of falls

Time frame

Time to evaluate attainment e.g. by the end of the program

Adapted from Bovend'Eerdt et al. 2009

Case examples for setting SMART goals

Case 1: Mrs Smith		
Health condition/s, personal factors, external environment	**Deficits in intrinsic capacity**	**Functional ability**
• 82 years old • Moderate dementia (GDS 5) • Becoming more frail • Lives with husband who is her carer • They live in an independent unit within an aged care village • Has HCP funding • Enjoys spending time with their adult children	• Difficulty with problem solving • Able to recognise the goal of an activity, but struggles with initiation and often becomes confused with sequencing of the steps • Independently manages glasses to support vision • Can read and follow basic written instructions • Gets fatigued after standing for >30 mins	• Manages own basic ADLs • Is requiring increasing help from husband to organise shopping (writing lists, gathering groceries and paying) • Has been struggling to manage meal preparation (timing, sequencing of steps, physically standing in the kitchen)

Client reported goal:

Person with dementia: "I want to cook a nice meal for my husband and kids"

Current function towards goal: Mr Smith has been concerned over the potential for Mrs Smith to accidentally do something unsafe in the kitchen, so has been doing most of the cooking himself. Sometimes Mr Smith will set Mrs Smith up with a task such as stirring a pot or peeling carrots (such that she is providing <25% of the effort towards the meal).

SMART goal (specific, measurable, achievable, relevant, and time-bound): By the end of the 12-week reablement program, Mrs Smith will prepare Sunday dinner for her family once per week (providing 51-75% of the effort) with assistance (set up and prompting) from Mr Smith.

Reablement program activities:

Occupational therapy: Mrs Smith will develop skills in following a purpose-made, step-by-step, recipe for her favourite family meal. Mr Smith will develop skills in setting up the activity (i.e. getting the ingredients out of the fridge and the utensils out onto the bench, ensuring the bench is uncluttered to help Mrs Smith attend to the task) and verbal prompting to engage Mrs Smith in the activity, and assist in progressing to the next steps when needed. Mr and Mrs Smith will learn alternative strategies to support Mrs Smith's engagement while managing her fatigue, for example, sitting at a table when peeling and chopping vegetables.

Exercise physiology: Mrs Smith will work on balance and endurance to support standing in the kitchen and upper body exercises to support moving items across the bench to cook a Sunday meal.

Case 2: Mr Wong

Health condition/s, personal factors, external environment	Deficits in intrinsic capacity	Functional ability
• 76 years old • Mild dementia (GDS 4) • Co-morbidities: hypertension, diabetes, peripheral neuropathy • Lives with wife • History of falls • Has CHSP funding • Previously worked as a market gardener	• Able to walk around, but slow and unsteady • Reduced sensation in feet due to peripheral neuropathy • Limitations in scanning the environment for potential hazards • Impaired planning of complex tasks • Some memory deficits	• Able to self-initiate going into the garden, but struggles to plan what tasks need doing • Sometimes doesn't recognise or avoid a potential hazard such as an uncoiled hose when moving around • Sometimes forgets to pack away items he has used such as the hose • When he falls, Mr Wong struggles to get up

Client reported goal:

Person with dementia: "I want to work in my vegetable garden"

Carer: "I know he loves being out in that garden, but I am worried about him falling, and when he does, I am not strong enough to help him up. I want him to be safe"

Current function towards goal: Mr Wong waters the garden with a hose and inconsistently bends over to pull out some weeds. Recently, Mr Wong tripped on the hose and fell to the ground; he was unable to get up and his wife called an ambulance for assistance. Now Mrs Wong provides stand-by assistance when they are in the garden.

SMART goal (specific, measurable, achievable, relevant, and time-bound): Identify and trial the most appropriate gardening aids for Mr Wong, so that by the end of the reablement program, he will be able to effectively use the aids (with verbal prompting from his wife) in the garden to reduce his chance of falling while watering the plants and doing the weeding.

Reablement program activities:

Occupational therapy: Assess Mr Wong's outdoor mobility, dexterity and functional cognition (to determine his ability to use selected aids), and identify the best mobility and garden aids to support his continued participation in gardening (e.g. raised garden beds, door alarm to facilitate supervision from Mrs Wong when Mr Wong enters the garden). Introduce aids to Mr and Mrs Wong and provide support in strategies for use while doing Mr Wong's preferred activities of watering and weeding the garden. Provide guidance to Mrs Wong in communication and activity support strategies.

Physiotherapy: Assess Mr Wong's balance and strength and provide mobility aid to use when moving around outside in the garden. Mr and Mrs Wong will learn strategies for getting up if he were to fall.

Exercise physiology: To support engagement in preferred gardening activities (e.g. bending to weed, carrying a hose), and to improve his chances of getting up if he were to have a fall, Mr Wong will engage in lower limb exercises including balance and strength to support bending, core related exercises to support leaning forwards in the garden, and arm strength to support use of selected aids.

Case 3: Mrs Singh

Health condition/s, personal factors, external environment	Deficits in intrinsic capacity	Functional ability
• 76 years old • Mild dementia (GDS 4) • Co-morbidities: osteoporosis, hearing loss • Lives alone in a house • Widowed 2 years ago • Has CHSP funding	• Losing muscle tone in her legs • Anxiety around falling while out walking	• Able to walk to the corner shop once per week, but is becoming slower and is worried about falling.

Client reported goal:

Person with dementia: "I want to improve the strength in my legs and feel more confident walking to the corner shop".

Current function towards goal: Mrs Singh walks to the corner shop once per week but is becoming increasingly slow. She used to walk to the shop three times per week, but now is very tired after each trip and is worried about falling. Although she enjoys being out of the house, Mrs Singh has been reluctant to go on her walks to the corner shop.

SMART goal (specific, measurable, achievable, relevant, and time-bound):By the end of the 12-week reablement exercise program, Mrs Singh will have improved the strength in her legs and her confidence in walking outside in the community so that she will walk to the corner shop three times per week.

Reablement program activities:

Exercise physiology: Mrs Singh will improve her strength, balance and mobility through engaging in an exercise program to increase her confidence in walking safely to the corner shop three times per week. Therapists would accompany Mrs Singh to ensure walking to the shop is safe and provide education on falls prevention strategies while doing so.

3. Score – using GAS-Light

a) Prior to beginning the reablement program, rate the client's current level of functioning towards their SMART goal.

b) At the end of the program (or at another pre-specified time), rate the client's level of attainment towards that goal.

Once the goal has been identified (step 1) and the parameters defined 'SMART'ly (step 2), the GAS-Light scoring system may be applied to determine the client's level of attainment at the end of their reablement program. Table 2 presents a practical tool for using the GAS-Light approach.[6, 9] **This tool allows practitioners to score GAS-Light using a verbal description of functioning with no need to apply the numerical scoring system.** However, the scoring system has been linked with the verbal scoring system to facilitate broader reablement program monitoring.

The process of applying GAS-Light is as follows:

1. The client's expected outcome towards the goal should be recorded (the SMART goal that has been developed in steps 1 and 2 of this guide).
2. Prior to beginning the program ('baseline') the client's level of functioning towards their identified goal should be rated as either having some function (-1) or no function at all (-2; there is no possibility for the client to become worse in function towards this goal).
3. At the end of the program ('after reablement program' - or at another pre-specified time), the client's goal will be revisited and their level of function towards that goal rated again. At this point, it will be determined whether the goal was achieved as expected (0), a little more than expected (1), a lot more than expected (2), or if it was not achieved, whether it was partially achieved or no change (-1) or if it got worse (-2).[6, 9]

For a more detailed guide on using GAS and calculating GAS scores in a rehabilitation setting, see Turner-Stokes (2017).[9]

Table 2: GAS-Light scoring system for people with dementia engaged in a reablement program

Baseline date:			✓	Scoring
Regarding the reablement goal, do they have		No function (as bad as they could be)		-2
		Some function		-1
After reablement program – date:				
Was the goal achieved?	Yes	A lot more		+2
		A little more		+1
		As expected		0
	No	Partially achieved		-1
		No change		-1/-2
		Got worse		-2

Adapted from Turner-Stokes (2009, 2017)

Glossary

Activities of Daily Living (ADLs): ADLs, or everyday living activities, are the varying tasks that we all complete on a daily basis. They range from basic activities (e.g. bathing or toileting) to more complex tasks (e.g. cooking a meal or doing the shopping). Limitations in being able to carry out these activities can impact on a person's independence and quality of life.

Commonwealth Home Support Programme (CHSP): the CHSP is an entry-level program for older people who need assistance, aimed at providing support to maintain independence in the community and remain living at home.[16]

Goal Attainment Scaling (GAS): GAS is a person-centred tool that is useful both as an outcome measure and in supporting communication and decision-making with the client and between practitioners.[14] In the context of reablement, GAS involves identifying an individual's aims for their reablement program and using a systematic approach to scoring their level of attainment towards this aim at the end of the program.
The original process of GAS involves a number of steps, as follows[6, 15]:

1. Identify at least three personally meaningful intervention goals in partnership with the person with dementia, the practitioner, and where appropriate the family/support people (one GAS scale for each goal);
2. Determine the current level of functioning associated with that goal (baseline);
3. Set the follow-up time period for measurement of goal attainment;
4. Formally set the goal. Note that the 'expected outcome' is set to '0';
5. Identify and record the other possible attainment levels:
   a. 'much less than expected' = -2,
   b. 'somewhat less than expected' = -1,
   c. 'somewhat better than expected' = 1, and
   d. 'much better than expected' = 2;

At the end of the intervention (or specified time-frame), the attained level of functioning is recorded.

Home Care Packages (HCP): a HCP provides a package of services, often including case management, to support older people to live independently in their own homes. A HCP provides more comprehensive services for people with higher needs than available through the Commonwealth Home Support Program (CHSP). In order to access a HCP, an ACAT/ACAS assessment is required to confirm the level of support required.[17]

International Classification of Functioning, Disability and Health (ICF): The International Classification of Functioning, Disability and Health (ICF) provides a broad biopsychosocial framework to describe health and functioning within the context of a disability, such as that resulting from dementia.[3] Applying the biopsychosocial model in this way has previously been described as a useful tool to guide practice in dementia.[13]

Reablement: Reablement is an intervention approach that promotes the regaining or maintenance of functional performance in older people.[1] For people with dementia, reablement is about maintaining function for as long as possible, regaining lost function, or even improving everyday function.[2]

SMART goals: SMART goals are Specific, Measurable, Attainable, Relevant, and Time-bound.[8]

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Choose meaningful goals in partnership with clients, define as SMART goals, and score using Goal Attainment Scaling-Light to effectively evaluate outcomes from reablement programs for people living with dementia.