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

Client Workbook

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This is an individualised client workbook designed to be used 'in the field' to guide the process of goal setting and evaluation for a client who is engaged in a reablement program.

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References

For the full reference list associated with this Client WorkBook, please refer to the Practitioner Guide: O'Connor CMC, Poulos CJ. *Setting goals and evaluating meaningful outcomes for people living with dementia who are participating in reablement programs: practitioner guide.* Sydney: HammondCare, 2021.

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Client name:

Practitioner name:

Reablement program:

Program start date:

Program end date:

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.

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

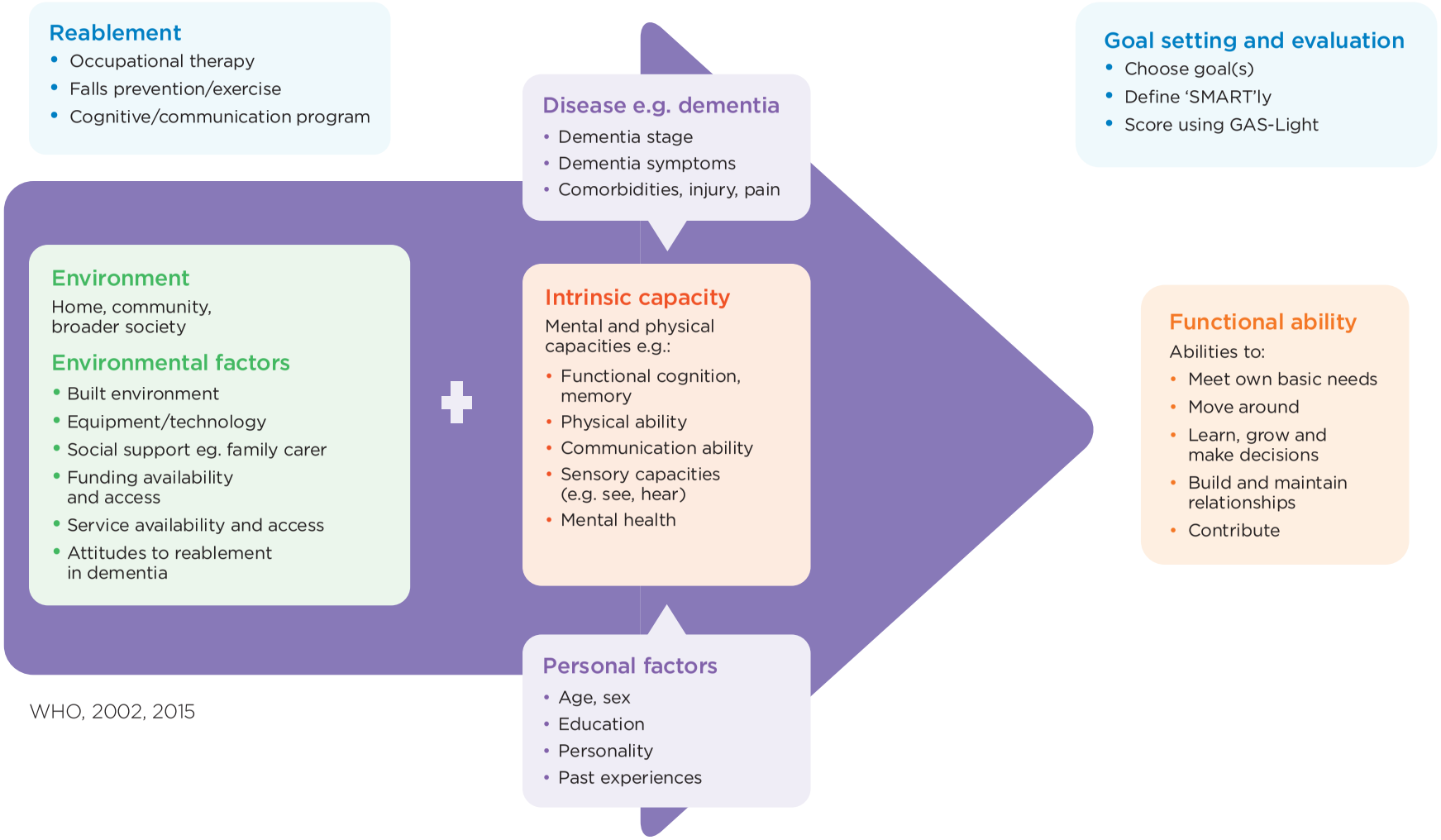
This guide includes the novel amalgamation of the following three concepts into a single framework to guide the use of GAS to evaluate meaningful outcomes for people living with dementia who are participating in reablement programs:

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

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.

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 of the Practitioner Guide).[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 of the Practitioner Guide).

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.

Use the relevant List(s) to guide a discussion with your client. Circle identified goals.

Program 1: Reablement Goal List – Occupational therapy for everyday living (circle identified goals)

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 (circle identified goals)

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 (circle identified goals)

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

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]

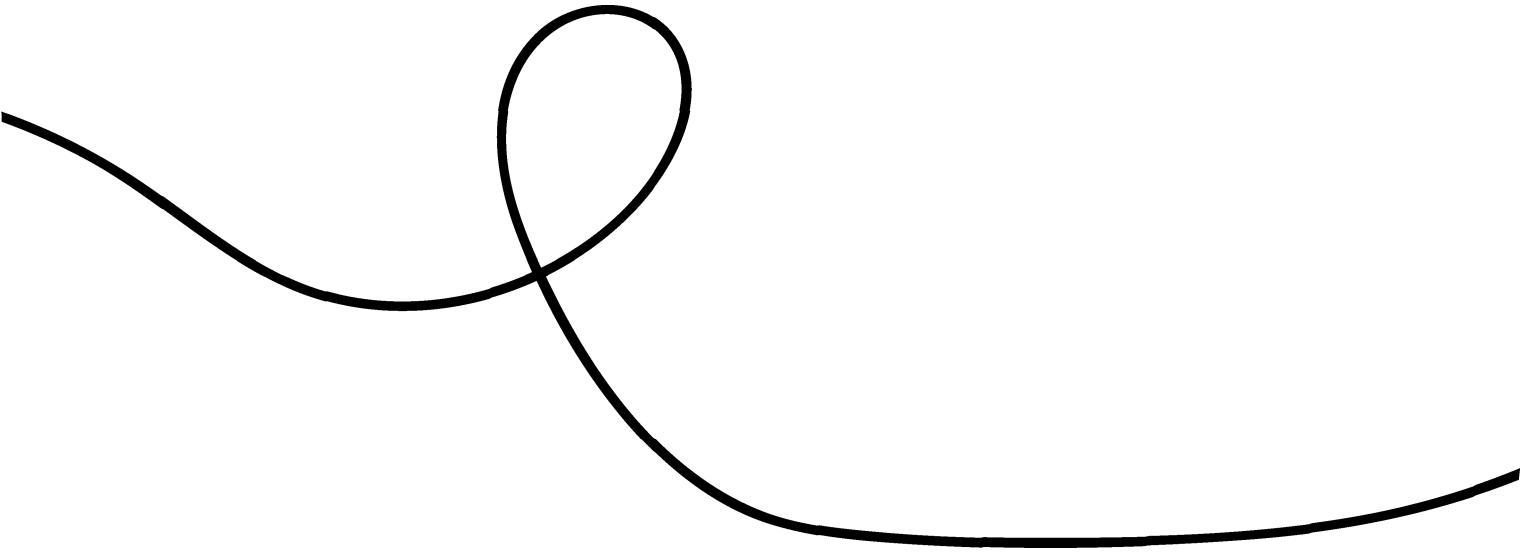
For a more detailed guide on using GAS and calculating GAS scores in a rehabilitation setting, see Turner-Stokes (2017).[9]

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)

The following one page reablement plan is to be completed together with your client. This page is for the client to keep so they have a record of their goals and their reablement plan to achieve these goals.



MY REABLEMENT PLAN

Name: Date:

Therapist/ clinician:

This is what I want to work on (my goal):
My program involves: e.g. building strength in my legs, practicing using a timer while cooking a meal
My supporting team: e.g. allied health team members, family members
I am aiming to achieve this goal in: _____weeks (time frame) (add date)
At the beginning of my program, I have (circle): • No ability towards my goal • Some ability towards my goal
At the end of my program, I have (circle): • Achieved my goal: as expected, a little more, a lot more (circle one) • Partially achieved my goal • Not achieved my goal: no change, less ability towards my goal (circle one)

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