Standardised methods for setting person centred goals in stroke

Clinician Manual

Version 1

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Translational Public Health and Evaluation Division

Stroke and Ageing Research Group

Monash University

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GLOSSARY

Behaviour: The observable behaviour that is being targeted. May include tasks, activities or roles.

Conditions: The conditions required for the person to perform the behaviour e.g. aids, assistance, equipment, supervision.

Context: Where the behaviour will occur or environmental factors that may influence the difficulty with which the goal can be achieved.

Enable Me: Stroke Foundation website resource for stroke survivors, family and carers. www.enableme.org.au

Goal Attainment Scaling (GAS): GAS is a standardised method of scoring the extent to which a survivor's individual goals are achieved.

Measurement: How achievement will be measured e.g. time, frequency, intensity or using a validated measure.

Performance standard: The acceptable standard of the performance of the behaviour may include the quality or consistency of the performance.

Person-centred care: Respect for the needs, wants, preferences and values of individuals.

SMART-GEM: A standardised method for measuring the clinical usefulness of set goals

SMART goal: An acronym used to provide criteria to guide in the setting of objectives.

ABBREVIATIONS

AFO: Ankle foot orthosis.

BGL: Blood glucose level.

BMI: Body mass index.

BP: Blood pressure.

DBP: Diastolic blood pressure.

GP: General Practitioner.

HbA1c: Haemoglobin A1c. A form of haemoglobin that is bound to glucose.

HDL-cholesterol: High density lipoprotein cholesterol.

LDL-cholesterol: Low density lipoprotein cholesterol.

mmHg: Millimetres of mercury.

mmol/l: Millimoles per litre.

SBP: Systolic Blood Pressure.

TIA: Transient ischaemic attack.

VAS: Visual analogue Scale.

INTRODUCTION

Background

Goal setting is recommended in the Australian Clinical Guidelines for Stroke Management.[1] Goal setting should always occur with the stroke survivor and next-of-kin, which may include family / primary informal caregiver, unless they choose not to, or are unable to participate. Goal setting may support survivors of stroke in adhering to medication use; undertaking lifestyle changes for secondary prevention of stroke; and adjusting to altered functional and emotional abilities.[1] Goal setting is also recognised as an effective way of achieving behavioural change, promoting person-centred care (see below), facilitating better self-management and improving satisfaction with the care received.[2, 3] However, goal setting can be difficult, time consuming, and can lack a fully person-centred approach.[2]

The goal setting package presented in this manual has been designed to: simplify the goal setting process between clinicians and patients; ensure that a comprehensive range of goals known to be important to survivors of stroke are discussed; facilitate a collaborative person-centred approach to goal setting; and ensure goals are set in a standardised manner to allow objective assessment of goal attainment. Although the package has been primarily developed for use as part of comprehensive discharge care planning, the components have been developed with sufficient flexibility for use across a range of settings for research and clinical practice.

Person centred goal setting

Person-centred care is defined as respect for the needs, wants, preferences and values of individuals[4] and is characterised by mutually beneficial partnerships among health care providers and consumers. Collaborative goal setting provides a valuable opportunity to enhance person centred care.

The stroke survivor's past life experiences, previous experience (if any) with goal setting, stage of recovery and level of self-efficacy will influence the collaborative goal setting process. Some may already be familiar with the concept of setting goals. However, for many, it may be completely new. It is important that survivors are educated about goal setting and engaged from the onset so that they are empowered to be an equal participant in the process. The concept of goal setting should be conveyed in a language appropriate to the health literacy level and communication needs of the survivor. Alternate language such as "What would you like to improve?", "At the moment, what aren't you doing, that you would

like to be doing?" Or "What would you like to return to?" May be more appropriate than asking "What goals would you like to set?"

Special consideration should be given to survivors of stroke with communication disorders, cognitive problems or English as a second language. Stroke survivors with communication and cognitive impairment are often excluded from the goal setting process. Survivors with communication and cognitive impairments will have goals unrelated to communication and cognition and should be included in the process wherever possible. Using aphasia friendly materials, communication aids, images and input from speech pathologist may assist. The following strategies can assist with the process:

- Allow extra time for goal setting
- Use a pre-prepared script to ensure language is kept to an appropriate level
- Check understanding and validate responses
- Use visual or pictorial support
- Point to pictures
- Consider using a visual analogue scale (VAS) or similar against items
- Consider family involvement where appropriate

SMART goals

It is generally agreed for a goal to be quantifiable it should be Specific, Measurable, Action based, Realistic and Time specific (SMART).[5] The acronym SMART has several variations, which can be used to provide a more comprehensive definition of a SMART goal.

S - specific, significant, shared
M - measurable, meaningful, motivational, monitored
A – achievable, action-oriented, agreed upon, accessible, acceptable
R - realistic, relevant, reasonable, rewarding, results-oriented
T - time-bound, timely, tangible, trackable, transparent

The ***SMARTER*** framework developed by Hersh and colleagues[6] is particularly focused on people with aphasia, and also highlights the need for goals to be **E**volving and **R**elationship centred (i.e. a shared experience between the survivor and the clinician).

Goal setting, especially in discharge planning, needs to be adaptable to the changing needs, desires and priorities of survivors over time**.** In order for goals to evolve they need to be re-assessed regularly and the survivor needs to be empowered to revise their goals to suit their changing needs and situations.[6]

Converting a survivor stated goal into a SMART goal

Initial goals will tend to be broad and often participation focused. In the body of the manual we have provided examples of how to convert a survivor stated goal into a SMART goal. This has been done with reference to the SMART-Goal Evaluation Method (SMART-GEM) developed by Mogensen et al.,[7] a standardised method for measuring the clinical usefulness of set goals. It is important that this is done as a shared process so that the survivor still recognises the final SMART goal as their own. If the SMART goal is well stated, using familiar terminology, it will make it easier for the survivor or their family to monitor progress. This will also help them determine if additional assistance or assessment by a health professional is required or if the goals should be modified.

How to assess achievement of goals: Goal Attainment Scaling

As goals can be so diverse and subjective it is important for clinicians or researchers, when reviewing patient goals, to use a reliable method for determining whether goals have been achieved. Goal Attainment Scaling (GAS) is one method of goal setting that has support in the research literature[8] and is used in clinical practice and research. In GAS, the survivor's progress towards achieving goals is measured and scored on a five-point scale from -2 to +2 with reference to the SMART goal (score of 0). Importance and difficulty ratings can also be given on a 0-3 scale.[9]

-2	the same as or worse than baseline (i.e. no progress has been made)
-1	partially achieved
0	achieved as expected (as stated in the SMART goal)
+1	slightly exceeds expectation
+2	greatly exceeds expectation

In the GAS Scoring Guides section of the manual we provide specific guidelines for goal scoring using GAS methods. This includes some general guidelines as well as decision trees to improve the reliability of scoring for the following types of goals: (1) quantitative goals; (2) qualitative goals; (3) secondary prevention goals; (4) process goals; and (5) maintenance goals.

Having well defined goals is an important component of GAS[10, 11]. Although the standard GAS method is recommended for use in research, a more streamlined approach, the GAS-

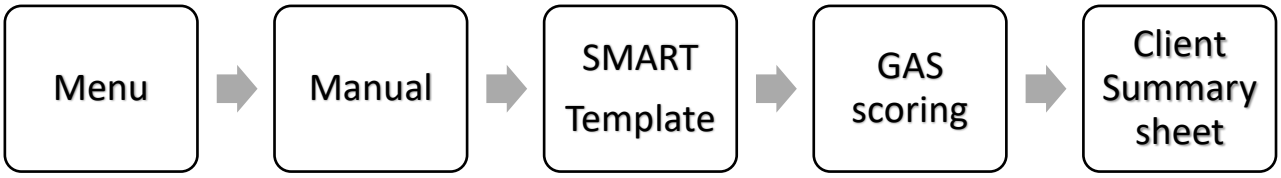
light method developed by Lynn Turner-Stokes,[9] can be used in clinical practice. Further details on the GAS and GAS-light scoring can be obtained from:

https://www.kcl.ac.uk/lsm/research/divisions/cicelysaunders/attachments/Tools-GAS-Practical-Guide.pdf

Managing unrealistic goals / goal negotiation

If the survivor stated goal is 'unrealistic' or unlikely to be achieved within a reasonable timeframe, interim goals or goals with shorter timeframes can be negotiated.[3] The strategies section of the client summary sheet can be used to develop a staged approach towards meeting these larger goals. GAS scoring can also be used to develop interim goals or quantify overly ambitious goals. For example, an overly ambitious goal can be scored in the +2 category with a more realistic goal recorded in the 0 category. This means that the survivor's desires are not diminished but that the level of difficulty in achieving the goal has been acknowledged.

Procedures for using the goal setting package



The goal setting menu

The goal setting menu is designed to facilitate discussion between the survivor and clinician about what is important to the survivor, some of the challenges that they may face during recovery and what their long-term goals and aspirations may be. The menu was designed with reference to the Australian Stroke Survivor and Carer Needs Assessment Survey[12] and the International Classification of Function (ICF).[13] It covers a broad spectrum of areas known to be important to people recovering from stroke.[12] The survivor should be given the menu and the goal setting process should be explained. They should then be given time to think about their goals and discuss these with their family or carer. Where appropriate, secondary prevention goals should be strongly encouraged by the team. For example, a person with stroke should not be discharged from hospital with high blood pressure without a goal related to blood pressure management encouraged. Survivors should be encouraged to select 3 to 5 areas from the menu that they would like to set a goal. For those with mild impairment it may be appropriate to set 1 to 2 goals.

The clinician manual

Once the survivor has identified the areas in which to set goals the manual can be used to help clinicians guide them through the process of converting these to SMART goals. The manual sections provide additional information for each menu category and contains: clinical guideline information; evidence based strategies; examples of survivor stated goals; and worked examples of converting these to SMART goals. Although the manual is extensive it will only be necessary for the clinician to access the sections relevant to the goal setting areas chosen by the survivor.

The SMART template

The SMART goal should be recorded on the GAS scoring template (Appendix 2A and 2B). The survivor stated goal should always be written at the top of the sheet to maintain the linking relationship between what the survivor has expressed and the derived SMART goal. The survivor's baseline function, the negotiated SMART goal and the timeframe should also always be recorded. Strategies for achieving the goal should be discussed with the survivor and recorded on the back of the template page. These may include: interim steps or progressions towards achieving the SMART goal; services or information the survivor may need to achieve the goal; anticipated barriers and enablers to achieving their goal; and how anticipated barriers can be negotiated to achieve the final outcome. A copy of the client summary sheet, which includes the agreed goals and strategies, should be given to the survivor and their family.

The template has also been designed to allow the clinician or research to perform GAS scoring. For research purposes, it has been advised that the GAS scoring for categories -2, -1, +1 and +2 be scored by an independent rater to promote objectivity. However, for clinical purposes the GAS scoring can be used to facilitate goal negotiation and there is benefit from active collaboration between the clinician, and the survivor and their family in the GAS scoring process where apprpriate.[9]

To promote ongoing monitoring of goal achievement and evolution of goals beyond the hospital setting we recommend that a copy be:

1. Provided to the survivor and their family (client summary sheet only i.e. summary and strategies section).
2. Kept in the medical records (GAS scoring template and client summary sheet).
3. Sent to the survivor's General Practitioner and any other health professional involved in their post-discharge management (GAS scoring template and client summary sheet).

YOUR HEALTH

Health and Secondary Prevention

CONTROLLING BLOOD PRESSURE
(Blood Pressure Monitoring / Control)

Guidelines

- The ideal long-term blood pressure (BP) is not well established. However, a target of <130mmHg systolic is recommended.[1]
- High BP is defined as > 140/90 mmHg.[14]

All survivors of stroke or transient ischaemic attack (TIA) with a BP of > 140/90 should have long term blood pressure lowering therapy initiated or intensified unless contraindicated. In survivors with a systolic blood pressure of 120–140mmHg who are not on treatment, initiation of antihypertensive medication should also be prescribed to prevent further vascular events.

Note: The higher the baseline BP the greater the potential reduction.
Realistic reductions should not result in a BP lower than normal.

Examples of Stroke Survivor Stated Goal
'Reduce my blood pressure'
'Get my blood pressure to recommended range'
'Take my blood pressure medication'
'Stop needing blood pressure medication'

Converting to SMART Goal (metrics)

- Observable outcome: Reduction in blood pressure.
- Conditions: Measurement tool used, body position, assistance required.
- Context: Time of day, location that BP was measured, person performing measurement (e.g. nurse, self).
- Measurement: SBP and DBP.
- Performance standard: How often, consistency / stability, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Adherence to antihypertensive medications (all survivors should be discharged on these medications following stroke).
- Physical activity: at least 30 minutes of moderate exercise on most days of the week (See Exercising section).
- Weight control/reduction (See Losing or putting on weight section).
- Reduce salt intake (See Eating well section).
- If blood pressure is difficult to control, suggest the purchase of an automatic BP machine and provide (or organise) education on its use.

Worked examples

1. ***Survivor stated goal: 'Reduce my blood pressure'*.**

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: BP 140/100 measured by nurse at GP clinic at monthly reviews with manual blood pressure monitor cuff and stethoscope.
- Observable outcome: Reduction of blood pressure levels to within a normal range.
- Conditions: Manual blood pressure monitor cuff and stethoscope, on right upper limb.
- Context: Measured by nurse at general practitioner (GP) clinic at regular monthly review.
- Measurement: SBP/DBP. Interim goal established to coincide with 4-week review period.
- Performance standard: Good accuracy (standardised conditions by a trained professional).

Survivor goal	Reduce my blood pressure	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	BP >135/95 measured under stated conditions in 4 weeks.		
Partially achieved	**-1**	BP > 130/90 and less than 135/95 measured under stated conditions in 4 weeks.		
SMART goal	**0**	**BP 130/90 measured with manual BP monitor cuff and stethoscope, on right upper limb by nurse at GP clinic at regular monthly review in 4 weeks time.**		
Somewhat better than expected	**+1**	BP < 130/90 and greater than 125/85 measured under stated conditions in 4 weeks.		
Much better than expected	**+2**	BP < 125/85 and within normal recommended range measured under stated conditions in 4 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Get my blood pressure to recommended range'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: BP 140/105 Varies between 145/105 and 135/100 over the past month.
- Observable outcome: Reduce BP to within recommended range.
- Conditions: Automatic BP machine measured at home by stroke survivor's wife. Cuff attached to either right or left arm. Context: Measured most mornings at home.
- Measurement (timeframe/amount): SBP/DBP, estimated that the required reduction should take about 6 months.
- Performance standard: Moderate level of accuracy (self-measurement with fluctuations) and so should be measured over multiple occasions.

Survivor goal	Get my blood pressure to recommended range	**Timeframe** 6 months	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	BP >135/100 measured under stated conditions in 6 months (average of 3+ readings).		
Partially achieved	**-1**	BP >120/80 and < 135/100 measured under stated conditions in 6 months (average of 3+ readings).		
SMART goal	**0**	**BP 120/80 measured under stated conditions in 6 months (average of last 3+ readings)**.		
Somewhat better than expected	**+1**	BP 120/80 measured under stated conditions in 5 months (average of 3+ readings).		
Much better than expected	**+2**	BP 120/80 measured under stated conditions in 4 months (average of 3+ readings).		

*Agreed strategies are to be recorded on the client summary sheet

MANAGING DIABETES
(Diabetes Control)

Guidelines

- Diabetes and glucose intolerance following stroke have been found to be independent risk factors for future stroke.
- Assessment of glucose intolerance after stroke and TIA should be done to allow identification and subsequent management of undiagnosed diabetes and glucose intolerance.
- Survivors of stroke with diabetes and glucose intolerance should be managed according to the national guidelines for diabetes.
  - HbA1c target for individuals with Type 2 diabetes is ≤7%. Adjustment to diabetes treatment should be considered when HbA1c is above this level.
  - Targets for self-monitored blood glucose levels are 6-8mmol/L fasting and pre-meal and 6– 10mmol/L 2 hours post-meal.
  - Interventions to achieve targets should begin with lifestyle modification followed by therapeutic options selected on the basis of individual clinical presentations. However, pharmacotherapy may also be required in individuals presenting with significant hyperglycamia.[15]

Examples of Stroke Survivor Stated Goal

'Remember to check blood sugar levels daily'

'Manage my diabetes with diet'

'Control fluctuations in my blood sugar'

'Follow my diabetes plan'

Converting to SMART Goal (metrics)

- Observable outcome: Manage diabetes.
- Conditions: How it was measured, fasting / non-fasting, home testing.
- Context: Where and when was it measured and by whom.
- Measurement: Blood glucose level test (BGL).
- Performance standard: Consistency / stability.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Management of glycaemic status using education, behavioural modification, diet, exercise and pharmacotherapy (See sections relating to Eating well, Exercising, and Taking medications properly for related goals).
  A referral to a dietician, exercise physiologist, diabetes educator, or other health professional may be required.

Worked examples

1. ***Survivor stated goal: 'Remember to check my blood sugar levels daily'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Management plan includes daily assessment of BGL with home test kit. Survivor remembers to do this approximately half of the time.
- Behaviour: Self-assessment of BGL.
- Conditions: Able to test own BGL independently with home test kit.
- Context: In survivor's own home, before meals.
- Measurement: Frequency of checking and recording.
- Performance standard: Consistency (aim for > 80% of the time) over the past 2 weeks.

Survivor goal	Remember to check my blood sugar levels daily		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Checks and records BGL at home with home test kit 50% of the time over the past 6 weeks.			
Partially achieved	**-1**	Checks and records BGL daily at home with home test kit 60 -80% of the time over the past 6 weeks.			
SMART goal	**0**	**Checks and records BGL daily at home with test kit. Remembers to do this >80% of the time over the next 6 weeks.**			
Somewhat better than expected	**+1**	Checks and records BGL daily at home with test kit. Remembers to do this >80% of the time over the past 6 weeks, and levels are in the goal range 50-75% of the time.			
Much better than expected	**+2**	Checks and records BGL daily at home with test kit most of the time (>80 over the past 6 weeks, and levels are in the goal range >75% of the time.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Manage my diabetes with diet'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Recent diagnosis of diabetes. Survivor would prefer to manage diabetes by modifying her diet. Goal is to maintain BGL between 8.0 – 10.0 two hours post eating meal. If unable to manage BGL with diet modifications after 4 weeks she will need to go on medication.
- Observable outcome: Control diabetes by dietary modification.
- Conditions: Prepares own meals and snacks at home. Does shopping for self.
- Context: Most dietary decisions made in own home, occasionally eats with family and friends.
- Measurement (timeframe/amount): Proportion of time following diabetic diet as prescribed. BGL maintained within desired range measured using home testing kit.
- Performance standard: High level of accuracy. Consistency (self-report) over the past 4 weeks.

Survivor goal	Manage my diabetes with diet		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Has not yet implemented prescribed diabetic diet. BGL not maintained within desired range of 8.0 – 10.0.			
Partially achieved	**-1**	Implemented prescribed diabetic diet and following 50 -75% of the time.			
SMART goal	**0**	Implemented prescribed diabetic diet and following the majority of the time (>75%).			
Somewhat better than expected	**+1**	Implemented prescribed diabetic diet and following strictly > 90% of the time.			
Much better than expected	**+2**	Implemented prescribed diabetic diet and following strictly > 90% of the time and has introduced other lifestyle changes (e.g. exercise) to better manage BGL.			

*Agreed strategies are to be recorded on the client summary sheet

EATING WELL
(Nutrition / Diet)

Guidelines

- All stroke survivors should be referred to an accredited practising dietitian who can provide individualised dietary advice.
- Survivors of stroke and TIA should manage their dietary requirements in accordance with Australian Dietary Guidelines.[16]
- Adult recommended daily serves (75g per serve) of vegetables = 5-6 serves.
- Adult recommended daily serves (150g per serve) of fruit = 2 serves.
- Recommended dietary sodium intake preferably <1 600mg/day for adults (4g or 3/4 of a teaspoon of salt).

Examples of Stroke Survivor Stated Goal
'Eating better and healthier'
'Reducing salt in my diet'
'Learn more about healthy eating'
'Reducing how often I have fast food and take away'

Converting to SMART Goal (metrics)

- Behaviour: Consumption of healthy diet.
- Conditions: Modified textured diet or special dietary requirements.
- Context: Where is consumption taking place (home, care facility, in community café / restaurant).
- Measurement: How is it being measured (e.g. food diary, retrospective recall, questionnaire). Amount (grams)/serves of vegetables, fruit, sodium, saturated fat, kilojoules.
- Performance standard: How often, consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- National dietary guidelines recommend achieving and maintaining a healthy weight; enjoying a wide variety of nutritious food and limiting the intake of foods containing saturated fat, added salt, added sugar and alcohol.
- Consume recommended daily intake of vegetables and fruits.
- Limit intake of foods high in saturated fat such as biscuits, cakes, pastries, pies, processed meats, burgers, pizza, fried foods, chips etc.
- Limit intake of foods and drinks containing added sugars such as confectionary, sugar-sweetened soft drinks, cordials and fruit drinks.
- Limit intake of foods and drinks containing added salt.
- Consume recommended daily intake of water.

Worked examples

1. ***Survivor stated goal: 'Eating better and healthier'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Consuming 2 serves fruit and 2 serves vegetables most days of week.
- Behaviour: Increase consumption of vegetables to improve diet.
- Conditions: No special dietary needs.
- Context: Majority of meals are consumed in survivor's own home. Eats with daughter once per week. Occasionally eats at local café if out doing shopping.
- Measurement: Number of serves of vegetables most days (i.e. >5 days a week). Count number of standard serves of vegetable. 1 serve will equal half a cup of uncooked vegetables.
- Performance standard: Moderate level of accuracy, self-reported, measured over the last week.

Survivor goal	Eating better and healthier	**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Consuming 2 serves of fruit and 2 serves of vegetables most (>5) days of week measured over the past week.		
Partially achieved	**-1**	Consuming 2 serves of fruit and between 3 to 4 serves of vegetables most (>5) days of week over the past week.		
SMART goal	**0**	**Consuming 2 serves of fruit and 5 serves of vegetables most (>5) days of week over the past week.**		
Somewhat better than expected	**+1**	Consuming 2 serves of fruit and 5 serves of vegetables most (>5) days of week over the past 2 weeks.		
Much better than expected	**+2**	Consuming 2 serves of fruit and 5 serves of vegetables every day of week and has consistently done this over the past 2 or more weeks.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Reducing salt in my diet'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Consuming approximately 10 grams of sodium in daily dietary intake.
- Behaviour: Reduce sodium intake.
- Conditions: No special dietary needs.
- Context: Eating at home and occasionally at café or restaurant.
- Measurement: Sodium in grams per day calculated by dietician. Food diary to be reviewed by dietician weekly over the next 4 weeks.
- Performance standard: Moderately high accuracy with dietician review.

Survivor goal	Reducing salt in my diet	**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	≥10 grams of daily sodium dietary intake over the past week.		
Partially achieved	**-1**	7 to 9 grams of daily sodium dietary intake most days (>5) over the past week.		
SMART goal	**0**	**6 grams of daily sodium dietary intake most days (>5) over the past week assessed after 4 weeks.**		
Somewhat better than expected	**+1**	6 grams of less of daily sodium dietary intake most days (>5) over the last ≥2 weeks.		
Much better than expected	**+2**	6 grams of less of daily sodium dietary intake every day over the last ≥2 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

EXERCISING
(Physical Activity to Improve Fitness)

Guidelines

- Strong evidence from the literature that physical activity has a protective effect against stroke.[1]
- Recommendation: > 150 minutes of moderate physical activity or > 75 minutes of vigorous physical activity, or an equivalent combination of both.
- For adults > 65 years guidelines recommend at least 30 minutes of moderate intensity physical activity on most, preferably all days of the week.
- Moderate intensity activities require some effort, but conversation is possible this will vary depending on the baseline fitness of the survivor. For those will very low baseline fitness any activity is better than no activity (e.g. short frequent bursts, reducing sitting time etc.).
- Activities may include chair exercises for fitness, walking, swimming, social tennis and dancing.

Examples of Stroke Survivor Stated Goal
'Sit less during the day'
'Increase my endurance'
'Walk the dog most days'
'Return to using the treadmill'

Converting to SMART Goal (metrics)

- Behaviour: Participation in physical activity.
- Conditions: Use of aids / supervision, equipment.
- Context: Type of activity, where the activity will take place, individual or group.
- Measurement: Duration, number of breaks required, frequency, intensity.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Survivors of stroke and TIA should be advised and supported to undertake appropriate, regular physical activity.
- Finding a type of exercise you enjoy is the key to keeping motivated and consistent e.g. walking, cycling, gym work, swimming, yoga and tai chi.
- Build exercise into your daily/weekly routine.
- Join a fitness centre, club in the community, exercise program at your local community health care centre or exercise with a friend.

Worked examples

1. ***Survivor stated goal: 'Sit less during the day'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Spends most of the day sitting (3-4 hours at a time). Only gets up to walk to meals, bathroom or to car to go out (<5 minutes, approximately 6 times a day). Walks with a walker and is not able to walk independently outside the home.
- Behaviour: Spend less time sitting for long periods during the day.
- Conditions: Uses walker with supervision, able to stand independently.
- Context: At home.
- Measurement: Duration of sitting, frequency of standing.
- Performance standard: Consistently performs task over a 2 week period.

Survivor goal	Sit less during the day		**Timeframe** 6 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Only standing and walking for short periods to go to meals or the bathroom. Often sitting for 3-4 hours at a time during the day.			
Partially achieved	**-1**	Has been standing up for 5-10 minutes every 1.5-2 hours when sitting for long periods during the day measured over the last 2 weeks.			
SMART goal	**0**	**To stand up and/or walk for 5 minutes every hour when sitting for long periods during the day, measured over the last 2 weeks.**			
Somewhat better than expected	**+1**	Has been standing up and/or walking for 5-10 minutes every hour when sitting for long periods during the day, measured over the last 2 weeks.			
Much better than expected	**+2**	Has been standing up and/or walking for 5- 10 minutes every hour when sitting for long periods during the day and has started to go for short walks outside, measured over the last 2 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Increase my endurance'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Walking 50m with single point stick outside on level concrete path most days.
- Behaviour: Increase walking endurance.
- Conditions: Independent walking with single point stick.
- Context: On level concrete path outside survivor's home.
- Measurement: Distance in meters, number of breaks, frequency.
- Performance standard: Measure achievement based on performance over the last week.

Survivor goal	Increase my endurance		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 1
Baseline (no change or worse)	**-2**	Walk 50m or less with single point stick outside under stated conditions.			
Partially achieved	**-1**	Walks 100m under stated conditions daily but needs to stop after 75m most times (>75% of attempts).			
SMART goal	**0**	**To walk with a single point stick 100 m without stopping, on path (concrete) around house daily >75% of the time in the last week**.			
Somewhat better than expected	**+1**	Walks 100m under stated conditions without stick and without stopping or walks ≥ 125m under stated conditions with stick and without stopping daily.			
Much better than expected	**+2**	Walks ≥ 125m under stated condition without stick and without stopping daily.			

*Agreed strategies are to be recorded on the client summary sheet

TAKING MEDICATION PROPERLY
(Medication Adherence)

Guidelines

- All survivors of stroke should be on secondary prevention medication unless contraindicated.
- Education should be offered regarding the benefits of medication which may also help modify negative perceptions towards medications.
- All medications should be taken as prescribed this includes dose, frequency, time of day and special instructions e.g. with food.

Examples of Stroke Survivor Stated Goal

'Remember to take all of my tablets'

'Fill my own dosette-box and manage my medications each week'

'Not to miss any doses of my tablets'

'Remembering to keep my prescriptions up to date'

Converting to SMART Goal (metrics)

- Behaviour: Taking medication as prescribed.
- Conditions: Use of aids (Webster packs, alarms, electronic reminders, supervision or assistance required.
- Context: Where the activity will take place.
- Measurement: Occasions missed, taken as prescribed, missed filling a prescription.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions to promote adherence with medication should be provided to all survivors of stroke.
- Know and understand medication.
- Consult your GP if you want to change medications.
- Dose administration aids e.g. dosette box filled by the survivor or family member.
- Webster pack filled by the pharmacist to facilitate taking of medications correctly.
- Setting an alarm, using reminders / diary e.g. mobile phones and other technology.
- Filling repeats in a timely manner.
- Support from health professionals and family e.g. pharmacist, district nurse.
- Regular monitoring e.g. blood tests for warfarin, blood pressure monitoring.

Worked examples

1. ***Survivor stated goal: 'Remember to take all of my tablets'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Takes tablets am and pm. Currently forgets to take tablets once a week.
- Behaviour: Taking regular tablets as prescribed.
- Conditions: Independently taking tablets without use of any aids/help (e.g. dosette box).
- Context: In own home.
- Measurement: Missed doses in a 7-day period.
- Performance standard: Take medications without missing a dose measured over last 2 weeks.

Survivor goal	Remember to take all of my tablets		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Missing at least once dose (of all tablets) once a week.			
Partially achieved	**-1**	Take all medication as prescribed almost every day without missing a dose (i.e. forgets no more than once a week over the last 2 weeks).			
SMART goal	**0**	**To take all medication as prescribed every day without missing a dose over the last two week period.**			
Somewhat better than expected	**+1**	Has taken all medication as prescribed every day without missing a dose over the last 3 weeks.			
Much better than expected	**+2**	Has taken all medication as prescribed every day without missing a dose over the last 4 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Fill my own dosette-box and manage my medications each week'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Wife fills medication dosette each Sunday and arranges repeat prescriptions with GP and pharmacist if not enough tablets for week ahead.
- Behaviour: Taking medications as prescribed. Making sure supply is maintained.
- Conditions: Filling medication dosette. Contact with GP and pharmacist if required.
- Context: In own home monitored by family member.
- Measurement: Errors in medication dosette box, missed doses from running out.
- Performance standard: 100% correct. Measured for consistency over 2 weeks by wife.

Survivor goal	Do my own filling of dosette-box and managing medication each week		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Wife filling the dosette and arrange ongoing supply of medication.			
Partially achieved	**-1**	Able to fill the dosette on own most (75%) of the time but not able to consistently identify if there are enough tablets for the next week **or** is able to identify if there are enough tablets for the next week but not able to fill the dosettes most of the time.			
SMART goal	**0**	To accurately fill the dosette with medications for the week. Identify if there are not enough tablets for the next week and contact doctor for new repeat if necessary. To be monitored by wife and measured over the last 2 weeks.			
Somewhat better than expected	**+1**	Able to accurately fill dosette on own and able to identify if there are enough tablets for the next week and has done this consistently for the last 3 weeks.			
Much better than expected	**+2**	Able to fill dosette on own 100% of the time and able to identify if there are enough tablets for the next week 100% of the time. Has done this consistently for the last 3 weeks. Supervision is no longer required and has become part of weekly routine.			

*Agreed strategies are to be recorded on the client summary sheet

MANAGING CHOLESTEROL
(Cholesterol Monitoring)

Guidelines

- Recommended: Total cholesterol <4 mmol/l, "bad" LDL-cholesterol <2.5 mmol/l, "good" HDL-cholesterol >1 mmol/l, Triglyceride levels <2 mmol/l. [14]
- High total cholesterol >5.5 mmol/l.

All survivors of ischaemic stroke or TIA should use statins unless contraindicated. Survivors with haemorrhagic stroke should not use statins routinely in the acute and initial rehabilitation phase.

Note: Realistic reductions should not result in levels lower than normal.

Examples of Stroke Survivor Stated Goal

'Reduce my cholesterol'

'Exercise regularly and eat well to reduce my cholesterol'

'Avoid having to go onto cholesterol medication'

'Stick to the diet to reduce my cholesterol'

Converting to SMART Goal (metrics)

- Observable outcome: Reduced blood cholesterol levels.
- Conditions: How it was measured, fasting / non-fasting.
- Context: Where and when was it measured?
- Measurement: Total cholesterol, LDL, HDL, and Triglycerides.
- Performance standard: Consistency / stability.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Education about cholesterol lowering and adherence to statin medications.
- Lifestyle changes e.g. dietary modifications, physical activity, weight control (See sections relating to Eating well, Exercising and Losing or putting on weight for related goals).
- Consumption of foods low in saturated fat. Referral to a dietician may be beneficial.

Worked examples

1. ***Survivor stated goal: 'Reduce my cholesterol'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Fasting total blood cholesterol level 6.5 at recent blood test.
- Observable outcome: Reduced total cholesterol.
- Conditions: Measured by a fasting cholesterol blood test.
- Context: Measured in the last week at local pathology lab.
- Measurement: Total Cholesterol. 6 weeks was considered a realistic timeframe and coincides with planned review.
- Performance standard: High level of accuracy.

Survivor goal	Reduce my cholesterol		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Total blood cholesterol ≥6.5mmol/l measured under stated conditions in 6 weeks.			
Partially achieved	**-1**	Total Blood cholesterol between 4.0 and 6.4mmol/l under stated conditions in 6 weeks.			
SMART goal	**0**	**Total Blood cholesterol between <4.0 mmol/l measured by a fasting cholesterol blood test at the local pathology laboratory in 6 weeks.**			
Somewhat better than expected	**+1**	Total cholesterol ≤4mmol/l and LDL-cholesterol <2.5mmol/l, or HDL-cholesterol >1mmol/l, or Triglyceride levels <2mmol/l.			
Much better than expected	**+2**	Total cholesterol ≤4mmol/l and LDL-cholesterol <2.5mmol/l and HDL-cholesterol >1mmol/l and Triglyceride levels <2mmol/l.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Exercise regularly and eat well to reduce my cholesterol'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Total blood cholesterol 5.4 at recent blood test. GP has prescribed 30 minutes of walking per day and provided dietary advice to lower blood cholesterol.
- Observable outcome: Reduced blood cholesterol with exercise and diet only.
- Conditions: Blood cholesterol measured by a fasting cholesterol blood test.
- Context: Measured 3 weeks ago at local pathology lab. Planned review in 6 weeks.
- Measurement: Total Cholesterol, plus other cholesterol levels. 6 weeks coincides with planned review.
- Performance standard: High level of accuracy.

Survivor goal	Exercise regularly and eat well to reduce my cholesterol		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Total Cholesterol 5.6 mmol/l measured under stated conditions in 6 weeks.			
Partially achieved	**-1**	Total Cholesterol between 4.1 and 5.5mmol/l measured under stated conditions in 6 weeks.			
SMART goal	**0**	**Total Cholesterol <4.0mmol/l measured under stated conditions in 6 weeks, using exercise and diet only.**			
Somewhat better than expected	**+1**	Total Cholesterol less than 4.0mmol/l measured under stated conditions and LDL-cholesterol <2.5mmol/l, or HDL-cholesterol >1mmol/l, or Triglyceride levels <2mmol/l.			
Much better than expected	**+2**	Total Cholesterol less than 4.0mmol/l measured under stated conditions and LDL-cholesterol <2.5mmol/l and HDL-cholesterol >1mmol/l, and Triglyceride levels <2mmol/l.			

*Agreed strategies are to be recorded on the client summary sheet

REDUCING ALCOHOL INTAKE
(Reducing Alcohol Consumption)

Guidelines

- Recommendation: Limit alcohol intake or abstain.
- < 2 standard drinks on any day for men and women.[17]

A standard drink = 10g alcohol (equivalent to 12.5ml pure alcohol)[17], or 375ml mid-strength beer, or approximately 100ml standard serve of wine.

Examples of Stroke Survivor Stated Goal
'Have at least 1 – 2 alcohol free days a week'
'Reduce alcohol consumption during the week'
'Limit drinking at home'
'Only drink when having a meal with friends or special occasions'

Converting to SMART Goal (metrics)

- Behaviour: Reduce consumption of alcohol.
- Conditions: Type of alcohol consumed, associated behaviours (e.g. socialising).
- Context: Where alcohol consumption takes place.
- Measurement: Amount of alcohol consumed, duration of alcohol consumption, frequency.
- Performance Standard: Consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Survivors of stroke and TIA should be advised to avoid excessive alcohol consumption (> 2 standard drinks per day).[18]
- Limit intake of alcohol: Avoid situations where you might be tempted to drink a lot.
- Limit intake to specific times e.g. with main meal.
- Replace full strength with low alcohol.

Worked examples

1. ***Survivor stated goal: 'Have at least 1 – 2 alcohol free days a week'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Drinking 2 standard glasses of red wine with dinner most nights of week.
- Behaviour: Reduce alcohol consumption.
- Conditions: Red wine, standard glass, man.
- Context: Eating dinner at home with wife who also has wine with evening meal.
- Measurement: Number of standard drinks, nights per week.
- Performance standard: 2 alcohol free days/ week. Consistency measured over the last 4 weeks.

Survivor goal	Have at least 1 – 2 alcohol free days a week		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Consuming 2 standard drinks daily over the last 4 weeks.			
Partially achieved	**-1**	One alcohol free day each week for the last 4 weeks.			
SMART goal	**0**	**To consume 2 standard drinks 5 days a week and no alcohol consumed on the other 2 days of the week over the last 4 weeks.**			
Somewhat better than expected	**+1**	Between 3 or 4 alcohol free days per week each week over the last 4 weeks.			
Much better than expected	**+2**	≥5 alcohol free days a week over the last 4 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Reduce alcohol consumption during the week'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Consumption of up to 4 full strength bottles of beer most days of week.
- Behaviour: Reduce alcohol consumption.
- Conditions: Full strength beer 375ml bottle (1.5 standard drinks), man.
- Context: At own home with or without a friend.
- Measurement: Amount of beer, strength of beer, and frequency.
- Performance standard: Reduce and sustain alcohol consumption. Consistently performed over the last 4 weeks.

Survivor goal	Reduce alcohol consumption during the week		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Consumption of 4 bottles of full strength beer daily (6 standard drinks).			
Partially achieved	**-1**	Consumption of 3 standard serves of alcohol daily (this could be 2 full strength or 4 low strength) over the last 2+ weeks.			
SMART goal	**0**	**To consume 2 standard serves of alcohol daily (2 bottles of low strength beer or 1 bottle of full strength beer). Measured over the last 4 weeks**.			
Somewhat better than expected	**+1**	Consumption of less than 2 standard serves of alcohol daily or at least 2 alcohol free days a week and 2 standard serves the other days over the last 4 weeks.			
Much better than expected	**+2**	Consumption of less than 2 standard serves of alcohol daily and at least 2 alcohol free days a week over the last 4 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

LOSING OR PUTTING ON WEIGHT
(Weight Management)

Guidelines

- Recommended: BMI<25kg/m^2 but over 18.5kg/m^2.[18]
- Recommended: Waist circumference <80 cm (women) and <94 cm (men).[18]

Note: Realistic reductions should not result in levels below the recommended range.
For those who are underweight the goal will be the lower limit of the recommendations.[18]

Examples of Stroke Survivor Stated Goal

'Lose weight'

'Put on weight'

'Maintain current weight i.e. not lose or put on too much weight'

'Fit into my clothes better'

Converting to SMART Goal (metrics)

- Observable outcome: Achieving a healthy weight.
- Conditions: How it will be measured, clothing during measurement.
- Context: Where the measurement will take place, time of day.
- Measurement: Weight in kilograms, waist circumference in centimetres, and / or calculation of BMI.
- Performance standard: How often, consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Healthy diet / calorie modification.
- Eating habits e.g. (1) reduce snacking, alcohol intake (weight loss); (2) small frequent meals (weight gain).
- Regular exercise.
- Increase incidental physical activity.

Worked examples

1. ***Survivor stated goal: 'Lose weight'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Weight 100kg. BMI 34.6. Weight has been stable over the past 6 months.
- Observable outcome: Weight loss.
- Conditions: Weigh in the morning before food with light clothes on and no shoes.
- Context: Measured on bathroom scales at home.
- Measurement: Weight in kilograms.
- Performance standard: Weight in kg averaged over the last 3 days for consistency. Long-term goal should be to obtain a healthy BMI range within an achievable timeframe.

Survivor goal	Lose weight		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Weight 100 kg or more measured under specified conditions averaged over the last 3 days.			
Partially achieved	**-1**	Lost 1kg measured under specified conditions averaged over the last 3 days.			
SMART goal	**0**	**To lose 2 kg after 4 weeks measured on the home scales in the morning before food, light clothing and no shoes averaged over the last 3 days.**			
Somewhat better than expected	**+1**	Weight loss 3kg measured under above conditions averaged over the last 3 days.			
Much better than expected	**+2**	Lost 4kg measured under above conditions, averaged over the last 3 days.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Put on weight'***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Weight 55kg. BMI 17.6. Lost 12kg over past 3 months since stroke.
- Observable outcome: Weight gain.
- Conditions: Measured in the morning after breakfast, wearing light clothes and no shoes.
- Context: Measured at daughter's house on her bathroom scales.
- Measurement: Weight in kilograms.
- Performance standard: Weight in kg averaged over the last 3 days for consistency.

Survivor goal	Put on weight		**Timeframe** 6 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Weight 55kg or less measured under stated conditions averaged over the last 3 days.			
Partially achieved	**-1**	Weight between 56 and 58kg measured stated conditions averaged over the last 3 days.			
SMART goal	**0**	**To increase weight to 59kg measured in the morning after breakfast wearing light clothes and no shoes using daughter's scales averaged over the last 3 days.**			
Somewhat better than expected	**+1**	Weight 60kg measured under stated conditions averaged over the last 3 days.			
Much better than expected	**+2**	Weight 61kg or more measured under stated conditions averaged over the last 3 days.			

*Agreed strategies are to be recorded on the client summary sheet

QUITTING SMOKING
(Smoking)

Guidelines

- Tobacco dependence is a chronic condition that typically requires repeated cessation treatment and ongoing care.
- Survivors of stroke and TIA who smoke should be advised to stop and assisted to quit.
- An Australian smoking cessation guide developed by The Royal Australian College of General Practitioners recommends the 5As approach (ask, assess, advise, assist, and arrange follow up).
- If it is not possible to stop immediately, smoking should be reduced as part of a short-term goal with the long-term goal being to quit.[19]

Examples of Stroke Survivor Stated Goal

'Quit Smoking'

'Reduce Smoking' – Interim goal. Long term goal should be smoking cessation.

'Cut down smoking to 5 cigarettes a day'

'Avoid situations where I will be tempted to smoke'

Converting to SMART Goal (metrics)

- Behaviour: Stopping smoking.
- Conditions: Type of cigarettes.
- Context: Where smoking takes place, associated behaviours (e.g. socialising).
- Measurement: Number of cigarettes smoked in given period (i.e. in a 24-hour period), frequency of smoking.
- Performance standard: Consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed

Strategies

- Pharmacotherapy including Nicotine replacement products.
- Seek help and support from a health professional or through a community program.
- Telephone or face-to-face counselling.
- Regular follow-up to monitor progress.

Worked examples

1. ***Survivor stated goal: 'Quit smoking'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Currently smoking 10 – 12 cigarettes a day.
- Behaviour: Stopping smoking.
- Conditions: Smoking commercial brand cigarette.
- Context: Smoking in own home and when out.
- Measurement: Number of cigarettes a day.
- Performance standard: Complete cessation of smoking.

Survivor goal	Quit smoking		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Smoking 10 – 12 cigarettes a day most days for the last 5 years.			
Partially achieved	**-1**	Smoked < 10 cigarettes daily over the past 4 weeks or no cigarettes on some but not all days.			
SMART goal	**0**	**To cease cigarette smoking over a 4-week period. This will be achieved with some difficulty of will.**			
Somewhat better than expected	**+1**	Has not smoked any cigarettes in the last 4 weeks with minimal effort.			
Much better than expected	**+2**	Has not smoked any cigarettes in the last 4 weeks with minimal effort and is confident that this is sustainable.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Reduce smoking'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Smoking approximately 25 cigarettes daily.
- Behaviour: Reduce number of cigarettes smoked daily.
- Conditions: Rolls own tobacco cigarettes.
- Context: Smoking typically occurs outside at own home.
- Measurement: Number of cigarettes daily over 4 weeks.
- Performance standard: Gradually reduce cigarettes smoked in the short term but with a longer-term goal of complete cessation.

Survivor goal	Reduce smoking		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Smoking 25 cigarettes daily.			
Partially achieved	**-1**	Smoking between 13 and 24 cigarettes daily over the past week.			
SMART goal	**0**	**To reduce smoking to 12 cigarettes daily measured over the last week.**			
Somewhat better than expected	**+1**	Smoking less than 12 cigarettes daily over the last week, but still smoking.			
Much better than expected	**+2**	Complete cessation of smoking. No cigarettes smoked over the last week.			

*Agreed strategies are to be recorded on the client summary sheet

MIND AND BODY

Health / Body Function

MOVING AND GETTING AROUND
(Mobility and Walking)

Guidelines

- Stroke survivors should be given the opportunity to undertake tailored, repetitive practice of walking (or components of walking) as much as possible.
- The use of individually fitted AFOs for survivors with persistent foot drop or walking aids if required should be documented when setting goals.
- Walking should be encouraged both indoors and in the community.
- Mobility includes practice in assisted and independent transfers, and use of wheelchairs.

Examples of Stroke Survivor Stated Goal

'Stand up and take a step'

'To be able to walk around my house without the walker'

'Walk to dining room on my own'

'Able to walk around the local shops'

Converting to SMART Goal (metrics)

- Behaviour: Walking, transferring, using wheelchair.
- Conditions: Use of aids, supervision or quality of the performance.
- Context: Where the activity will take place.
- Measurement: Time, distance, number of steps, frequency.
- Performance standard: Consistency, accuracy, quality, safety.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Assisted, supervised, or unsupervised practice (or part practice) of walking/transfers.
- Assisted, supervised, or unsupervised high intensity resistance training/treadmill.
- Prescription of individualised gait aids and / or orthosis if necessary with regular review to ensure appropriateness of fit and benefits.
- Stroke related fatigue may need to be considered when setting mobility goals.

Worked examples

1. ***Survivor stated goal: 'Stand up and take a step'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Able to sit independently in a chair but needs assistance of one to stand and transfer.
- Behaviour: Stand and take a step.
- Conditions: Stand using armrests of chair, step using frame with supervision.
- Context: Living room chair in own home.
- Measurement: 1 step.
- Performance standard: Performed consistently and safely 75% of the time over a one-week period.

Survivor goal	Stand up and take a step	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Able to stand and transfer with frame and assistance of one person.		
Partially achieved	**-1**	Able to stand using chair arms with supervision but unable to take a step measured over the last week.		
SMART goal	**0**	**To stand up using the chair arms and take one step using a walking frame with supervision 75% of the time. Measured over the last week.**		
Somewhat better than expected	**+1**	Able to stand up using chair arms with supervision > 75% of the time and take ≥2-3 steps with frame, or perform the task in 3 or less minutes.		
Much better than expected	**+2**	Able to stand up using chair arms with supervision > 75% of the time and take ≥2-3 steps with frame, and perform the task in 3 or less minutes.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To be able to walk around my house without the walker'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Able to walk between rooms of own home with assistance of walker.
- Behaviour: Walking independently.
- Conditions: Without walker and supervision.
- Context: Within survivor's own home (inside only).
- Measurement: At least 75% of time during the daytime.
- Performance standard: Performed consistently and safely 75% of the time over a one week period.

Survivor goal	To be able to walk around my house without the walker	**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Able to walk between rooms of own home with assistance of walker.		
Partially achieved	**-1**	Able to walk between rooms in own home without walker 50 - 75% of the time.		
SMART goal	**0**	**To walk within own home safely between rooms during the day most of the time (>75%) without the need for a walker consistently over the last week.**		
Somewhat better than expected	**+1**	Able to walk without frame inside own home 100% of the time during the day safely consistently over the last week.		
Much better than expected	**+2**	Able to walk inside without frame 100% of the time and outside in the back garden safely without the frame consistently over the last week.		

*Agreed strategies are to be recorded on the client summary sheet

TRIPS, SLIPS AND FALLS
(Falls)

Guidelines

- The rate and risk of falls can increase post stroke.
- A falls risk assessment should be performed to identify the underlying cause of the falls.
- Consider cognitive and emotional, as well as physical factors.
- Ability to get up following a fall should be assessed.

Examples of Stroke Survivor Stated Goal
'Improve my balance'
'To reduce falls'
'To be able to get up from the floor'
'Feel less afraid of falling when in a busy shopping centre'

Converting to SMART Goal (metrics)

- Behaviour: Minimising falls, trips, slips and near misses.
- Conditions: Use of aids, supervision, environmental conditions (e.g. floor surface).
- Context: Where the falls take place e.g. in home, outside, during specific activities, time of day (day vs night).
- Measurement: Number of falls, severity (on floor, stumble), time of day.
- Performance standard: Consistency, accuracy (recall).
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Multifactorial interventions, including individually tailored exercise program should be prescribed for individuals at risk of falls.
- Where the cause is stroke specific, goals may need to be set from within other categories e.g. mobility or cognitive.
- An intermediate goal related to additional assessments may be required (e.g. falls assessment, home environment modifications, education, implementation of falls reduction strategies, or medication review).

Worked examples

1. ***Survivor stated goal: 'Improve my balance'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Walks 10 meters heel to toe at gym with head turns. Has to stop 2 – 4 times and regain balance.
- Behaviour: Dynamic balance when walking.
- Conditions: Level surface, well lit room. Performs task independently.
- Context: At local community gym.
- Measurement (timeframe/amount): Number of times has to stop in each 10-meter attempt.
- Performance standard: Performed without losing balance 5 out of 6 attempts.

Survivor goal	Improve my balance		**Timeframe** 6 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Walking heel/toe along 10m straight line with head turns. Completes 5-6 times and unable to complete any without having to stop as feeling like losing balance.			
Partially achieved	**-1**	Walk along 10m straight line 6 times. Can do it without losing balance 2-4 of the 6 times or not able to complete without losing balance but the severity is reduced by 50%.			
SMART goal	**0**	**At gym, to be able to walk a 10m straight line using a 'heel toe' walking and head turning without loss of balance (having to stop/fall off the line) 5 out of 6 attempts.**			
Somewhat better than expected	**+1**	Can be performed consistently 6/6 attempts without losing balance and requires very little concentration/effort.			
Much better than expected	**+2**	Can be performed without losing balance and whilst doing other tasks e.g. talking to someone or can do it in other more challenging environments e.g. whilst walking outside.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To reduce falls'.***

This SMART goal has been developed as an intermediate/process goal. A subsequent goal may be required to ensure that the assessment recommendations have been implemented effectively.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Loss of balance/stumbles 2-3 times a day when walking around the home.
- Behaviour: Stumbling when walking.
- Conditions: Walks independently around house without aids. Cause of balance loss is unknown.
- Context: At home.
- Measurement: Whether an assessment was performed.
- Performance standard: The assessment must be by an appropriately trained professional and appropriate recommendations provided.

Survivor goal	To reduce falls		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 1
Baseline (no change or worse)	**-2**	No action taken.			
Partially achieved	**-1**	Appointment made for a home falls assessment with an appropriate health professional (e.g. occupational therapist) but assessment has not yet taken place.			
SMART goal	**0**	**To have a home visit with falls assessment from an appropriately trained health professional who has provided suitable recommendations.**			
Somewhat better than expected	**+1**	Assessment has occurred and has planned the next stage of action e.g. has organised for home modifications to be implemented.			
Much better than expected	**+2**	Assessment has occurred and has taken the next stage of action e.g. the home environment has been modified according to the assessment recommendations.			

*Agreed strategies are to be recorded on the client summary sheet

CONTROLLING YOUR BLADDER AND BOWEL
(Incontinence)

Guidelines

- All stroke survivors with suspected urinary incontinence should be assessed by a trained person using a structured functional assessment.
- Stroke survivors with confirmed continence difficulties should have a management plan formulated, documented, implemented and monitored.
- If incontinence persists the stroke survivor should be referred to a medical specialist.

Examples of Stroke Survivor Stated Goal
'Control my bladder better'
'Independently manage my continence aids'
'Control my bowel'
'Decrease how often I need to change my incontinence pad'
'No leakage when I am exercising'

Converting to SMART Goal (metrics)

- Observable Outcome: Management of urinary and / or faecal incontinence.
- Conditions: Bowel and / or bladder incontinence, continence plan, use of containment or other aids.
- Context: When it takes place (full bladder, stress incontinence/activity related), related conditions (e.g. due to poor mobility).
- Measurement: Number of occasions (day and night), severity/amount (e.g. leak or full void).
- Performance standard: Consistency, maintenance.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- The cause of incontinence should be determined so an appropriate continence plan can be established e.g. functional incontinence, physiological causes, rule out infection.
- A community continence management plan should be developed with the stroke survivor and family / carer prior to discharge from hospital and should include information on accessing continence resources and appropriate therapy and review.
- For survivors with functional incontinence a whole team approach is recommended.
- If continence is unachievable, containment aids can be used to assist with social continence.

Worked examples

1. ***Survivor stated goal: 'Control my bladder better'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Requiring incontinence pad day and night for regular bladder leakage during day with 3 changes each day and one overnight.
- Observable Outcome: Managing urinary incontinence.
- Conditions: Use of incontinence pads for bladder leakage day and night.
- Context: Incontinence occurs with cough, sneeze, or moving around. More likely with full bladder.
- Measurement: Amount of urinary leakage measured by the number of pad changes per day.
- Performance standard: Majority of days (≥75%) and consistently over 7 days.

Survivor goal	Control my bladder better	**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Requiring 3 changes per day of incontinence pad due to soaking of pad.		
Partially achieved	**-1**	Requiring 2 changes of incontinence pad every second day due to soaking of pad and 3 changes on the other days. Measured over the past 7 days with 75% consistency.		
SMART goal	**0**	**Reduce the urinary incontinence measured by needing only 2 changes per day of incontinence pad due to soaking. Measured over the past 7 days with 75% consistency**.		
Somewhat better than expected	**+1**	Requiring 1 change per day of incontinence pad due to soaking of pad. Measured over the past 7 days with 75% consistency.		
Much better than expected	**+2**	Requiring 1 change on average every second day of incontinence pad due to soaking of pad. Measured over the past 7 days with 75% consistency.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Independently manage my continence aids'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Faecal accident approximately twice per week. Wears containment aid all of the time and requires assistance of one carer to change soiled pad.
- Behaviour: Independent management of incontinence pads.
- Conditions: Requires a containment aid at all times in case of faecal incontinence.
- Context: At home.
- Measurement: Amount of assistance required to change soiled pad.
- Performance standard: Independence with changing soiled pad consistently over 2 weeks.

Survivor goal	Independently manage my continence aids	**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Required assistance of one carer 100% of the time to change soiled incontinence pad.		
Partially achieved	**-1**	Required assistance of carer 100% of the time to change soiled pad. Survivor completing 25% of the task consistently over the last 2 weeks.		
SMART goal	**0**	**Required assistance of carer 100% of the time to change soiled pad. Survivor completing 50% of the task consistently over the last 2 weeks.**		
Somewhat better than expected	**+1**	Required assistance of carer 100% of the time to change soiled pad. Survivor completing 75% of the task consistently over the last 2 weeks.		
Much better than expected	**+2**	Required supervision and prompting only from carer to change soiled pad. Survivor requiring hands on assistance for < 25% of the task consistently over the last 2 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

MANAGING PAIN
(Pain)

Guidelines

- There are specific guidelines for two types of pain:
  - Shoulder pain: for stroke survivors who develop shoulder pain management should be evidenced based for acute or chronic musculoskeletal pain (e.g. shoulder strapping, education about preventing trauma, active motor training to improve function).
  - Persisting central post stroke pain: management should involve referral to a specialist pain management team.
- There are no stroke specific guidelines for the many other potential causes of pain including musculoskeletal pain, chronic regional pain syndrome, headache etc.

Examples of Stroke Survivor Stated Goal

'Pain to not stop my going out'

'Reduce pain when dressing with left arm'

'To be pain free' (may not be a realistic goal. An interim goal may need to be negotiated).

'Have less pain when I exercise'

Converting to SMART Goal (metrics)

- Behaviour: Managing pain.
- Conditions: Activity based, changing nature, use of analgesics, other pain-relieving modalities.
- Context: Where or when pain occurs, local or centrally driven.
- Measurement: Pain intensity (e.g. VAS 0-10), duration, frequency, nature of pain (e.g. sharp, burning), location/area of the pain.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- The focus should be on prevention, pain relief and restoring function, e.g. pain management, control and reduction of pain to a tolerable level, minimising the impact of pain on activities etc.
- Consider the impact of pain post stroke on physical function, emotional function, sleep and activity participation.
- Provide education and information to stroke survivor and family / carer on factors that may be contributing to experience of pain.
- Consider referencing guidelines for managing contracture, spasticity, and swelling that may be contributing to the survivor's experience of pain.
- Taking medication as prescribed.

Worked examples

1. ***Survivor stated goal: 'Pain not to stop me going out'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Persistent lower back pain, VAS 6/10 constant, limits community participation. Has only been out once in last 2 weeks to go to shops due to pain.
- Behaviour: Pain management.
- Conditions: Minimal change in pain intensity and duration over the last 8 months. Regular paracetamol used to manage pain.
- Context: Localised persisting lower back pain.
- Measurement: Number of occasions accessed the community.
- Performance standard: Measured over the last 2 weeks.

Survivor goal	Pain not to stop me going out		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Has left house once or less in the past 2 weeks to do a community based activity.			
Partially achieved	**-1**	Has left house 2-3 times in the past 2 weeks to do a community based activity without experiencing any increase in pain.			
SMART goal	**0**	**To leave the house to access the community 4 times in a fortnight without experiencing any increase in pain.**			
Somewhat better than expected	**+1**	Has left house 5-6 occasions in the past 2 weeks to do a community based activity without experiencing any increase in pain.			
Much better than expected	**+2**	Has left house > 6 occasions in the past 2 weeks to do a community based activity without experiencing any increase in pain.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Reduce pain when dressing with left arm'***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Able to use left upper limb for dressing. However, experiences 4/10 shoulder pain during dressing activity and for 2 hours post activity.
- Behaviour: Pain management.
- Conditions: Experienced during activity of dressing using left upper limb. Pain is slowly improving 6/10 lasting for up to 4 hours. Doesn't use analgesics.
- Context: Local pain in left shoulder girdle.
- Measurement: VAS during activity and duration for pain to subside.
- Performance standard: Performed consistently, i.e. 75% of the time over the past week.

Survivor goal	Reduce pain when dressing with left arm		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Pain 4/10 and lasting for 2 hours after dressing (>75% of the time).			
Partially achieved	**-1**	Pain 4/10 and lasting for 1-1.5 hours post dressing (>75% of the time) or pain 3/10 lasting for 2 hours after dressing consistently over a week.			
SMART goal	**0**	**To reduce shoulder pain to 3/10 and lasting for 1 hour 75% of the time after dressing, consistently over a week**.			
Somewhat better than expected	**+1**	Pain ≤2/10 and lasting 1 hour for 75% of the time over the last week or pain 3/10 lasting < 0.5 hours after dressing consistently over a week.			
Much better than expected	**+2**	Pain ≤2/10 and lasting < 0.5 hours for 75% of the time after dressing consistently over a week. Reductions have also occurred during other activities involving the left upper limb.			

*Agreed strategies are to be recorded on the client summary sheet

MANAGING EXCESSIVE TIREDNESS
(Fatigue)

Guidelines

- For this purpose, fatigue is defined as *"abnormal (or pathological) fatigue which is characterised by weariness unrelated to previous exertion levels and usually not ameliorated by rest."*[20]
- Fatigue is a common problem after stroke that can be a long-term issue.
- The aetiology of fatigue following stroke is not clear and is likely to be multifaceted.
- Consider screening for other problems which fatigue may be secondary to e.g. sleep related breathing disorders or depression.

Examples of Stroke Survivor Stated Goal

'Shower and dress without being exhausted'

'Manage my fatigue'

'Reduce fatigue particularly in the afternoon'

'To be able to go out for a meal with friends and not feel too exhausted'

Converting to SMART Goal (metrics)

- Behaviour: Management of excessive fatigue.
- Conditions: Associated with activity, sleep, rest, exercise, diet.
- Context: Where is excessive fatigue experienced (at home, in community, at work, during stressful activities).
- Measurement: Severity (VAS 1 – 10), time of day, duration, frequency.
- Performance standard: Consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Potential management strategies include exercise, establishing good sleep patterns, having a healthy diet and avoidance of sedating drugs and excessive alcohol.
- Pacing activities e.g. planning rest breaks before fatigue becomes too excessive, energy conservation, planning day/week to balance activities.
- Planning activities for times during the day when least likely to be fatigued.
- Use of assistive aids to conserve energy e.g. shower chair.
- Fatigue management may be an interim goal for a broader functional or participation goal e.g. getting back to golf.

Worked examples

1. ***Survivor stated goal: 'Shower and dress without being exhausted'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Excessive fatigue post showering and dressing. Survivor rates fatigue as 7/10. Limits showering to 3 times a week to manage this.
- Behaviour: Managing excessive fatigue.
- Conditions: Showering self independently in standing. Shower takes approximately 6 minutes. Dressing independently with approximately 3 rests, takes about 30 minutes.
- Context: At home in the morning, activities limited due to fatigue.
- Measurement: Self report of severity on Visual Analogue Scale.
- Performance standard: Consistently over a week. Goal achievement should not be at the expense of other regular activities.

Survivor goal	Shower and dress without being exhausted		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Fatigue post showering/dressing 7/10 following a six minute shower and 30 minutes for dressing with 3+ rests >75% of the time in the last week.			
Partially achieved	**-1**	Fatigue post showering 6/10 with 3 rests required whilst dressing or fatigue post showering/dressing is 7/10 but only requires 1-2 rests consistently over a week.			
SMART goal	**0**	**Able to complete a 6-minute shower on more than 4 days of the week with the fatigue score no more than 5/10 and only requiring 1-2 rests while dressing consistently over a week. This does not impact on his ability to perform other activities.**			
Somewhat better than expected	**+1**	Fatigue ≤4/10 post showering and dressing with 1 rest or fatigue 5/10 but no rests are required during dressing consistently over a week.			
Much better than expected	**+2**	Fatigue ≤4/10 post showering/dressing and no rest is required during dressing consistently over a week.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Manage my fatigue'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Exhausted post work and unable to cook dinner in evening due to fatigue.
- Behaviour: Managing excessive fatigue.
- Conditions: Works Monday, Tuesday, Thursday and Friday. Post work on Tuesday and Friday experiencing excessive fatigue. Too tired to manage cooking on these nights.
- Context: At home post returning from work approximately a 20-minute walk away.
- Measurement: Frequency of performance.
- Performance standard: Every week for the next 4 weeks.

Survivor goal	Manage my fatigue		**Timeframe** 4 weeks	**Importance** 1	**Difficulty** 1
Baseline (no change or worse)	**-2**	Only able to re-heat meals on Tuesday / Friday after work. Not able to cook due to fatigue.			
Partially achieved	**-1**	Has cooked an 'easy' straight forward meal once a fortnight on a Tuesday over the last 4 weeks.			
SMART goal	**0**	**On Tuesday nights after work, to cook an 'easy' meal (e.g. scrambled eggs) from scratch rather than reheating pre-prepared food. Every week for the next 4 weeks.**			
Somewhat better than expected	**+1**	On Tuesday nights after work, cooked a standard main meal (e.g. meat/fish and vegetables or curry and rice) or cooked an 'easy' meal on both days (last 2 weeks).			
Much better than expected	**+2**	On Tuesday nights after work, cooked a standard main meal (e.g. meat/fish and vegetables or curry and rice) and cooked on both Tuesdays and Fridays (last 2 weeks).			

*Agreed strategies are to be recorded on the client summary sheet

FEELING LESS DEPRESSED, ANXIOUS OR ANGRY
(Emotions)

Guidelines

- Personality and behavioural changes are common after stroke.
- The impact of behavioural changes on functional activities, participation, quality of life, relationships, employment and leisure, should be assessed.
- May be primary or secondary due to adjusting to altered post-stroke condition.
- All survivors of stroke should be screened for mood disorders using a validated tool.
- Survivors of stroke with suspected altered mood should be assessed by trained personnel using a standardised and validated scale.

Examples of Stroke Survivor Stated Goal
'Feel less anxious'
'Control depression better'
'Feel more confident'
'Learn how to relax'
'Control my temper better'

Converting to SMART Goal (metrics)

- Behaviour: Managing emotions.
- Conditions: Association with other stroke related conditions, use of medications.
- Context: Where or when low emotions take place (e.g. social and environmental context).
- Measurement: Severity (VAS 1 – 10), duration, frequency, type of emotion.
- Performance standard: Consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Stroke survivors and their families / carers should be given access to individually tailored interventions by a trained professional such as a psychologist.
- Psychological strategies e.g. problem solving or motivational interviewing may be effective in reducing depression.
- Emotional problems can be managed with appropriate medications prescribed by a health professional e.g. GP, medical rehabilitation specialist, psychiatrist.
- Structured exercise programs, particularly those of high intensity and/or acupuncture may assist with depression.

Worked examples

1. ***Survivor stated goal: 'Feel less anxious'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Feels anxious when she goes out to unfamiliar settings. Avoids new activities and situations where the setting is unfamiliar. Has only done this once in the last month.
- Behaviour: Reduce anxiety.
- Conditions: Has a management plan in place to manage this anxiety. Survivor not taking any medication for anxiety related disorder.
- Context: In unfamiliar settings outside survivor's own home. Measurement will apply to a busy setting e.g. shopping centre.
- Measurement: Self report of intensity (VAS) and number of exposures to new settings.
- Performance standard: Performed consistently over a 2 weeks period.

Survivor goal	Feel less anxious		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	VAS 8/10 when going out to new busy setting once in past 2 weeks.			
Partially achieved	**-1**	VAS 6-7/10 when going out to new busy setting once in past 2 weeks.			
SMART goal	**0**	**Reduce anxiety levels to 5/10 when going out to new busy setting consistently for 2 weeks. Will go out at least once a week.**			
Somewhat better than expected	**+1**	VAS ≤4/10 when going out to a new setting once in the past 2 weeks or VAS 5/10 when going out to new setting ≥ 2 occasions consistently for 2 weeks.			
Much better than expected	**+2**	VAS ≤4/10 when going out to a new setting once in the past 2 weeks and has gone out to new setting on ≥ 2 occasions consistently for 2 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Control depression better'***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor gets teary and feels low without a trigger. Occurs approximately three times a week lasting up to 30 minutes.
- Behaviour: Manage depression.
- Conditions: GP recently commenced on antidepressant medication.
- Context: Most often occurs when survivor is in own home but can occur at other places.
- Measurement: Frequency and duration of teariness.
- Performance standard: Consistently over a 2 week period.

Survivor goal	Control depression better		**Timeframe** 8 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Became teary without a particular trigger 3 times in the last week for 30 minutes.			
Partially achieved	**-1**	Became teary without a particular trigger 2 times a week for 30 minutes, or 3 times a week lasting 15 minutes measured over the last 2 weeks.			
SMART goal	**0**	**To reduce teariness without a particular trigger to once in the week and lasting for only 15 minutes measured over the last 2 weeks.**			
Somewhat better than expected	**+1**	Became teary once in the past 2 weeks lasting for 15 mins or became teary once in the last week lasting for 10 minutes measured over the last 2 weeks.			
Much better than expected	**+2**	Survivor became teary once in the past 2 weeks and teariness lasts for < 15 minutes and felt low for < 1 hour post episode of being teary measured over the last 2 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

THINKING AND REMEMBERING
(Concentration, Memory and Cognition)

Guidelines

- Cognitive impairment is common post stoke and commonly involves memory, attention, orientation, language, executive functions, neglect, apraxia, and agnosia.
- All survivors should be screened for cognitive deficits using valid and reliable tools.
- Survivors identified as having deficits should be referred for comprehensive neuropsychological assessment by a neuropsychologist.

Examples of Stroke Survivor Stated Goal
'Improve concentration'
'To be able to remember people's names'
'Learning memory strategies'
'Better understanding of what I read'
'Remember to attend appointments'
'Manage my own daily schedule'

Converting to SMART Goal (metrics)

- Behaviour: Managing cognition, concentration or memory.
- Conditions: Use of cognitive/memory aids, supervision or assistance required.
- Context: Where the activity will take place, complexity of the environment, complexity of the social context.
- Measurement: Time of day, time able to attend to task, severity (formal cognitive screening tool), frequency, complexity of activity.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Cognitive rehabilitation can be used in survivors with attention and cognitive impairments.
- Education and context specific training for survivor and family / carer on approaches to improve memory.
- Consider using cognitive or memory aids to reduce disability including notebooks, diaries, audiotapes, electronic organisers, apps and audio alarms.
- Mental fatigue management and pacing may be useful.

Worked examples

1. ***Survivor stated goal: 'Improve concentration'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Attends community theatre group weekly. Session lasts 60 minutes. Survivor only managing to stay focused on session for 20 minutes.
- Behaviour: Improve concentration.
- Conditions: Reading materials provided by facilitator to all group members.
- Context: Facilitated session face to face in the community with 6 other participants.
- Measurement: Time (in minutes) that survivor is able to concentrate (self-report).
- Performance standard: Majority of sessions (i.e. 75% of the time). Measured over 1 month.

Survivor goal	Improve concentration	**Timeframe** 3 months	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Able to maintain concentration in class for 20 minutes before losing focus.		
Partially achieved	**-1**	Able to maintain concentration in class for 30 minutes before losing focus.		
SMART goal	**0**	**To maintain concentration in my theatre group session with 6 other participants for 40 minutes for 75% of sessions. Measured over the past 4 weeks.**		
Somewhat better than expected	**+1**	Able to maintain concentration in session for 50 minutes 75% of sessions over the past 4 weeks.		
Much better than expected	**+2**	Able to maintain concentration in session for the full 60 minutes over the past 4 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To be able to remember people's names'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Difficulties remembering the names of new people, particularly names of doctors, nurses and allied health clinicians. This is happening approximately 50% of the time these people are encountered.
- Behaviour: To recall names of clinicians encountered during the day.
- Conditions: Using a memory aid and prompting from staff.
- Context: When coming in contact with doctors, nurses and allied health clinicians on the hospital ward.
- Measurement: Percentage of times able to recall clinician names per day.
- Performance standard: With prompts and without prompts.

Survivor goal	To be able to remember people's names	**Timeframe** 2 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Able to recall clinician's name 50% percent of the time independently, with accuracy increasing to 75% with association prompts from staff.		
Partially achieved	**-1**	Able to recall clinician's name 50% percent of the time independently, with accuracy increasing to 100% with association prompts from staff.		
SMART goal	**0**	**To recall clinician's name 75% percent of the time independently, with accuracy increasing to 100% with association prompts from staff.**		
Somewhat better than expected	**+1**	Able to recall clinician's name 90% percent of the time independently, with accuracy increasing to 100% with association prompts from staff.		
Much better than expected	**+2**	Able to recall clinician's name 100% percent of the time with no prompts and minimal effort required.		

*Agreed strategies are to be recorded on the client summary sheet

SWALLOWING (EATING AND DRINKING)
(*Swallowing)*

Guidelines

- Stroke survivors should be screened for swallowing deficits by a trained clinician using a valid screening tool. Survivors identified to have swallowing issues should be referred to a speech pathologist for comprehensive assessment.
- Survivors with persistent weight loss or recurrent chest infections should be referred for a swallowing assessment with a speech pathologist.
- Oral/dental hygiene should be addressed.
- Consideration should be given to appropriate hydration and calorie intake.

Examples of Stroke Survivor Stated Goal
'To be able to eat normal foods comfortably'
'To be able to have a cup of tea'
'To be able to eat normal textured foods'
'To be able to eat and drink the food I like'

Converting to SMART Goal (metrics)

- Behaviour: Swallowing.
- Conditions: Current diet prescribed by speech pathologist, consistency/type of food, supervision required, positioning.
- Context: Where the activity (eating or drinking) will take place.
- Measurement: Screening tool used for assessment, frequency of aspiration, severity.
- Performance standard: How often assessed, consistency, accuracy, safety.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Direct / compensatory:
  - Fluid and diet modification;
  - Safe swallowing strategies;
  - Optimising eating position.
- Indirect Strategies prescribed by speech pathologist:
  - Oral musculature exercises;
  - Stimulation of oral and pharyngeal structures.
- Carers involved in feeding survivors of stroke should be given appropriate training in safe swallowing and dietary modification.

Worked examples

1. ***Survivor stated goal: 'To be able to eat normal foods comfortably'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Is able to maintain adequate hydration/nutrition with optimum safety on a pureed diet but finds it difficult to swallow solids.
- Behaviour: Swallowing solids.
- Conditions: Sitting at the dinner table.
- Context: Eating in home environment.
- Measurement: Whether or not this task can be performed.
- Performance standard: Must be performed with optimum safety i.e. no overt signs of aspiration and must not reduce nutrition or hydration. Performed consistently over 3+ days.

Survivor goal	To be able to eat normal foods comfortably		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Only able to consume a pureed diet. This is consumed safely, and the survivor is able to maintain adequate nutrition/hydration on this diet.			
Partially achieved	**-1**	Able to swallow foods that require some chewing but still has difficulty with more solid foods and could be at risk of choking consistently for ≥3 days.			
SMART goal	**0**	**To swallow mashed solids safely without any risk of choking when eating at home. Consistently over the last 3+ days. Achievement must not reduce nutrition or hydration.**			
Somewhat better than expected	**+1**	Can swallow mashed solids easily and safely without coughing or any fear of food going down wrong way and has a clean mouth at the end of eating consistently for ≥3 days.			
Much better than expected	**+2**	Can swallow soft solids (e.g. pasta) easily and safely without coughing or any fear of food going down wrong way and has a clean mouth at the end of eating consistently for ≥3 days.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To be able to have a cup of tea'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Is able to maintain hydration safely with thickened fluids.
- Behaviour: Drinking normal fluids.
- Conditions: Sitting upright to drink in a chair and only when alert/fully awake.
- Context: Drinking in home environment.
- Measurement: Successfully able to drink safely and to maintain hydration.
- Performance standard: Swallow safely with no coughing or signs of aspiration; no fear of aspiration and no signs of inability to remain hydrated. Performed consistently over 3+ days.

Survivor goal	To be able to have a cup of tea		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Requiring thickened fluids because of risk of aspiration with thin/normal fluid.			
Partially achieved	**-1**	Able to manage sips of tea using agreed strategies with reminders to sip and supervision. Other drinks to remain as thickened fluids when drinking alone for safety and hydration consistently for ≥3 days.			
SMART goal	**0**	**To drink cup of tea, and other thin fluids, at home in small sips, using a chin tuck, without coughing or signs of aspiration, and ability to maintain hydration demonstrated for 3 consecutive days.**			
Somewhat better than expected	**+1**	Reliably managing to remember to sip tea and other drinks using strategies without the need for reminders or supervision, no coughing or signs of aspiration, and ability to maintain hydration consistently for ≥3 days.			
Much better than expected	**+2**	Reliably managing to drink thin fluids with normal size mouthfuls as desired with no coughing or signs of aspiration, and ability to maintain hydration consistently for ≥3 days.			

*Agreed strategies are to be recorded on the client summary sheet

SPEAKING AND COMMUNICATING
(Speech and Language Including reading and writing)

Guidelines

- Survivors with a suspected communication deficit should receive formal comprehensive assessment by specialist clinician, usually a speech pathologist.
- Communication deficits can be complicated by visual or hearing impairments.
- Cultural and linguistic diversity need to be considered.
- Monitor mood in survivors with chronic aphasia.

Examples of Stroke Survivor Stated Goal
'To be able to express needs and wants'
'Clear understanding of others speaking'
'To get the right words out'
'To be able to write what I want to say'

Converting to SMART Goal (metrics)

- Behaviour: Speaking, understanding, reading and writing.
- Conditions: Use of total communication/communication supports.
- Context: Where the activity will take place, complexity of the environment, complexity of the social context.
- Measurement: Assessment tool, frequency of communication, quality.
- Performance standard: How often assessed, consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- All written documentation should be available in aphasia friendly formats.
- Interventions should be individually tailored but may include:
  - Treatment of aspects of language using cognitive neuropsychology models;
  - Constraint induced language therapy;
  - Use of gesture;
  - Supported conversation techniques;
  - Computed delivered therapy techniques.
- Consider use of functional language approaches including communication partner training, discourse, and conversational therapies and group therapy / social opportunities.

Worked examples

1. ***Survivor stated goal: 'To be able to express needs and wants'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Can speak with some difficulty. People outside the family often have difficulty understanding her. Survivor has coffee with her husband every Saturday but since her stroke husband has always ordered.
- Behaviour: Communicating a need to someone outside family/friends.
- Conditions: Whether assistance is required from husband.
- Context: In the local café with a service provider.
- Measurement: Ease with which survivor is understood.
- Performance standard: The appropriate outcome should result from the interaction.

Survivor goal	To be able to express needs and wants		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Has not been able to order the coffees with or without assistance from her husband.			
Partially achieved	**-1**	Has ordered the coffees but has needed some assistance from her husband in order to be fully understood (e.g. clarification of order).			
SMART goal	**0**	**To order coffee for herself and her husband when they go to the local café and be understood by the café attendant with correct coffees received from the order.**			
Somewhat better than expected	**+1**	Successfully ordered the coffees on her own using clear and fluent language and was easily understood.			
Much better than expected	**+2**	Successfully ordered the coffees on her own and was easily understood and had a brief conversation with the café attendant.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Clear understanding of others speaking'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Understands basic conversation with help from contextual cues, but feels confused by more complex language and by complex instructions, especially at a faster pace. Behaviour: Being able to follow what others are saying to survivor.
- Conditions: Can use a card to explain post stroke aphasia, presence of carer / spouse.
- Context: Outside home in shops or other service areas.
- Measurement: Ease with which he understands others and interacts.
- Performance standard: Appropriately able to follow interaction and achieve desired outcome.

Survivor goal	Clear understanding of others speaking		**Timeframe** 3 months	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Not feeling confident unless accompanied by spouse under stated conditions. Finding it hard to make sense of what people are saying, even with some contextual cues.			
Partially achieved	**-1**	Requires context to follow what people are saying, and needs to ask them to slow down or repeat message. Uses a card which explains aphasia and asks for people to be patient; prefers spouse to be present.			
SMART goal	**0**	**To comprehend sufficiently well to manage simple, predictable or social exchanges in service areas such as shops, post office and bank, within 3 months. Prefers spouse to be present in case of a difficulty.**			
Somewhat better than expected	**+1**	Comprehends sufficiently well to independently manage simple, predictable or social exchanges in areas such as shops or bank and no longer requires spouse to be present.			
Much better than expected	**+2**	To comprehend sufficiently well to independently manage a more complex variety of exchanges in service areas such as shops, post office and bank.			

*Agreed strategies are to be recorded on the client summary sheet

SEEING AND RECOGNISING
(Vision)

Guidelines

- Visual impairment including visual field loss, diplopia, difficulties with ocular divergence, impaired saccadic movements, over sensitivity to light, nystagmus and dry eyes are common post stroke.
- Stroke survivors who appear to have difficulty recognising objects should be screened using specific screening tools. Survivors identified as having a visual deficit should be referred for comprehensive assessment.

Examples of Stroke Survivor Stated Goal

'Check-up for my reading glasses'

'To be able to cross the road safely'

'To recognise family and friends'

'To be able to tell the time'

'To be able to read the newspaper'

Converting to SMART Goal (metrics)

- Behaviour: Implement strategies to maximise vision or manage vision problem.
- Conditions: Use of aids, visual field.
- Context: Where the activity will take place, complexity of the environment.
- Measurement: Visual screening tool used, quality/clarity, field range.
- Performance standard: How often assessed, consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Pre-stroke visual impairments should be clarified as many stroke survivors may have pre-existing impairments.
- Treatment depends on the type of vision impairment and its cause.
- Referral to an optometrist, ophthalmologist or other specialist may be required.
- For lasting vision loss, training, aids, equipment and modifications may help to maintain independence.
- Referral to specialist organisations such as Guide Dogs Australia or Vision Australia may be appropriate.

Worked examples

1. ***Survivor stated goal: 'Check-up for my reading glasses'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Has a lot of difficulty reading standard sized print material since stroke. A full visual assessment is required to determine the cause of the reading problem.
- Behaviour: Vision assessment and cause determined.
- Conditions: Appointment with an ophthalmologist is required.
- Context: A referral must be obtained from his GP first, and an appointment made.
- Measurement: Achieved if they have had the assessment and appropriate outcome achieved.
- Performance standard: Assessment must be appropriate for the problem.

Survivor goal	Check-up for my reading glasses		**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 1
Baseline (no change or worse)	**-2**	No action has been taken.			
Partially achieved	**-1**	Has visited the GP and obtained a referral but has not yet had his vision assessed or has had an appointment with the ophthalmologist but the cause has not been determined.			
SMART goal	**0**	**To determine the cause of the vision problem. i.e. have an assessment with an ophthalmologist. The cause of the vision problem must be established and communicated to the survivor prior to further action.**			
Somewhat better than expected	**+1**	Has planned the next stage of action that was informed by the ophthalmologist appointment.			
Much better than expected	**+2**	Has taken the next stage of action to resolve the problem e.g. has new prism glasses and this has resolved his reading problem.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To be able to cross the road safely'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Requires supervision from spouse to cross the road as doesn't consistently see oncoming traffic.
- Behaviour: Safely crossing the road.
- Conditions / quality: Wearing glasses, spouse supervising.
- Context: Local suburban street, no traffic lights or designated crossings available.
- Measurement (timeframe/amount): Recognise and give way to all oncoming traffic.
- Performance standard: Must be done consistently and safely over a 1 week period.

Survivor goal	To be able to cross the road safely		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Requires supervision from spouse to cross the road as survivor infrequently sees oncoming traffic (> 75% of occasions).			
Partially achieved	**-1**	Requires supervision from spouse to cross the road as doesn't consistently see oncoming traffic (50%-75% of occasions).			
SMART goal	**0**	**Recognises and gives way to oncoming traffic when crossing local roads near survivors' own home on his own approximately half of the time wearing glasses. Wife has to assist with identifying oncoming traffic the other times.**			
Somewhat better than expected	**+1**	Recognises and gives way to traffic the majority of the time (> 75% of the time). Spouse has to assist < 25% of the time.			
Much better than expected	**+2**	Survivor consistently recognises and gives way to oncoming traffic. Spouse accompanies survivor but doesn't have to intervene for safety reasons.			

*Agreed strategies are to be recorded on the client summary sheet

EVERYDAY ACTIVITIES

Activities and Participation

ATTENDING TO HYGIENE, DRESSING AND EATING
(Self Care)

Guidelines

- Survivors with difficulties in performance of daily self-care activities should be assessed by a trained clinician.
- Survivors with confirmed difficulties in personal ADL should have specific therapy (e.g. task specific practice and trained use of appropriate aids).
- Survivor, family, and staff should be advised regarding techniques and equipment to maximise ADL and sensorimotor, perceptual and cognitive capacities.

Examples of Stroke Survivor Stated Goal

'Take a shower and dress without the assistance of my wife'

'Improved use of cutlery to feed myself'

'To be able to go to the toilet by myself'

'Clean my own teeth'

Converting to SMART Goal (metrics)

- Behaviour: Showering, dressing, eating, toileting.
- Conditions: Use of aids, supervision, utensils or equipment involved.
- Context: Where the activity will take place.
- Measurement: Amount, time, quality, frequency.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions targeting specific areas including sensorimotor impairments and motor activities, cognition and communication.
- Occupational therapist interventions focused on personal ADL.
- Task specific training should occur in the actual environment of task performance as often as possible, or in an environment that has been designed to replicate the actual environment.
- Consider use of assistive equipment to maximise outcomes.
- Some strategies may require a staged approach.

Worked examples

1. Survivor stated goal: 'Take a shower and dress without the assistance of my wife'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Showers daily at home. Is able to walk into shower and sit on shower chair independently. Showers with assistance ~25% of the time. Wife assists with drying and dressing survivor's lower body.
- Behaviour: Showering and dressing.
- Conditions: Shower chair and hand-held shower. Assistance with some components.
- Context: In survivor's own bathroom at home.
- Measurement: Amount of assistance required with task.
- Performance standard: Majority of occasions (75% of the time). Consistently for 1 week.

Survivor goal	Shower and dress without the assistance of my wife	**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Showering with shower chair and hand-held shower with occasional assistance ~ 25% of the time. Assistance required for towel drying, and dressing lower body.		
Partially achieved	**-1**	Showering with shower chair and hand-held shower with supervision only. Assistance required for towel drying, and dressing lower body most (75%) of the time.		
SMART goal	**0**	**To shower with shower chair and hand-held shower independently with supervision. Initiate towel drying with assistance to dry back, lower legs and feet. Dress lower body with assistance with shoes and socks only, most (75%) of the time over a week.**		
Somewhat better than expected	**+1**	Showering with shower chair and hand-held shower independently. Able to towel dry without assistance but still requires assistance with shoes and socks.		
Much better than expected	**+2**	Showering with shower chair and hand-held shower independently and able to towel dry without assistance and dress lower body without assistance.		

*Agreed strategies are to be recorded on the client summary sheet

2. Survivor stated goal: 'Improved use of cutlery to feed myself'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Unable to use knife and fork to cut food. Wife cuts food into pieces for him.
- Behaviour: Using cutlery to cut own food.
- Conditions: Unsupervised, medium hard foods e.g. potatoes, fish, chicken (may still need assistance with difficult to cut foods such as steak). Can use modified cutlery.
- Context: In own home sitting at the dining table during evening meal.
- Measurement: Proportion/type of foods that meet the stated conditions that are cut.
- Performance standard: Able to cut most food (75%) without other foods falling off the plate consistently for ≥3 days.

Survivor goal	Improved use of cutlery to feed myself	**Timeframe** 6 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Wife is still cutting food into bite size pieces. Not using left arm/hand.		
Partially achieved	**-1**	Able to stabilise food with a modified fork but only able to cut soft foods e.g. potatoes or able to cut all food types but with difficulty and with other food falling off the plate consistently for ≥3 days.		
SMART goal	**0**	**To use a knife and modified fork to cut own food (>75%) into bite size pieces at the evening meal. Other food remains on the plate. To be done consistently for ≥3 days.**		
Somewhat better than expected	**+1**	Able to use a knife and modified fork to cut own food into bite size pieces at the evening meal 100% of the time. Able to do this easily with minimal concentration consistently for ≥3 days.		
Much better than expected	**+2**	Able to use a knife and standard fork to cut own food into bite size pieces at the evening meal 100% of the time. He is able to do this easily with minimal concentration consistently ≥3 days.		

*Agreed strategies are to be recorded on the client summary sheet

DOING INSIDE TASKS – COOKING, VACUUMING, WASHING
(Household Tasks - Inside)

Guidelines

- Survivors with difficulties in performance of domestic daily activities should be assessed by a trained clinician.
- Survivors with confirmed difficulties in domestic ADL should have specific therapy (e.g. task specific practice and trained use of appropriate aids).
- Survivor, family, and staff should be advised regarding techniques and equipment to maximise ADL and sensorimotor, perceptual and cognitive capacities.

Examples of Stroke Survivor Stated Goal

'Make the bed'

'Prepare a simple meal for my family'

'To be able to do the laundry'

'To be able to set the table'

'Keep my house tidy'

'Prepare my own breakfast'

Converting to SMART Goal (metrics)

- Behaviour: Cooking, cleaning inside the house, clothes washing.
- Conditions: Use of aids, supervision, equipment required.
- Context: Where in the house will the activity take place (bathroom, kitchen, bedroom), time of day.
- Measurement: Time, amount, number of rests, frequency.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions targeting specific areas including sensorimotor impairments and motor activities, cognition and communication.
- Occupational therapy interventions focused on domestic ADL.
- Training should occur in the actual environment of task performance as often as possible, or in an environment that has been designed to replicate the actual environment.
- Consider use of assistive equipment to maximise outcomes.
- Some strategies may require a staged approach.

Worked examples

1. ***Survivor stated goal: 'Make the bed'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor has a king single bed with fitted and flat sheet, cotton blanket and light doona. Currently not performing task. Survivor's daughter makes the bed each morning.
- Behaviour: Making own bed.
- Conditions: No aids used.
- Context: Survivors own bed, each morning.
- Measurement: Amount of assistance required to complete task.
- Performance standard: Consistency (>75% of the time) measured over the last week. Bed must be neatly made.

Survivor goal	Make the bed		**Timeframe** 6 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Survivor's daughter is making bed without any assistance from survivor.			
Partially achieved	**-1**	Daughter pulls up and tucks in sheet and cotton blanket. Survivor pulls up and straightens the doona 75% of the time measured over the last week.			
SMART goal	**0**	**To tuck in sheet and blanket with some assistance from daughter, and to pull up and straighten doona independently. 50 to 75% of the task will be done independently and the bed will be made neatly on most (> 75%) occasions measured over the last week.**			
Somewhat better than expected	**+1**	Survivor making bed with supervision. Occasional assistance (25 – 50% of the time) to complete task to desired quality on most occasions (75% of the time) measured over the last week.			
Much better than expected	**+2**	Survivor completing task independently. Assistance required <25 of the time to complete task to desired quality on most occasions (75% of the time) measured over the last week.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Prepare a simple meal for my family'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Heating and serving pre-prepared purchased meals.
- Behaviour: Prepare and cook a simple meal.
- Conditions: Independently using appropriate strategies. Husband will buy ingredients.
- Context: In own home, cooking for spouse and two teenage children.
- Measurement: Two evenings a week.
- Performance standard: Simple meal, measured over a 2 week period.

Survivor goal	Prepare a simple meal for my family		**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Heating and serving pre-prepared purchased meals for spouse and children.			
Partially achieved	**-1**	Plan, prepare and serve a simple meal 1 evening a week without assistance.			
SMART goal	**0**	**Plan, prepare and serve a simple meal 2 evenings a week for my family without assistance measured over the last two-weeks.**			
Somewhat better than expected	**+1**	Plan, prepare and serve a simple meal $\geqslant$ 3 evenings a week without assistance, or prepare a more complex meal on at least one of the 2 evenings.			
Much better than expected	**+2**	Plan, prepare and serve a simple meal $\geqslant$ 3 evening a week without assistance, and prepare a more complex meal on at least one of the evenings.			

Agreed strategies are to be recorded on the client summary sheet

DOING OUTSIDE TASKS – GARDENING, SWEEPING, LAWN MOWING
(Household Tasks - Outside)

Guidelines

- Survivors with difficulties in performance of domestic daily activities should be assessed by a trained clinician.
- Survivors with confirmed difficulties in domestic ADL should have specific therapy (e.g. task specific practice and trained use of appropriate aids).
- Survivor, family, and staff should be advised regarding techniques and equipment to maximise ADL and sensorimotor, perceptual, and cognitive capacities.

Examples of Stroke Survivor Stated Goal

'Spend time in the garden'

'Return to mowing my lawns'

'Be able to get off the ground after weeding'

'To be able to use woodfire stove / BBQ'

'Be able to prune my plants'

Converting to SMART Goal (metrics)

- Behaviour: Gardening, sweeping, lawn mowing, home maintenance.
- Conditions: Use of aids, supervision, equipment required.
- Context: Where in the garden will task take place (garden bed, level/sloping lawn), time of day.
- Measurement: Time, amount, number of rests, frequency.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions targeting specific areas including sensorimotor impairments and motor activities, cognition and communication.
- Occupational Therapy interventions focused on domestic ADL.
- Training should occur in the actual environment of task performance as often as possible, or in an environment that has been designed to replicate the environment.
- Consider use of assistive equipment to maximise outcomes.
- Some strategies may require a staged approach.

Worked examples

1. ***Survivor stated goal: 'Spend time in the garden'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Currently spends time in own garden once a month for 2 hours. Weeds garden and sweeps the path independently. Has not returned to trimming and pruning plants.
- Behaviour: Gardening.
- Conditions: Standard garden tools used without adaptive aids.
- Context: In survivor's own front garden consisting of garden beds, pot plants and garden path.
- Measurement: Number/type of gardening tasks completed and time spent doing these tasks.
- Performance standard: Measured over the last 3 months.

Survivor goal	Spend time in the garden		**Timeframe** 6 months	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Spent 2 hours in the garden once a month. Has only been able to complete weeding and sweeping the path.			
Partially achieved	**-1**	Has spent 2 hours in the garden and completed weeding and sweeping and one of pruning or tidying the pot plants over the last 3 months.			
SMART goal	**0**	**To spend time in the garden twice a month for 2 hours each time. Tasks will involve tidying the front garden, trimming/pruning plants, tidying the pot plants and weeding the front garden. Measured over the last 3 months.**			
Somewhat better than expected	**+1**	Has spent 3 hours twice a month doing the stated tasks plus at least one additional garden task, or 3 hours more than twice a month doing the stated tasks over the last 3 months.			
Much better than expected	**+2**	Has spent 3 hours in the garden more than twice a month doing all of the stated tasks plus at least one additional garden task over the last 3 months.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to mowing my lawns'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Not currently completing this task.
- Behaviour: Mowing lawns at home.
- Conditions: Manual push lawnmower. Can break up task to manage fatigue.
- Context: At home. Small level front yard.
- Measurement (timeframe/amount): Would like to mow fortnightly.
- Performance standard: Lawn is neat and has not missed any sections of lawn. Completed safely. To be measured over a month.

Survivor goal	Return to mowing my lawns		**Timeframe** 3 months	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Not mowing front lawn.			
Partially achieved	**-1**	Mowing front lawn safely with manual lawn mower fortnightly, splitting task into 2 sections done on separate days. Measured over the last month.			
SMART goal	**0**	**Safely mow the front lawn with a manual lawn mower fortnightly without missing patches, doing half in the morning and the other half in afternoon, with a rest in between. Measured over the last month.**			
Somewhat better than expected	**+1**	Mowing all front lawn safely with manual lawn mower fortnightly without missing patches and without requiring a rest measured over the last month.			
Much better than expected	**+2**	Mowing front lawn safely with manual lawn mower fortnightly, without missing patches and without requiring a rest. Also completing edging around garden beds with brush cutter. Measured over the last month.			

*Agreed strategies are to be recorded on the client summary sheet

OTHER ACTIVITIES – WRITING, READING A BOOK, MUSIC, CRAFT
(Writing, reading a book, music, craft)

Guidelines

- Survivors with difficulties in performance of daily activities should be assessed by a trained clinician.
- Survivors with confirmed difficulties should have specific therapy (e.g. task specific practice and trained use of appropriate aids).
- Survivor, family, and staff should be advised regarding techniques and equipment to maximise ADL and sensorimotor, perceptual, and cognitive capacities.

Examples of Stroke Survivor Stated Goal

'Improve my handwriting'

'Return to playing piano at home'

'Read the sports sections of the local newspaper'

'Return to needlework / sewing'

Converting to SMART Goal (metrics)

- Behaviour: Completing tasks such as writing, reading, playing music and participating in craft activities.
- Conditions: Use of aids, supervision, equipment required.
- Context: Where will the activity take place, time of day, alone or with others.
- Measurement: Time, amount, number of rests, frequency.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions targeting specific areas including sensorimotor impairments and motor activities, cognition and communication.
- Training should occur in the actual environment of task performance as often as possible, or in an environment that has been designed to replicate the actual environment.
- Consider use of assistive equipment to maximise outcomes.
- Some strategies may require a staged approach.

Worked examples

1. ***Survivor stated goal: 'Improve my handwriting'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Can write 5 sentences of >6 words cursive writing at 50% (5/10) of pre-stroke quality.
- Behaviour: Writing clearly.
- Conditions: Using a pen and lined paper.
- Context: At home sitting at dining table.
- Measurement: 5 sentences of > 6 words.
- Performance standard: Self-reported quality score of at least 8/10 (10/10 is pre-stroke level).

Survivor goal	Improve my handwriting		**Timeframe** 6 weeks	**Importance** 1	**Difficulty** 2
Baseline (no change or worse)	**-2**	Can write 5 sentences of 6-8 words cursive writing at a quality of 5/10.			
Partially achieved	**-1**	Improved legibility of running or cursive writing to 6-7/10 when writing 5 sentences of 6-8 words.			
SMART goal	**0**	**To improve legibility of running or cursive writing as determined by self-report (score of 8/10) when writing 5 sentences of > 6 words using a pen and lined paper.**			
Somewhat better than expected	**+1**	Improved legibility of running or cursive writing to 9-10/10 when writing 5 sentences of 6-8 words or able to write 7 or more sentences with a legibility of 8/10.			
Much better than expected	**+2**	Able to write 7 or more sentences of 6-8 words or equivalent with a legibility of 9-10/10.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to playing piano at home'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Able to play basic tunes hands separately but not together (able to play at a grade 5 level prior to stroke).
- Behaviour: Playing the piano.
- Conditions: Play hands together at a grade 2 level/standard.
- Context: At home on own piano.
- Measurement: Able to complete a piece with minimal errors.
- Performance standard: Consistently at grade 2 standard.

Survivor goal	Return to playing piano at home		**Timeframe** 6 months	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Able to play basic tunes hand separately on own piano.			
Partially achieved	**-1**	Able to play a basic tune to completion (below grade 2 level) with both hands together and minimal errors or able to play a grade 2 piece hands together but not to completion and/or with many errors.			
SMART goal	**0**	**To be able to perform a basic piano piece (grade 2 level) on own piano, hands together, to completion with minimal errors most (75%) of the time after 6 months**.			
Somewhat better than expected	**+1**	Able to perform a more complex piece of music (e.g. grade 3 level) hands together but not to completion and/or with many errors at the end of 6 months.			
Much better than expected	**+2**	Able to perform a more complex piece of music (grade 3 level or above) hands together, to completion with minimal errors most (75%) of the time after 6 months.			

*Agreed strategies are to be recorded on the client summary sheet

MANAGING YOUR MONEY AND FINANCES
(Finances)

Guidelines

- Survivors with difficulties in managing financial affairs should be referred to and assessed by a trained professional e.g. social worker, case worker, financial planner.
- Following stroke, survivor's financial situation is often characterised by an increase in expenses and loss of income. Specific assistance may be needed to access entitlements and adjust to altered finances.

Examples of Stroke Survivor Stated Goal
'To be able to manage my weekly budget i.e. for shopping'
'Pay bills and do banking'
'To be able to use calculator'
'Pay for items at the shops'

Converting to SMART Goal (metrics)

- Behaviour: Managing finances, paying bills, budgeting.
- Conditions: Use of aids or online devices, supervision/checking required, assistance.
- Context: Circumstances and complexity of the financial management requirements.
- Measurement: Time required to complete task, number of bills missed / overdue, frequency.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions targeting specific areas including cognition and communication may assist in certain situations. This may require referral to health professionals such as occupational therapists, psychologists, speech pathologist etc.
- Access to a financial advisor may be of benefit.
- Assessment by a social worker may help survivors determine eligibility for financial support and assist with accessing support.

Worked examples

1. Survivor stated goal: 'To be able to manage my weekly budget'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Not managing budget, often needs to access savings for everyday expenses.
- Behaviour: Managing my weekly budget.
- Conditions: Able to complete task independently. Use of spreadsheet / computer.
- Context: Monitors bank balance via internet banking.
- Measurement: Appropriate allocation of funds for all expenses over the next fortnight and transfer of surplus into savings account via internet transfer at end of each fortnight. Manages to get through each fortnight without having to access savings.
- Performance standard: Consistently over a 2-month period.

Survivor goal	To be able to manage my weekly budget	**Timeframe** 3 months	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Needing to access savings for everyday expenses.		
Partially achieved	**-1**	Managing most expenses including shopping over fortnight. Has needed to access savings for unexpected bills approximately once a month.		
SMART goal	**0**	**Using agreed strategies will monitor spending each fortnight to ensure funds are allocated to bills and shopping without having to access savings, consistently for 2 months.**		
Somewhat better than expected	**+1**	Monitoring spending each fortnight to ensure funds allocated to bills and shopping. Has put $20 a month into savings account or equivalent monthly, consistently for 2 months.		
Much better than expected	**+2**	Monitoring spending each fortnight to ensure funds allocated to bills and shopping. Has put $20 into savings account fortnightly, consistently for 2 months.		

*Agreed strategies are to be recorded on the client summary sheet

2. Survivor stated goal: 'Pay bills and do banking'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Previously managed regular household bills (utility bills, rates, insurances etc). Daughter has been attending to this task since stroke.
- Behaviour: Paying regular household bills on time.
- Conditions: Perform task with supervision of daughter.
- Context: At local post office, requires pre planning.
- Measurement: All household bills payed before due date.
- Performance standard: All household bills payed on time over the last 4 week period.

Survivor goal	Pay bills and do banking	**Timeframe** 8 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Not performing the activity. Daughter has been performing these tasks.		
Partially achieved	**-1**	Paying household bills on time with active assistance of daughter at the post office most of the time (>75%) for the last 4 weeks.		
SMART goal	**0**	To pay all household bills on time and withdraw required cash for the week ahead with supervision from daughter at the local post office. Measured over the past 4 weeks.		
Somewhat better than expected	**+1**	Paying all household bills on time and withdrawing required cash for the week ahead independently (no supervision) at the local post office for the last 4 weeks.		
Much better than expected	**+2**	Paying all household bills on time and withdrawing required cash for the week ahead independently at the local post office and has done this consistently for the last 6 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

USING TECHNOLOGY – EMAILS, SOCIAL MEDIA, MOBILE PHONE / iPAD
(Email, Social Media, Mobile Phone / iPad)

Guidelines

- There are no specific guidelines relating to use of technology or online activities following stroke.
- Technology use may be impacted by the survivor's inability to function in their previous capacity due to physical, cognitive, behavioural or communication changes.

Examples of Stroke Survivor Stated Goal

'Return to using my social media account'

'Managing my emails'

'Return to following posting feeds/short messages of colleagues'

'Make regular social media posts'

'Use my mobile phone to text and make calls'

'Use my ipad to look up the daily news'

Converting to SMART Goal (metrics)

- Behaviour: Using technology.
- Conditions: Type of technology used, support required.
- Context: Where the technology use will occur and who it will occur with i.e. at home, in community, or at work.
- Measurement: Frequency, duration, amount and appropriateness of use and responses.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Provide information specific to the use of technology.
- Training on effective and appropriate communication using social media.
- Education about socially appropriate responses when using social media.
- May require functional training for use of keyboard etc. or visual aids.

Worked examples

1. ***Survivor stated goal: 'Return to using my social media account'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Previously actively using social media account. Spent approximately 1 hour on social media most days. Has been logging into account, but only making 1 post/week.
- Behaviour: Online relationships.
- Conditions: No assistance required to log in and use keyboard / smart phone.
- Context: Social media for communicating with friends.
- Measurement: Number of posts/active interactions per week.
- Performance standard: Needs to post comments not just 'likes' etc. Measured over one week.

Survivor goal	Return to using my social media account		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Logging onto social media account most days (5 days/week). Making one post per week.			
Partially achieved	**-1**	Logged onto social media account most days (5 days/week). Made between 2 and 4 posts per week.			
SMART goal	**0**	**Log onto social media account ≥5 days/week. Make 5-7 posts a week and have contact/conversation with 1–2 friends (via social media) measured over the last week.**			
Somewhat better than expected	**+1**	Logged onto social media most days. Made 8-10 posts per week and contacted 1-2 friends or made 5-7 posts and made contact with ⩾ 3 friends via social media.			
Much better than expected	**+2**	Logged onto social media account most days. Made > 5 posts per week, and made contact with > 3 friends on social media.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Managing my emails'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Receives about 10 emails per day of which ~20% require a response. Takes 2–3 days to respond to emails and doesn't respond to up to 5 emails that require a response.
- Behaviour: Read and appropriately respond to emails.
- Conditions: Open and read emails independently.
- Context: Checks emails from home computer.
- Measurement: Proportion of emails requiring a response that are addressed within 48 hours.
- Performance standard: Responses to be 1 or more sentences and appropriate for the email measured over a 1-week period. Occasional spelling or grammatical errors allowed up to 25%.

Survivor goal	Managing my emails		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Taking 2 – 3 days to respond to emails requiring response / action. Approximately 5 emails a week are missed.			
Partially achieved	**-1**	Taking 2 – 3 days to respond to the majority of emails requiring a response. 2-3 emails a week are missed, and responses are brief (a few words).			
SMART goal	**0**	**To respond to all emails requiring a response within 48 hours of receiving the email. The typed response must be appropriate and of one or more sentences in length with limited spelling or grammatical errors (<25%) measured over 1 week.**			
Somewhat better than expected	**+1**	Responded to all emails requiring a response within 24 hours of receiving email. Typed appropriate response with limited spelling or grammatical errors (10 -20%) measured over 1 week.			
Much better than expected	**+2**	Responded to all emails requiring a response within 24 hours of receiving email and responses have become more complex with few spelling or grammatical errors (≤10%) measured over one week.			

*Agreed strategies are to be recorded on the client summary sheet

OUT AND ABOUT

Participation

USING PUBLIC OR PRIVATE TRANSPORT SERVICES
(Public Transport)

Guidelines

- The effects of stroke can lead to isolation and reduced community access.
- The transport needs of survivors should be assessed, including use of public transport, especially for those who were not previously regular public transport users or are likely to experience difficulties due to mobility or cognitive problems. This could be provided as an outpatient service post-discharge.

Examples of Stroke Survivor Stated Goal

'To go to hairdresser weekly via TAXI'

'Go shopping using public transport'

'Use the bus to get to shops'

'Take the train to city to go to the afternoon football match'

'To be able to catch train or bus to access my GP'

Converting to SMART Goal (metrics)

- Behaviour: Using bus, train, tram, taxi or other forms of public transport. May include planning, ticket purchase, physical access.
- Conditions: Type of public transport, use of aids, supervision required.
- Context: Where the activity will take place (local, time of day), complexity (e.g. multiple modes of transport).
- Measurement: Time, distance (kilometres or destination based), frequency.
- Performance standard: Consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Survivors should undertake tailored strategies such as multiple (ie. up to 7) escorted outdoor journeys (which may include crossing roads, visit to local shops, bus, train or tram travel), aids and equipment, and written information about local transport options / alternatives.
- Familiarise survivor with local public transport options.
- A staged approach may be required.

Worked examples

1. ***Survivor stated goal: 'Go to hairdresser weekly via TAXI'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Stroke survivor kept a weekly appointment with hairdresser prior to stroke and accessed these appointments via TAXI. She has not done this since her stroke.
- Behaviour: Using private TAXI independently to go to hairdresser and back home.
- Conditions: Walker used to walk to and from the TAXI.
- Context: From survivor's own home to hairdresser at local shopping strip in the morning.
- Measurement: Successful completion of the task.
- Performance standard: To have occurred at least once over the next 4-week period.

Survivor goal	Go to hairdresser weekly via TAXI	**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Did not go to the hairdresser via TAXI or other public transport.		
Partially achieved	**-1**	Planned the activity i.e. made the appointment and booked the taxi but did not attend the appointment.		
SMART goal	**0**	**Successfully attend the hairdresser independently using a TAXI to get to the appointment and back once in the last 4 weeks.**		
Somewhat better than expected	**+1**	Attended hairdresser on 2 or more occasions over the past 4 weeks via TAXI.		
Much better than expected	**+2**	Attended hairdresser on 2 or more occasions over the past 4 weeks via TAXI and has used a TAXI to on at least one other occasion to go to a different destination.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Go shopping using public transport'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Able to walk to bus stop near house. Yet to catch bus to local shops.
- Behaviour: Catching local bus.
- Conditions: Independently, able to carry a small bag of shopping.
- Context: Local bus. Bus stop approximately 400m walk from survivor's home on level footpath. Seat at bus stop to wait for bus. Bus stops at local shops.
- Measurement: Performance of task.
- Performance standard: Needs to have occurred consistently over the last 2 weeks.

Survivor goal	Go shopping using public transport	**Timeframe** 2 months	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Walked to the bus stop near house most days. Yet to catch the bus.		
Partially achieved	**-1**	Has taken bus to local shops once a week over the last 2 weeks but did not manage to do the shopping.		
SMART goal	**0**	**To catch the bus to the local shops and complete a small shop (one bag of light groceries) and catch bus home once a week. Measured over the last 2 weeks**.		
Somewhat better than expected	**+1**	Caught bus to and from local shops and completed a small shop. Has done this twice a week in the last 2 weeks.		
Much better than expected	**+2**	Caught bus to and from local shops to complete a small shop. This has happened twice a week over the past 4 weeks, and has taken the bus on a different and longer journey on $\geqslant$ 1 occasion.		

*Agreed strategies are to be recorded on the client summary sheet

DRIVING

(Driving Assessments, Return to Driving, Improving Driving Confidence)

Guidelines

- **Stroke survivors are not to return to driving for a minimum of one month (three months for commercial drivers) even if there are no significant neurological, perceptive or cognitive deficits.**
- A survivor of stroke who is assessed as medically fit but has residual motor, sensory, or cognitive changes that may impact driving should be referred for an occupational therapy conducted driving assessment.
- A medical assessment to determine fitness prior to return to driving should be completed. An unconditional licence may be granted if there is no significant impairment in any of the following: visuospatial perception, insight, judgement, attention, reaction time, sensation, muscle power, co-ordination and vision (including visual fields).
- A conditional licence may be considered after assessment of fitness to drive.

Examples of Stroke Survivor Stated Goal
'Drive longer distances'
'Return to driving'
'Clarify driving restriction'
'Improve confidence to drive into city'
'Return to driving in the evening'
'Complete driving assessment'

Converting to SMART Goal (metrics)

- Behaviour: Either return to driving or improving driving.
- Conditions: Use of aids, modifications to car, vehicle type.
- Context: Location the driving will take place (e.g. freeway/local), traffic conditions, passengers, time of day.
- Measurement: Time, distance (kilometres or destination based), frequency.
- Performance standard: Safety (e.g. alertness) and consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

Survivors should set individualised goals and undertake tailored strategies including:

- Help to resume driving including assessment of suitability to drive.
- Driving aids and equipment.
- Written information about local transport options / alternatives.
- Individualised motor, sensory, visual, and cognitive training.
- Assistance with improving driving confidence post-stroke.

Worked examples

1. ***Survivor stated goal: 'Drive longer distances'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Since stroke only drives car locally. Is more than 1-month post stroke and has medical approval for a non-conditional licence. Drives most days.
- Behaviour: Driving confidence.
- Conditions: Manual car with passengers.
- Context: Beyond suburban streets and involving freeway / highway for at least 100km.
- Measurement: Distance travelled, frequency, time of day.
- Performance standard: Driving must be safe and not impacted by fatigue.

Survivor goal	Drive longer distances		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Has only driven locally in the last 4 weeks.			
Partially achieved	**-1**	Drove from Melbourne to Ballarat (114 km) one way in one day with family or drove for half the time for the return journey.			
SMART goal	**0**	**To drive to Ballarat and back in one day (or similar distance) in manual car with family in car as passengers. Must be performed with appropriate alertness and safety.**			
Somewhat better than expected	**+1**	Has driven to Ballarat and back (or similar distance) twice in the last 4 weeks.			
Much better than expected	**+2**	Has driven 1.5 times longer distance than Ballarat and back on multiple occasions in the last 4 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to driving'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Not currently driving. Booked for driving assessment with occupational therapist driving assessor.
- Behaviour: Return to driving.
- Conditions: Automatic car without modification.
- Context: Local driving on suburban streets.
- Measurement: Pass/fail of driving test and subsequent driving activities if passes.
- Performance standard: Conditional licence for local driving or better.

Survivor goal	Return to driving		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Not driving.			
Partially achieved	**-1**	Failed driving assessment. Has booked in for practice sessions with occupational therapist and developed strategies to improve driving.			
SMART goal	**0**	**To pass driving assessment with occupational therapist in automatic car.**			
Somewhat better than expected	**+1**	Is driving > 3 times a week during the day to local shops, appointments and to visit family within 10km drive from home.			
Much better than expected	**+2**	Is driving > 3 times a week during the day to local shops, appointments and to visit family within 10km drive from home and has driven in the evening to visit family.			

*Agreed strategies are to be recorded on the client summary sheet

RETURNING TO PAID OR UNPAID WORK
(Returning to Paid or Unpaid Work)

Guidelines

- Stroke survivors who wish to return to work should be offered:
    - Assessment inclusive of cognitive, language, and physical abilities relative to work requirements
    - Assistance to resume or take up work
    - Referral to a supported employment service
    - Empowerment to talk to their current employer (i.e. from prior to stroke) about returning to work and performing different tasks or working fewer hours, if required

Examples of Stroke Survivor Stated Goal
'Return to work as crossing supervisor'
'Find ways to use a keyboard with my right hand'
'Volunteer at Red Cross each week'
'Help in food van'

Converting to SMART Goal (metrics)

- Behaviour: Return to paid or voluntary work, or study.
- Conditions: Use of aids, modified activities, supervision, quality of the performance.
- Context: Where the activity will take place, task complexity.
- Measurement: Time (hours), breaks required.
- Performance standard: Frequency, consistency, accuracy, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Engage the support of an Occupational Therapist and / or employment agencies and services. Additional allied health input, including neuropsychology assessment, may be required.
- Consider pursuing other meaningful activities in the community (not specifically work related) if unable to return to paid work.
- Work related task specific practice outside of the workplace.
- If unable to return to previous occupation, other options should be explored:
    - Other roles within previous or new workplace
    - Part time employment
    - Volunteer work
    - Training in other areas

Worked examples

1. ***Survivor stated goal: 'Return to work as a crossing supervisor'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor currently doing the afternoon shift as school crossing supervisor. One and a half hour shift Monday to Friday. Previously worked morning and afternoon shift (three hours in total).
- Behaviour: Return to pre-stroke work hours and role.
- Conditions: Activity has been modified in relation to total hours worked.
- Context: Crossing outside primary school on moderately busy suburban street.
- Measurement: Total number of 1.5 hour shifts worked in a week.
- Performance standard: Return to pre-stroke amount of work.

Survivor goal	Return to work as a crossing supervisor	**Timeframe** 3 months	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Working one-and-a-half-hour shift 5 days a week (Monday to Friday) in afternoon.		
Partially achieved	**-1**	Working a total of 6 – 7 one and a half hour shifts a week.		
SMART goal	**0**	**To return to working one and a half hour shift, morning and afternoon, 5 days a week. Needs to have been achieved consistently for the last 2 weeks.**		
Somewhat better than expected	**+1**	Return to working one and a half hour shift, morning and afternoon, 5 days a week. Has been able to do this for the last 4 weeks. Now able to do it with minimal effort required.		
Much better than expected	**+2**	Return to working one and a half hour shift, morning and afternoon, 5 days a week. Has been able to do this for the last 4 weeks and has started some other 'part time' work.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Find ways to use a keyboard with my right hand'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Limited functional use of Right upper limb. Currently typing with left hand only. This is slow and impacts on her productivity at work.
- Behaviour: Requires an assessment/treatment plan to improve ability to type at work.
- Conditions: This is an interim goal, conditions relate to achieving an assessment.
- Context: Attending a local, appropriately trained occupational therapist.
- Measurement: Achieved if they have had an appropriate assessment.
- Performance standard: Full assessment and appropriate management plan

Survivor goal	Find ways to use a keyboard with my right hand	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 1
Baseline (no change or worse)	**-2**	No action has been taken.		
Partially achieved	**-1**	Has visited the GP and obtained a referral for an occupational therapy assessment but has not yet had the assessment.		
SMART goal	**0**	**Has been assessed by an occupational therapists and a treatment plan has been determined and discussed with the survivor.**		
Somewhat better than expected	**+1**	Has planned the next stage of action that was discussed with the occupational therapist. E.g. has commenced right upper limb task specific training.		
Much better than expected	**+2**	Has implemented the next stage of the action plan. e.g. has commenced typing with both hands.		

*Agreed strategies are to be recorded on the client summary sheet

RETURNING TO LEISURE ACTIVITIES
(Leisure Activities)

Guidelines

- Many survivors are unable to continue with usual leisure and social activities and / or do not take up new ones.
- This can lead to:
    - Social isolation
    - Depressed mood
    - Relationship problems

Examples of Stroke Survivor Stated Goal

'Return to painting with watercolours'

'Return to bowls'

'Return to craft day at Salvation Army'

'Get out in the local community'

'To find new hobbies to do during the day'

Converting to SMART Goal (metrics)

- Behaviour: Return to leisure or social activity.
- Conditions: Use of aids, supervision required, activity specific equipment.
- Context: Where the activity will take place, complexity of the activity.
- Measurement: Amount, time (in minutes), frequency, activity specific measure.
- Performance standard: Consistency, accuracy, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Targeted occupational therapist programs can be used to increase participation in leisure activities.
- Involvement of a recreational therapist should be considered.
- Consider taking up new leisure and/ or social activity.
- If lack of motivation is a problem, interventions targeting low mood may be useful.

Worked examples

1. ***Survivor stated goal: 'Return to painting with watercolours'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Prior to stroke regularly painted with watercolours. Hasn't yet attempted post stroke due to hand function. Has managed to sketch with pencils.
- Behaviour: Painting with watercolours.
- Conditions: Multiple colours, standard brushes and 8 x 6 inch watercolour paper.
- Context: At kitchen bench in own home.
- Measurement: Successful completion of task.
- Performance standard: Must involve brush strokes in a coordinated manner (not just blotches).

Survivor goal	Return to painting with watercolours	**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 3
Baseline (no change or worse)	**-2**	Has not attempt painting with water colours.		
Partially achieved	**-1**	Set up paint tray with 2-4 water colours and paint with 2-4 colours on the paper once under above conditions.		
SMART goal	**0**	**Set up paint tray at home with 5 water colours, hold paint brush, paint 5 different colours onto watercolour paper using brush strokes (8x6 inch paper) at least once.**		
Somewhat better than expected	**+1**	Paint 5 or more different colours onto the paper on 2 or more occasion and has started a water colour painting.		
Much better than expected	**+2**	Complete a full water colour painting at a satisfactory standard using 5+ colours.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to bowls'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Hasn't yet returned to bowls.
- Behaviour: Playing social lawn bowls.
- Conditions: Using adaptive equipment. Regulation lawn bowls.
- Context: At local bowling club. Survivor has been an active member of this club for many years.
- Measurement: Frequency and time.
- Performance standard: Performed consistently over the last 2 weeks.

Survivor goal	Return to bowls	**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Social visits to bowling club. Yet to play bowls.		
Partially achieved	**-1**	Has practiced bowling when bowling green is not it use, using adaptive equipment at least 2 times but has not had a game.		
SMART goal	**0**	**Using adaptive equipment, will be able to participate in social lawn bowling for 20-30 minutes at local bowling club weekly. Measured over the past 2 weeks**.		
Somewhat better than expected	**+1**	Participated in social lawn bowling using adaptive equipment for 40 to 60 minutes at the local bowling club weekly over the past 2 weeks, or participated for 20-30 minutes twice a week over the past 2 weeks.		
Much better than expected	**+2**	Participate in social lawn bowling using adaptive equipment for 40 to 60 minutes at local bowling club at least twice a week over the past 2 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

GETTING ALONG WITH OTHERS - FAMILY
(Family Relationships)

Guidelines

- The physical and emotional aspects of stroke can alter family roles and dynamics.
- Anxiety/depression and quality of life in both carers/family and the survivor are common and are often impacted by the survivor's inability to function in their previous capacity as well as fear of future stroke.
- Interventions should involve both the survivor and family.

Examples of Stroke Survivor Stated Goal

'Return to looking after grandchildren'

'To be more involved with my children'

'Take care of my family'

'Caring more for my wife and son'

'Educating family about my health'

'To communicate my feelings to my family'

Converting to SMART Goal (metrics)

- Behaviour: Improving family and carer relationships.
- Conditions: Nature of the relationship.
- Context: Where the relationship/interactions will take place (face to face, telephone, social media).
- Measurement: Duration / time, frequency, amount.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Strategies can include:
  - Counselling
  - Information / education
  - Effective communication
- Family should be given education and information about peer-support groups.
- Goals should be set with family involvement.

Worked examples

1. ***Survivor stated goal: 'Return to looking after grandchildren'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Two grandchildren 6 and 8 years of age. Pre-stroke, survivor did after school pick up and looked after them for 2–3 hours. Husband is now doing this.
- Behaviour: Caring for grandchildren.
- Conditions: 6 and 8 year-old grandchildren. Amount of assistance required for duration of care period.
- Context: In survivor's own home.
- Measurement: Hours of care and frequency.
- Performance standard: Consistency over a 2 weeks period, unassisted >50% of the time.

Survivor goal	Return to looking after grandchildren		**Timeframe** 2 months	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Caring for grandchildren in own home 2 hours a day, 5 days a week, with the survivor's husband assisting with care of the grandchildren > 75% of the time.			
Partially achieved	**-1**	Caring for grandchildren in own home 2 hours a day, 5 days a week, with the survivor's husband assisting with care of the grandchildren 50 - 75% of the time.			
SMART goal	**0**	**Caring for grandchildren 2 – 3 hours a day in own home, 5 days a week, with assistance from husband 25 - 50% of the time consistently for 2+ weeks.**			
Somewhat better than expected	**+1**	Caring for grandchildren in own home 2 – 3 hours a day, 5 days a week, with assistance from husband occasionally < 25% of the time consistently for 2+ weeks.			
Much better than expected	**+2**	Caring for the grandchildren in own home with the husband present in the home but not proving any direct assistance with the care of the grandchildren, consistently for 2+ weeks.			

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'To be more involved with my children'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Has two children aged 7 and 9 years. Husband is picking children up from school and attending activities with children 3 evenings/ week. Survivor stays at home.
- Behaviour: Increasing time spent being involved with children afterschool outside of home.
- Conditions: Husband will drive and accompany wife.
- Context: Attending activities with children outside of the home.
- Measurement: Frequency of activities.
- Performance standard: Consistently over a 4-week period.

Survivor goal	To be more involved with my children		**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Husband doing school pickups and attending afterschool activities with children. Survivor has not attended.			
Partially achieved	**-1**	Attended school pick up and afterschool activities with husband and children one afternoon a week over the last month.			
SMART goal	**0**	**Attend school pick up and afterschool activities with husband and children 2 afternoons a week. Consistently over the last 4 weeks.**			
Somewhat better than expected	**+1**	Attended school pick up and afterschool activities with husband and children 3 afternoons a week over the last 4 weeks.			
Much better than expected	**+2**	Attended school pick up and afterschool activities with husband and children 3 afternoons a week and has commenced doing additional unstructured activities with the children outside of the home over the last 4 weeks.			

*Agreed strategies are to be recorded on the client summary sheet

GETTING ALONG WITH OTHERS - FRIENDS
(Friend Relationships)

Guidelines

- There are no specific guidelines relating to friendships.
- Friend relationships are often impacted by the survivor's inability to function in their previous capacity due to physical, cognitive, behavioural or communication changes.
- Any interventions or suggested strategies should address psychosocial aspects, as well as physical function.

Examples of Stroke Survivor Stated Goal
'Get out in evenings more often to see friends'
'Return to socialising at the cricket club'
'Return to seeing friends for coffee'
'Make new friends"

Converting to SMART Goal (metrics)

- Behaviour: Improving friend relationships, making new friends.
- Conditions: Nature of pre-stroke friendship.
- Context: Where the relationship/interactions will take place (face to face, telephone, social media).
- Measurement: Duration of contacts.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Strategies can include:
  - Counselling / information
  - Effective communication
- Educating friends and family about stroke.
- Joining a stroke support group or making new friends with similar interests.
- Where possible goals should be set with friend involvement.

Worked examples

1. ***Survivor stated goal: 'Get out in evenings more often to see friends'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: In the last 12 months stroke survivor has been out in the evening on 4 occasions for ≥ 2 hours. Pre-stroke would go out with friends approximately once a week.
- Behaviour: Socialising with friends.
- Conditions: Needs to organise and attend the events.
- Context: Out at a restaurant or bar, or at friends home with friends.
- Measurement: Number of occasions ⩾ 2 hours duration.
- Performance standard: Consistency over the past 4 weeks.

Survivor goal	Get out in evenings more often to see friends	**Timeframe** 8 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Has not gone out socially in the past month.		
Partially achieved	**-1**	Has gone out socially once in the evening in the last month, or has caught up with friends once a fortnight in the evenings but for < 2hrs.		
SMART goal	**0**	**Go out socially in the evening with friends once a fortnight for 2-3 hours, over the next month**.		
Somewhat better than expected	**+1**	Has gone out socially in the evenings once a week, or has gone out socially in the evenings once a fortnight for 3-4 hours in the last month.		
Much better than expected	**+2**	Has gone out socially in the evenings once a week in the evening for 3-4 hours in the last month.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to socialising at the cricket club'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Has been to cricket club once on match day. Watched 6 overs of match sitting in own car and returned home without going into social club rooms.
- Behaviour: Socialising with friends at the cricket club.
- Conditions: Can drive self to club rooms and access independently with a walker. Chairs available to sit once in club rooms.
- Context: Local cricket club rooms.
- Measurement: Duration and frequency.
- Performance standard: Attend once per fortnight over the next 4 weeks.

Survivor goal	Return to socialising at the cricket club	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Has not gone into the social club rooms.		
Partially achieved	**-1**	Attended cricket club once on match day and watched up to 10 overs in club rooms in past 4 weeks.		
SMART goal	**0**	Attend cricket club on a match day and watch (seated) 10 overs in club rooms twice in next 4 weeks.		
Somewhat better than expected	**+1**	Attended cricket club on match day and watched >10 overs of match in club rooms twice in past 4 weeks, or attended on 3 – 4 occasions to watch 10 overs. Measured over last 4 weeks.		
Much better than expected	**+2**	Attended cricket club on match day and watched >10 overs of match in club rooms more than twice in past 4 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

GETTING ALONG WITH OTHERS - PARTNER
(Partner Relationships)

Guidelines

- Stroke survivors and their partners should be offered:
  - The opportunity to discuss sexuality or intimacy issues with an appropriate health professional
  - Written information addressing issues relating to sexuality and relationship changes post stroke should be provided
- Any interventions should address psychosocial and emotional aspects or concerns, as well as physical intimacy.

Examples of Stroke Survivor Stated Goal

'Try to spend more time with partner'

'Return to being physically intimate with my partner'

'Return to sex'

'Return to caring for husband'

'Spend quality time with wife each day'

'To get a boyfriend/girlfriend'

Converting to SMART Goal (metrics)

- Behaviour: Improving relationship with partner.
- Conditions: Type of spousal activity, assistance required.
- Context: Where the activity will take place.
- Measurement: Duration, time, nature, frequency.
- Performance standard: Consistency, quality.
- Strategies and review plan: To be developed in collaboration with survivor / partner and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Interventions need to consider psychosocial aspects such as body image, anxiety, fear and change in roles.
- Strategies can include:
  - Counselling / information
  - Effective communication
  - Having dedicated time for the relationship
- Goals should be set with partner involvement if appropriate.

Worked examples

1. ***Survivor stated goal: 'Try to spend more time with partner'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Stroke survivor spending < 1 hour one on one with partner outside of carer role activities.
- Behaviour: Spending quality time with partner.
- Conditions: Must be alone with partner in a non-carer role.
- Context: On either day of the weekend. On an outing or at own home.
- Measurement: Time in minutes and frequency.
- Performance standard: Consistently over the last 2 weeks.

Survivor goal	Try to spend more time with partner	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Spending <1 hr on the weekend having one on one time with partner under above stated conditions.		
Partially achieved	**-1**	Spending 1-2 hours on the weekend with partner each weekend or spent half a day on the weekend once a fortnight over the last 2 weeks.		
SMART goal	**0**	**Spend at least half of the day on a weekend spending quality time with partner either at home or out together under the above stated conditions. Measured over the last 2 weeks.**		
Somewhat better than expected	**+1**	Spend half to full day a day with partner every weekend, or spend half a day with partner twice during the week. Measured over the last 2 weeks.		
Much better than expected	**+2**	Spend with partner every weekend, and half a day with partner twice during the week. Measured over the last 2 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Return to being physically intimate with my partner'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Physical contact with partner is focused on physical assistance rather than intimacy.
- Behaviour: Physical intimacy with partner.
- Conditions: Alone with partner in a non-carer role.
- Context: In own home.
- Measurement: Time in minutes and frequency.
- Performance standard: Consistently over the last 2 week period.

Survivor goal	Return to being physically intimate with my partner	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Physical contact with my partner is focused on physical assistance.		
Partially achieved	**-1**	Spent 10-30 minutes on one occasion during the week being physically intimate with partner.		
SMART goal	**0**	**To spend 10-30 minutes over the day on 3 days of the week being physically intimate with my partner e.g. holding hands, cuddling etc. Measured over last 2 weeks**		
Somewhat better than expected	**+1**	Spending more than 30 minutes on 3 days of the week being physically intimate with my partner. Measured over the last 2 weeks.		
Much better than expected	**+2**	Spending more than 30 minutes on 4 or more days of the week being physically intimate with my partner. Measured over the last 2 weeks.		

*Agreed strategies are to be recorded on the client summary sheet

BEING MORE INVOLVED IN YOUR TREATMENT AND CARE
(Involvement in Decisions About Treatment and Care)

Guidelines

- Stroke survivors and their families / carers who are involved in the recovery process should have their wishes and expectations established and acknowledged.
- The stroke survivor and their family / carer should be involved in management decisions and goal setting.
- All stroke survivors and their families / carers should be offered information tailored to meet their needs.

Examples of Stroke Survivor Stated Goal

'Ask questions at medical appointments'

'Making decisions for myself'

'Clarify options for treating my condition'

'I want my views to be acknowledged'

Converting to SMART Goal (metrics)

- Behaviour: Involvement in decisions about treatment and care.
- Conditions: Use of aids, supervision or assistance.
- Context: Where the activity will take place, other people involved.
- Measurement: Self report of satisfaction (VAS or Likert scale), validated and reliable satisfaction scale.
- Performance standard: How often assessed, consistency, quality of interactions.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Provide tailored information to stroke survivors and their families.
- Health professionals should collaboratively set appropriate management goals with survivors of stroke to promote optimal care and ongoing recovery. Goals should be recorded, reviewed and updated regularly, at least annually.
- Stroke survivors should be offered training in self-management skills that include active problem solving and individual goal setting.
- Survivors of stroke should be empowered to ask questions and make their viewpoints known and supported to take out an advanced care directive.

Worked examples

1. **Survivor stated goal: 'Ask questions at medical appointments'.**

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Doesn't usually discuss management with medical professionals. Takes a passive role during appointments. Often leaves with unanswered questions.
- Behaviour: Ask questions of medical professionals at scheduled follow up appointments to clarify plan and allow survivor to make informed decisions regarding ongoing care.
- Conditions: Attends most appointments with daughter.
- Context: At medical appointments (GP and specialist) in community or out-patients.
- Measurement: Number of pre-prepared questions asked and adequate answers obtained.
- Performance standard: Quality of responses received (on 1 -10 Likert Scale).

Survivor goal	Ask questions at medical appointments	**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Survivor asked <50% of prepared questions at last medical appointment in the last 4 weeks.		
Partially achieved	**-1**	Asked 50 – 75% of pre-prepared questions at recent medical appointment with >7/10 satisfaction or asked >75% of questions but with < 7/10 satisfaction with responses.		
SMART goal	**0**	**To ask >75% of pre-prepared questions at most recent medical appointment over the past 4 weeks. Overall satisfaction with responses to be rated as > 7 on Likert scale.**		
Somewhat better than expected	**+1**	Asked 100% of pre-prepared questions and 1–3 spontaneous questions at recent medical appointment. Survivor rated satisfaction with responses > 7 on Likert scale.		
Much better than expected	**+2**	Survivor asked 100% of pre-prepared questions and > 3 spontaneous questions at medical appointment. Survivor rated satisfaction with responses > 7 on Likert scale.		

*Agreed strategies are to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Making decisions for myself'***.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Relying on wife to make decisions about medical care and rehabilitation.
- Behaviour: To be actively involved in decisions about medical care and rehabilitation.
- Conditions: Wife to help survivor gather, organise and explain information relating to decisions to survivor, including potential benefits and risks.
- Context: Complexity of decisions will vary depending on the decision required.
- Measurement: Proportion of decisions whereby survivor decides and communicates final decision. Proportion whereby wife gathers, explains and discusses related information.
- Performance standard: To make final decision with the assistance of wife 100% of the time.

Survivor goal	Making decisions for myself	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 2
Baseline (no change or worse)	**-2**	Relying on wife to make decision relating to medical treatments and rehabilitation most of the time.		
Partially achieved	**-1**	Making decisions relating to medical treatments and rehabilitation 50% of the time. Wife assists with gathering, organising and explaining information 100% of the time.		
SMART goal	**0**	**To make decision relating to medical treatments and rehabilitation for myself 100% of the time with the assistance of my wife to gather, organise and explain relevant information 100% of the time.**		
Somewhat better than expected	**+1**	Making decisions relating to medical treatments and rehabilitation 100% of the time. Wife assists with gathering, organising and explaining information 75% of the time.		
Much better than expected	**+2**	Making decisions relating to medical treatments and rehabilitation 100% of the time. Wife assists with gathering, organising and explaining information 50% of the time.		

*Agreed strategies are to be recorded on the client summary sheet

HEALTHCARE AND SUPPORT

Environment

GETTING THE INFORMATION YOU NEED – GENERAL HEALTH, PREVENTING STROKE, LIFE AFTER STROKE
(Access to Information)

Guidelines

- All stroke survivors and their families/carers should be offered information tailored to their needs in a suitable format.
- Information should be provided at different stages of recovery.

Examples of Stroke Survivor Stated Goal
'Learn more about healthy eating'
'Learn more about stroke and getting better'
'Learn about community supports'
'Know what to work on to get better'
'Better understand risk factors that may lead to stroke'

Converting to SMART Goal (metrics)

- Behaviour: Accessing appropriate health and recovery information.
- Conditions: Source of information, assistance required to access.
- Context: Where information is accessed (online, brochures, health professionals).
- Measurement: Self report of satisfaction (VAS or Likert scale), validated and reliable satisfaction scale.
- Performance standard: How often, consistency, accuracy.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Ask your GP to recommend sources of information.
- Several sources of information are available online or as printed materials e.g. my stroke journey pack, Stroke Foundation and Enable Me websites.
- Information should be targeted to the health literacy level and the cognitive and communication needs of the client.

Worked examples

1. ***Survivor stated goal: 'Learn more about healthy eating'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor has been diagnosed as pre-diabetic. Has had a conversation with GP about pre-diabetic diet but hasn't accessed dietary information from any other source.
- Behaviour: Accessing appropriate dietary information.
- Conditions: Survivor is confident using internet independently to search for information.
- Context: Internet search. Survivor is planning to access the Enable Me website or other site with appropriate information.
- Measurement: Successfully accessing the required dietary information to survivor's satisfaction.
- Performance standard: Quality of information accessed.

Survivor goal	Learn more about healthy eating		**Timeframe** 4 weeks	**Importance** 1	**Difficulty** 1
Baseline (no change or worse)	**-2**	Has not accessed appropriate dietary information online.			
Partially achieved	**-1**	Has not accessed desired information on diet, but has found potential sources and commenced planning accessing this information.			
SMART goal	**0**	**Independently access appropriate information regarding diet specifically related to pre-diabetes at least once over the next 4 weeks using the internet.**			
Somewhat better than expected	**+1**	Has accessed information and has commenced/planned the diet i.e. developed a meal planner or shopped for specific foods.			
Much better than expected	**+2**	Has commenced and maintained the pre-diabetic diet for at least the last week.			

*Agreed strategies to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Learn about stroke and betting better'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Limited knowledge of stroke prior to having stroke. Received a lot of written information whilst in hospital. Hasn't read much of the information that was provided.
- Behaviour: Increase knowledge regarding stroke and recovery.
- Conditions: Has access to written information, booklets, and handouts from hospital staff.
- Context: Read through information at home.
- Measurement: Spend 15 minutes a day reading through provided information.
- Performance standard: To be done most days (6 – 7 days / week) with good comprehension.

Survivor goal	Learn about stroke and getting better		**Timeframe** 2 weeks	**Importance** 2	**Difficulty** 1
Baseline (no change or worse)	**-2**	Not reading any of the information provided by hospital.			
Partially achieved	**-1**	Spent < 15 minutes a day reading the information provided by the hospital or spent 15 minutes a day, 3-5 days a week, over the last 2 weeks.			
SMART goal	**0**	**Spend 15 minutes a day most days (6-7 days/week) over the next 2 weeks reading the information provided by the hospital with good comprehension.**			
Somewhat better than expected	**+1**	Spent 15 – 30 minutes a day over the last 2 weeks reading the information provided by the hospital with a high level of comprehension.			
Much better than expected	**+2**	Spent 15 – 30 minutes a day over the last 2 weeks reading information about stroke and sourced additional information when gaps in understanding on a topic were identified.			

*Agreed strategies to be recorded on the client summary sheet

ACCESSING PEER SUPPORT PROGRAMS – ONLINE OR FACE TO FACE GROUPS
(Online or face-to-face support groups)

Guidelines

- All stroke survivors and their families/carers should be offered available support tailored to their needs and in a suitable format (online or face to face).
- Support should be provided at different stages of recovery and can include family and carers if appropriate.

Examples of Stroke Survivor Stated Goal
'Regularly attend stroke support group with my wife'
'Learn about community supports'
'Seek out online support group'
'Look up support groups recommended by Stroke Foundation'

Converting to SMART Goal (metrics)

- Behaviour: Accessing appropriate support.
- Conditions: Source of support, assistance required to access this support.
- Context: Location of support (online, face to face).
- Measurement: Self report of satisfaction (VAS or Likert scale), validated and reliable satisfaction scale, appropriateness of support.
- Performance standard: How often, consistency, level of engagement.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- Ask GP, nurse or therapist to recommend reliable and appropriate sources of information and support groups.
- Discuss information for clarification and reinforcement.
- Involve family / carer in discussion. Several sources of information on local support groups are available online or as printed materials e.g. My stroke journey pack, Stroke Foundation and Enable Me websites.
- Strategies may need to address access issues e.g. transport, communication or cognitive support.

Worked examples

1. ***Survivor stated goal: 'Regularly attend stroke support group with my wife'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Has recently joined a Stroke support group that meets fortnightly for one hour. Has attended once but has a history of not continuing these types of groups.
- Behaviour: Accessing appropriate support via ongoing attendance at support group.
- Conditions: Survivor is able to access this group with assistance from wife. Wife is available to attend this group and will drive.
- Context: Stroke support group fortnightly at local Community Health Centre.
- Measurement: Number of occasions that the survivor attends the stroke support group over the next 3 months.
- Performance standard: Attendance the majority of the time (at least 80%) over the 3 months.

Survivor goal	Regularly attend stroke support group with my wife		**Timeframe** 3 months	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Has not attended the stroke support group at local Community Health Centre with wife over the past 3 months.			
Partially achieved	**-1**	Has attended the stroke support group at local Community Health Centre with wife 2-4 times over the past 3 months.			
SMART goal	**0**	**Attend monthly stroke support group at local Community Health Centre with wife at least 5 times over the next 3 months.**			
Somewhat better than expected	**+1**	Has regularly attended the stroke support group at local Community Health Centre with wife 5 or more times and has actively contributed to the group discussions.			
Much better than expected	**+2**	Has regularly attended the stroke support group at local Community Health Centre with wife 5 or more times and has become embedded in the group e.g. seeing members or contributing to group outside of meetings.			

*Agreed strategies to be recorded on the client summary sheet

2. ***Survivor stated goal: 'Learn about community supports'.***

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor feels socially isolated. Wants to find out about supports available in the local community.
- Behaviour: Gathering information regarding available supports in local community.
- Conditions: Online or face to face with GP.
- Context: In the GP clinic and using home computer.
- Measurement: Whether or not they have identified an appropriate local support group.
- Performance standard: Quality of information obtained.

Survivor goal	Learn about community supports		**Timeframe** 6 weeks	**Importance** 3	**Difficulty** 1
Baseline (no change or worse)	**-2**	Hasn't commenced investigating local support options.			
Partially achieved	**-1**	Has made an appointment with GP but not yet attended, or has attempted online search without success.			
SMART goal	**0**	**Has had a conversation with GP and identified available supports for stroke survivors in local community**.			
Somewhat better than expected	**+1**	Identified a local support group and made inquiries regarding attending this group.			
Much better than expected	**+2**	Identified and attended appropriate local support group.			

*Agreed strategies to be recorded on the client summary sheet

GETTING THE HELP THAT YOU NEED – ALLIED HEALTH, GP, HOME HELP
(Access to Health Professionals, General Practitioners, Community Services)

Guidelines

- Survivors of stroke with chronic impairments should be reviewed annually by their GP and those with ongoing rehabilitation needs should be referred to therapy to set new goals and improve function.
- Recovery from stroke may require input from several health professionals e.g. GP, specialists, nurses and allied health professionals including physiotherapist, speech pathologists, occupational therapists, dietitians etc., or access to other community services.

Examples of Stroke Survivor Stated Goal

'Follow up management plan with neurologist'

'Explore available supports to assist me at home'

'To make my home accessible'

'See my GP for referral to health professionals'

Converting to SMART Goal (metrics)

- Behaviour: Accessing appropriate health professionals.
- Conditions: Types of services accessed, needs addressed, assistance required to access services.
- Context: Where the services will be accessed, environmental barriers to access.
- Measurement: Length of consultation, how often services are accessed, self-report of satisfaction (VAS or Likert scale), validated and reliable satisfaction scale, appropriateness of service to needs.
- Performance standard: Consistency.
- Strategies and review plan: To be developed in collaboration with survivor / family and recorded on the client summary sheet.
- Timeframe: As agreed.

Strategies

- A GP should be able to recommend appropriated allied health professionals.
- All survivors of stroke are eligible to access approved allied health professions at private clinics with costs for the first five visits in a calendar year heavily subsidised by Medicare. This must be coordinated by the GP.
- Access may involve a number of settings as appropriate including rehabilitation centre, home visits, local gym, community or telehealth.
- Visit Enable Me website or Stroke Foundation website for more information.
- Access issues related to transport, community ambulation, and disability will need to be considered.

Worked examples

1. Survivor stated goal: 'Follow up management plan with neurologist'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor has a review appointment with the neurologist in 4 weeks' time and has made a list of specific questions that she would like to have addressed at this appointment.
- Behaviour: Communicating with neurologist.
- Conditions: Will attend appointment on own and have a list as a memory aid.
- Context: Specialist out-patient clinic at local public hospital.
- Measurement: Percentage of specific questions that survivor has had answered to acceptable standard (self-report of satisfaction, Likert scale 1-10).
- Performance standard: Quality/satisfaction with appointment (>7 on Likert Scale).

Survivor goal	Follow up management plan with neurologist		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	Did not receive answers to questions (<25%) and was not very satisfied with the appointment (<4 on satisfaction scale).			
Partially achieved	**-1**	Received answers to more than half the questions, but not all of the questions and overall satisfaction was 4-7 on satisfaction scale.			
SMART goal	**0**	**At the appointment with the Neurologist will ask questions and obtain answers to all pre-prepared questions re management plan, with an overall satisfaction of >7/10 on satisfaction scale**.			
Somewhat better than expected	**+1**	Received answers to all questions plus additional information and has developed a written plan based on the advice.			
Much better than expected	**+2**	Received answers to all questions and has taken positive action based on the advice e.g. accessed additional services.			

*Agreed strategies to be recorded on the client summary sheet

2. Survivor stated goal: 'Explore available supports to assist me at home'.

Converting this goal to a SMART goal collaboratively with survivor:

- Baseline function: Survivor has had two falls in last 6 months physiotherapy at local community rehabilitation centre helped post stroke, but has not had physiotherapy for >6 months.
- Behaviour: Obtain physiotherapy referral from GP.
- Conditions: Daughter would drive survivor to the GP appointment and attend appointment.
- Context: At GP clinic.
- Measurement: Successfully obtaining the physiotherapy referral.
- Performance standard: Completion of task and subsequent progression.

Survivor goal	Explore available supports to assist me at home		**Timeframe** 2 weeks	**Importance** **3**	**Difficulty** 1
Baseline (no change or worse)	**-2**	Has not taken any action towards seeing GP to obtain a referral to see a physiotherapist at the local Community Rehabilitation Centre.			
Partially achieved	**-1**	Has made an appointment with the GP, but has not yet obtained a referral to the local Community Rehabilitation Centre for physiotherapy.			
SMART goal	**0**	**To attend a GP appointment and obtained a referral to the local Community Rehabilitation Centre for physiotherapy to improve outdoor/community ambulation.**			
Somewhat better than expected	**+1**	Has seen the GP, obtained a referral and made an appointment to see a physiotherapist at the local Community Rehabilitation Centre.			
Much better than expected	**+2**	Has seen the GP, obtained the referral and attended one or more appointments with the physiotherapist at the local Community Rehabilitation Centre.			

*Agreed strategies to be recorded on the client summary sheet

GAS SCORING GUIDES

Scoring guidelines (decision trees)

We have identified 5 main types of goals that may arise under the menu categories.

These are:

1. Quantitative goals
2. Qualitative goals
3. Prevention goals
4. Process goals
5. Maintenance goals

To assist with scoring we have developed guidance in the form of decision trees. These scoring guides are based on recommendations from the published literature and theoretical frameworks such as behaviour change and skill acquisition theories.

Most goals that are accurately set using the SMART principle will be able to be scored using one or more of the decision trees. In some instances, multiple scoring methods may be used.

Where possible a goal should be outcome based. However, sometimes there are situations where a process goal may be required so that an outcome goal can be set[21] e.g. a driving assessment (process goal) may be required before a return to driving outcome goal can be set.

What constitutes a significant improvement will be left to the clinician's judgement and may depend on the task. A broad recommendation is >25% improvement. If someone is to perform a task consistently we would recommend that consistency be measured as >75% of the time.

QUANTITATIVE GOALS

- Goal may have multiple dimensions with at least one metric measured on a continuous scale e.g. time, distance, amount.
- The conditions, context and location should be stated and taken into account when scoring.

Scoring:

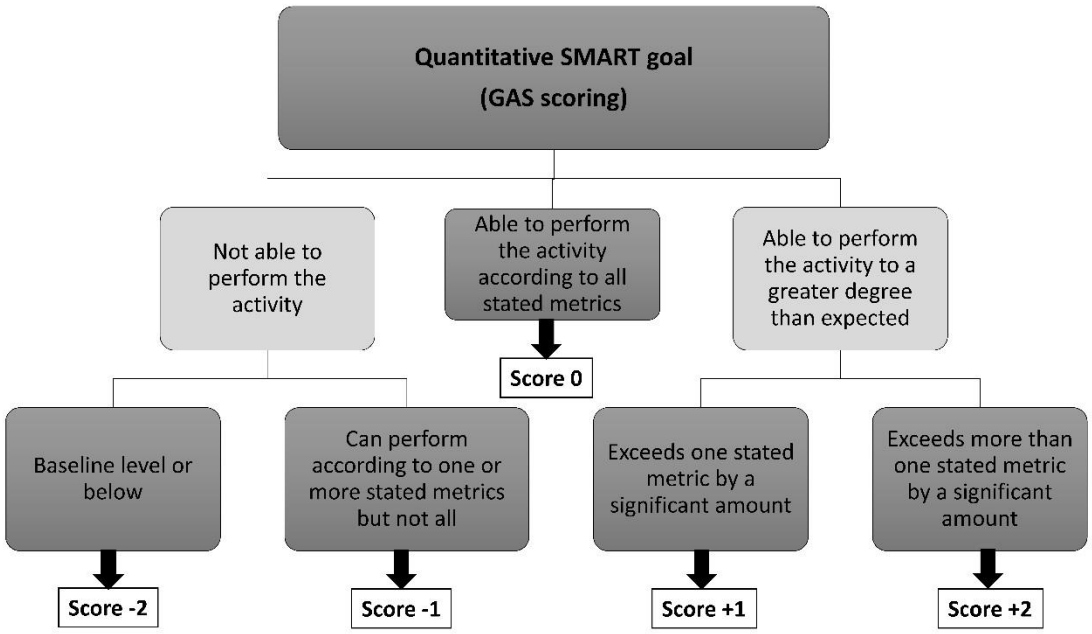
-2 = same as or worse than baseline

-1 = has met some (≥1) of the metrics that could not be performed at baseline but not all or has made significant progress in multiple metrics (>1), or if the goal has only one metric and is ≥ half way of achieving that metric.

0 = the task is performed according to all of the stated metrics under the stated conditions and within the stated context consistently

+1 = One of the metrics has been exceeded by a significant amount

+2 = Multiple (>1) metrics have been exceeded by a significant amount



QUALITATIVE GOALS

- Based on skill acquisition theory i.e. the goal is scored based on the quality of the performance, consistency with which it is performed and the level of concentration required to perform the task.
- Define consistency or quality level as >75%.

Scoring

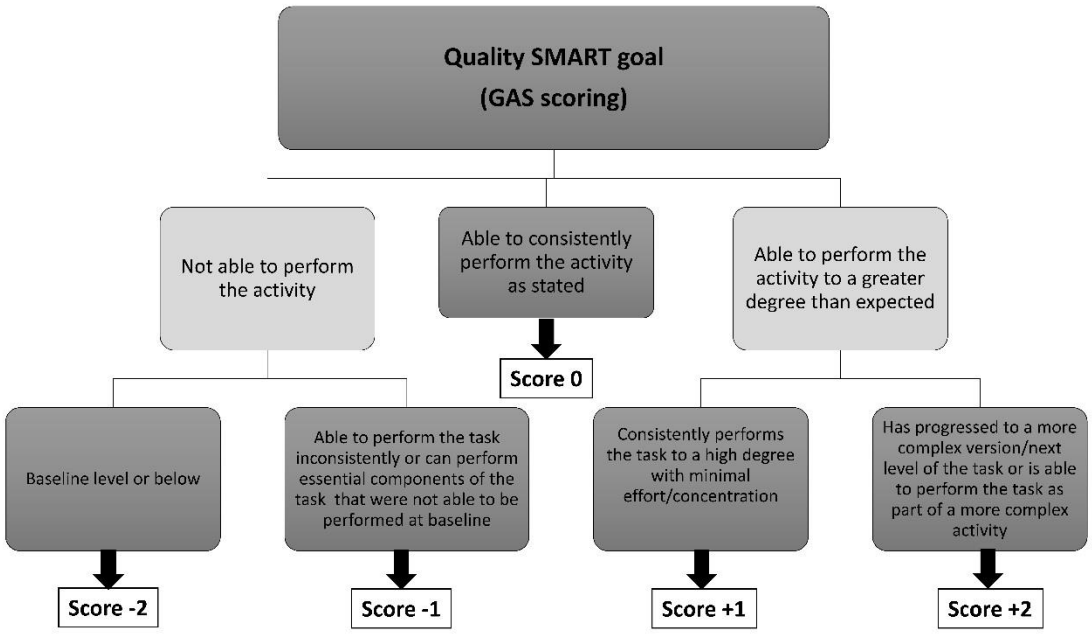
-2 = same as or worse than baseline

-1 = the cognitive phase of skill acquisition (they are getting there)
- Frequent errors
- Tasks broken down into sections but unable to perform the task as a whole

0 = the associative phase of skill acquisition (they can do it)
- The whole task can be performed consistently or with the desired level of quality with few errors, but significant effort is required

+1 = the autonomous stage of skill acquisition (they can do it well and easily)
- The person no longer thinks when performing the skill (it has become automatic)
- High quality movement with minimal minor errors

+2 = transfer of skill (they have moved onto something more complex)
- Able to integrate the skill into a complex multi-task or complex environment
- Or progressed to a new more complex task that builds upon the initial task



SECONDARY PREVENTION GOALS

- The survivor goal should be within a normal physiological range based on current guidelines.
- The timeframe will need to be calculated so that the required reductions are safe and achievable. In time limited trials an interim goal may be needed that is both achievable and safe i.e. is moving them towards the normal physiological range.
- Consistency and context should be stated to account for measurement error and fluctuations.

Scoring

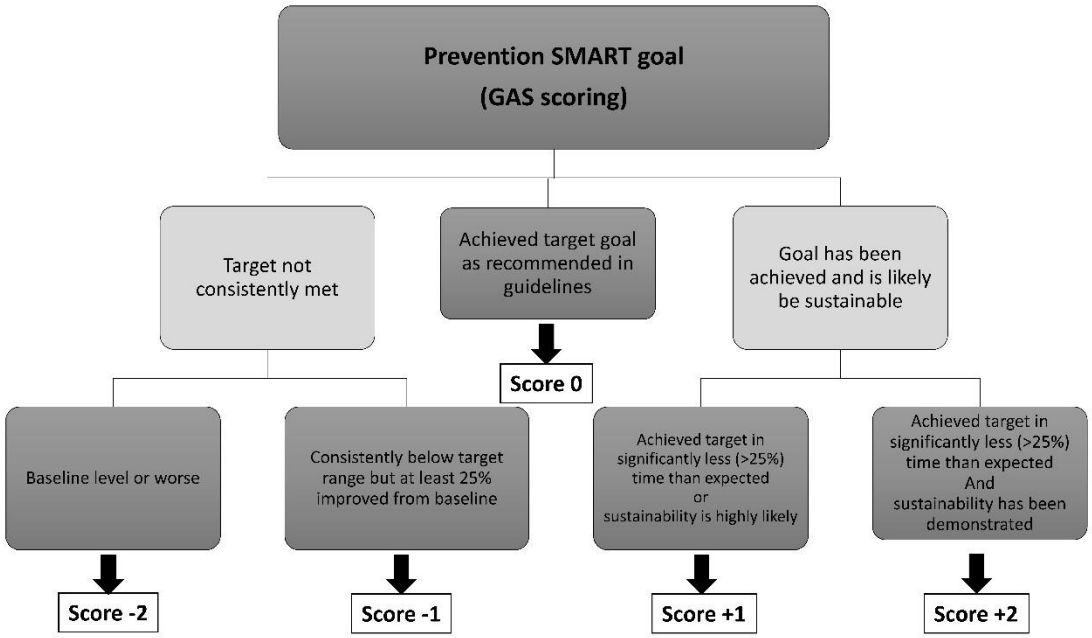
-2 = same as or worse than baseline

-1 = target has been partially met (25 - 50% improved from baseline) or inconsistently met e.g. may have been met on one or two occasions but with wide fluctuations

0 = has achieved the target goal as stated in the guidelines or an interim goal for time limited trials. This has been maintained for a consistent period e.g. 1 or more weeks

+1 = Achieved target goal for a consistent period in significantly less time than expected

+2 = Achieved target in significantly less time than expected and a high level of sustainability has been demonstrated utilizing a number of strategies e.g. medication and lifestyle changes with a possible reduction in medication



PROCESS GOALS

- Scoring draws upon Behaviour Change Theory.
- Process goals generally relate to an action such as accessing services, assessments, help or equipment that are necessary for informing the next phase of action, within a given timeframe.
- For clinical purposes +1 and +2 categories can be collapsed down to +1 only. However, for GAS scoring methods all categories should be considered.

Scoring

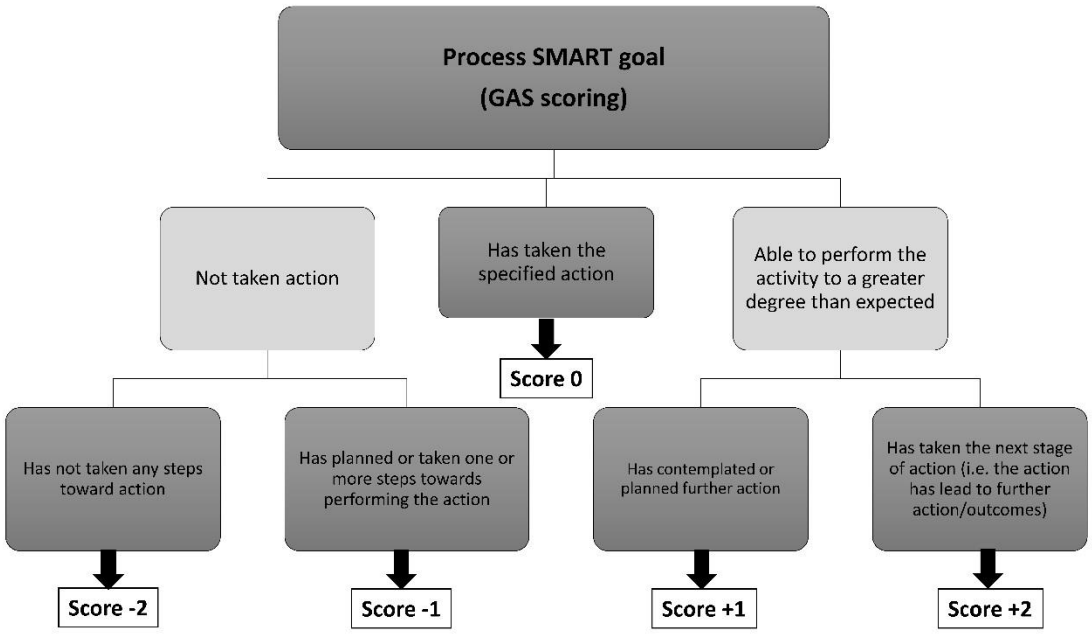
-2 = same as baseline i.e. no action has been taken

-1 = has not achieved or performed the process but has taken a first step e.g. has found a therapist and made an appointment

0 = has taken the specified action e.g. has had the assessment

+1 = has planned the next stage of action that has been informed by the process goal e.g. has found a hydrotherapy group and made enquiries

+2 = has performed the next stage e.g. has regularly attended the hydrotherapy group



MAINTENANCE GOALS

- Maintenance goals should be avoided as much as possible.
- May be appropriate for new behaviors that are difficult to maintain such as smoking cessation or where there has been difficulty sustaining this in the past.
- The baseline level is the goal and so a 0 score is achieved if the behavior is the same as baseline at the end of the nominated timeframe.
- The +1 and +2 scores are scored in the same way as the quantitative goals.
- -1 and -2 categories indicate levels of deterioration in the target behavior.

Scoring:

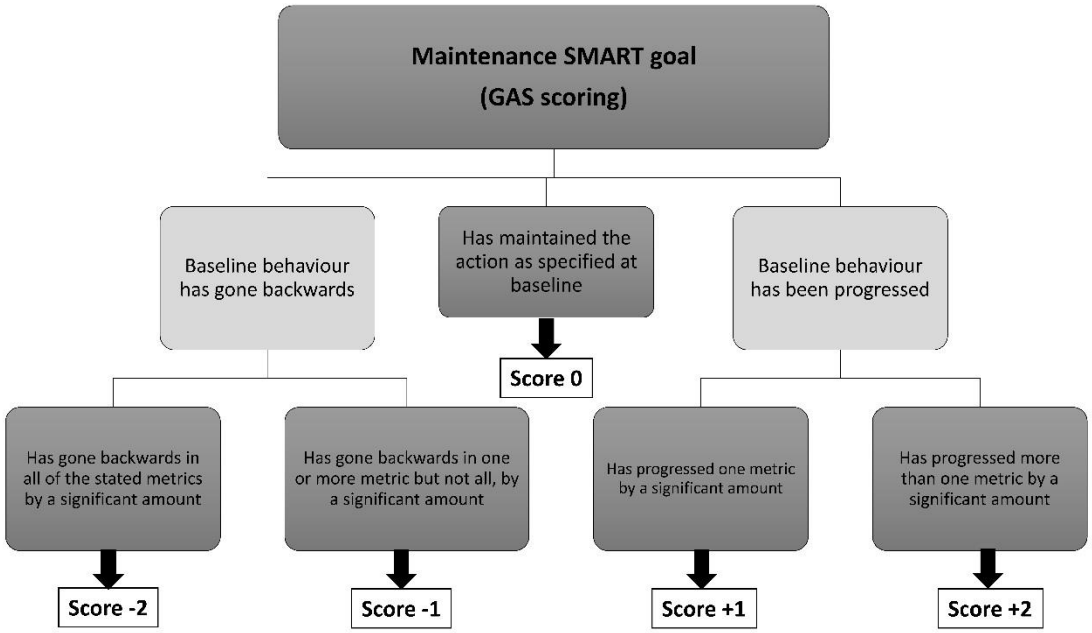
-2 = has deteriorated in all of the metrics that were being performed at baseline by a significant amount

-1 = has deteriorated in some (≥1) of the metrics that were being performed at baseline by a significant amount but not all

0 = the task is still being performed according to all of the baseline stated metrics under the stated conditions and within the stated context consistently

+1 = one of the metrics has been exceeded by a significant amount

+2 = multiple (>1) metrics have been exceeded by a significant amount



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APPENDIX 1 GOAL SETTING MENU

Please print the menu instructions and Goal Setting Menu and provide to the patient prior to setting goals.

Date __ __/ __ __/ __ __

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DOB..... SEX.....

Goal Setting Menu Instructions

A goal is something that you are trying to do or achieve. Setting goals has been shown to help with recovery and lifestyle changes following stroke.

Please read through the list of items in the attached goal setting menu.

- We would like you to think about the topics in the menu and choose 3 to 5 areas that you would like to work on as part of your recovery.
- It is important that the areas that you choose cover the things that are important to you.
- Once you are home you can continue to set goals for yourself as you recover or as your needs change.

A clinician from your care team will discuss the goal setting process with you to help you work out exactly what you want to achieve (i.e. your goals) so that you have something to work towards.

- Please ask as many questions as possible.
- Discuss things that you can do to help you achieve your goals.
- Discuss ways that you can monitor your progress and set new goals as you recover.

Date __ __ / __ __ / __ __ Name_____

Goal Setting Menu - Please choose up to 5 goals from the topics below

Your Health	
☐ Controlling Blood Pressure	☐ Managing Cholesterol
☐ Managing Diabetes	☐ Reducing Alcohol Intake
☐ Eating Well	☐ Losing or Putting on Weight
☐ Exercising	☐ Quitting Smoking
☐ Taking Medication Properly	
Mind and Body	
☐Moving and getting around	☐ Feeling less depressed, anxious or angry
☐ Trips, slips and falls	☐ Thinking and remembering
☐ Controlling your bladder and bowel	☐ Swallowing (eating and drinking)
☐ Managing pain	☐ Speaking and communicating
☐ Managing excessive tiredness	☐ Seeing and Recognising (Vision)
Everyday Activities	
☐ Attending to hygiene, dressing and eating	☐ Other activities – writing, reading a book, music, craft
☐ Doing inside tasks - cooking, vacuuming, washing	☐ Managing your money and finances
☐ Doing outside tasks - gardening, sweeping, lawn mowing	☐ Using technology –email, social media, mobile phone/iPad
Out and About	
☐ Using public or private transport services	☐ Returning to leisure activities
☐ Driving - assessments, return to driving, improving confidence	☐ Getting along with others - family, friends or partner
☐ Returning to paid or unpaid work	☐ Being more involved in your treatment and care
Healthcare and Support	
☐ Getting the information you need - general health, preventing stroke, life after stroke	☐ Accessing peer support programs - online or face-to-face groups
	☐ Getting the help that you need – Allied health, GP, home help

APPENDIX 2A DISCHARGE GOAL SETTING TEMPLATE AND CLIENT SUMMARY SHEET

There are 2 GAS Scoring template options.

Please print either Appendix 2A or 2B for use in goal setting depending on your scoring preference.

Date __ __/ __ __/ __ __

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DOB..... SEX.....

DISCHARGE GOAL SETTING TEMPLATE

Instructions: Survivors should be set between 3 and 5 goals to work on as part of their discharge care planning. As much as possible these should be chosen from the goal menu provided to the patient. At a minimum the clinician should complete the shaded areas of the scoring template so that goals can be reassessed by other clinicians. If GAS scoring is to be used then all components of the template should be completed. The survivor should rank the level of importance from 0 (not important) to 3 (very) important. The clinician should rank the difficulty from 0-3 in a similar manner.

A copy of the client summary sheet should be provided to the patient and/or carer. A copy of the template including the GAS scoring should be provided to all other health professionals involved in the patients next stage of care e.g. GP, Community therapists.

Survivor goal 1		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 2		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Date __ __ / __ __ / __ __ Name_____

Survivor goal 3		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 4		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 5		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Date __ __ / __ __ / __ __ Name_____

Client Summary Sheet		
Goals	**Strategies to Achieve Goals**	
Goal 1:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 2:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 3:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 4:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 5:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Agreed Reviews: Frequency of self-review / reflection towards meeting the goal and/or planned follow-up with health professional:		
Self-review (+/- family or carer): Health practitioner review:		

APPENDIX 2B DISCHARGE GOAL SETTING TEMPLATE AND CLIENT SUMMARY SHEET

There are 2 GAS Scoring template options.

Please print either Appendix 2A or 2B for use in goal setting depending on your scoring preference.

Date __ __/ __ __/ __ __

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DOB..... SEX.....

DISCHARGE GOAL SETTING TEMPLATE

Instructions: Survivors should be set between 3 and 5 goals to work on as part of their discharge care planning. As much as possible these should be chosen from the goal menu provided to the patient. At a minimum the clinician should complete the shaded areas of the scoring template so that goals can be reassessed by other clinicians. If GAS scoring is to be used then all components of the template should be completed. The survivor should rank the level of importance from 0 (not important) to 3 (very) important. The clinician should rank the difficulty from 0-3 in a similar manner.

A copy of the client summary sheet should be provided to the patient and/or carer. A copy of the template including the GAS scoring should be provided to all other health professionals involved in the patients next stage of care e.g. GP, Community therapists.

Survivor goal 1			**Timeframe**	**Importance**	**Difficulty**
Much better than expected	**+2**				
Somewhat better than expected	**+1**				
SMART goal	**0**				
Partially achieved	**-1**				
Baseline (no change or worse)	**-2**				

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 2			**Timeframe**	**Importance**	**Difficulty**
Much better than expected	**+2**				
Somewhat better than expected	**+1**				
SMART goal	**0**				
Partially achieved	**-1**				
Baseline (no change or worse)	**-2**				

*Agreed strategies are to be recorded on the client summary sheet

Date __ __ / __ __ / __ __ Name_____

Survivor goal 3		**Timeframe**	**Importance**	**Difficulty**
Much better than expected	**+2**			
Somewhat better than expected	**+1**			
SMART goal	**0**			
Partially achieved	**-1**			
Baseline (no change or worse)	**-2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 4		**Timeframe**	**Importance**	**Difficulty**
Much better than expected	**+2**			
Somewhat better than expected	**+1**			
SMART goal	**0**			
Partially achieved	**-1**			
Baseline (no change or worse)	**-2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 5		**Timeframe**	**Importance**	**Difficulty**
Much better than expected	**+2**			
Somewhat better than expected	**+1**			
SMART goal	**0**			
Partially achieved	**-1**			
Baseline (no change or worse)	**-2**			

*Agreed strategies are to be recorded on the client summary sheet

Date __ __ / __ __ / __ __ Name_____

Client Summary Sheet		
Goals	**Strategies to Achieve Goals**	
Goal 1:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 2:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 3:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 4:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Goal 5:		Timeframe
Measurable Goal:		Importance ☐ A little ☐ Moderate ☐ Very
Agreed Reviews: Frequency of self-review / reflection towards meeting the goal and/or planned follow-up with health professional:		
Self-review (+/- family or carer): Health practitioner review:		

APPENDIX 3. WORKED EXAMPLE USING TEMPLATES

Goal Setting Menu - Please choose up to 5 goals from the topics below

Your Health	
√ Controlling Blood Pressure	☐ Managing Cholesterol
☐ Managing Diabetes	☐ Reducing Alcohol Intake
☐ Eating Well	☐ Losing or Putting on Weight
☐ Exercising	☐ Quitting Smoking
☐ Taking Medication Properly	
Mind and Body	
√ Moving and getting around	☐ Feeling less depressed, anxious or angry
☐ Trips, slips and falls	☐ Thinking and remembering
☐ Controlling your bladder and bowel	☐ Swallowing (eating and drinking)
☐ Managing pain	√ Speaking and communicating
☐ Managing excessive tiredness	☐ Seeing and Recognising (Vision)
Everyday Activities	
☐ Attending to hygiene, dressing and eating	☐ Other activities – writing, reading a book, music, craft
☐ Doing inside tasks - cooking, vacuuming, washing	☐ Managing your money and finances
☐ Doing outside tasks - gardening, sweeping, lawn mowing	☐ Using technology –email, social media, mobile phone/iPad
Out and About	
☐ Using public transport	☐ Returning to leisure activities
☐ Driving - assessments, return to driving, improving confidence	☐ Getting along with others - family, friends or partner
☐ Returning to paid or unpaid work	☐ Being more involved in your treatment and care
Healthcare and Support	
☐ Getting the information you need - general health, preventing stroke, life after stroke	☐ Accessing peer support programs - online or face-to-face groups
	☐ Getting the help that you need – Allied health, GP, home help

DISCHARGE GOAL SETTING TEMPLATE

Instructions: Survivors should be set between 3 and 5 goals to work on as part of their discharge care planning. As much as possible these should be chosen from the goal menu provided to the patient. At a minimum the clinician should complete the shaded areas of the scoring template so that goals can be reassessed by other clinicians. If GAS scoring is to be used then all components of the template should be completed. The survivor should rank the level of importance from 0 (not important) to 3 (very) important. The clinician should rank the difficulty from 0-3 in a similar manner.

A copy of the client summary sheet should be provided to the patient and/or carer. A copy of the template including the GAS scoring should be provided to all other health professionals involved in the patients next stage of care e.g. GP, Community therapists, etc

Date 04 / 10 / 17

Survivor goal 1	To be able to walk around my house without the walker		**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Able to walk between rooms of own home with assistance of walker.			
Partially achieved	**-1**	Able to walk between rooms in own home without walker at least 50% of the time.			
SMART goal	**0**	**To walk within own home safely between rooms during the day most of the time (>75%) without the need for a walker.**			
Somewhat better than expected	**+1**	Able to consistently walk without frame inside own home 100% of the time during the day safely.			
Much better than expected	**+2**	Able to walk inside without frame 100% of the time and outside in the back garden safely without the frame.			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 2	Reduce my blood pressure		**Timeframe** 4 weeks	**Importance** 2	**Difficulty** 2
Baseline (no change or worse)	**-2**	BP >135/95 measured under stated conditions in 4 weeks time.			
Partially achieved	**-1**	BP > 130/90 and less than 135/95 measured under stated conditions in 4 weeks time.			
SMART goal	**0**	**Reduce BP to 130/90 measured with manual BP monitor cuff and stethoscope, on right upper limb by nurse at GP clinic at regular monthly review in 4 weeks time using agreed strategies.**			
Somewhat better than expected	**+1**	BP < 130/90 and greater than 125/85 measured under stated conditions in 4 weeks time.			
Much better than expected	**+2**	BP < 125/85 and within normal recommended range measured under stated conditions in 4 weeks time.			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 3	To be able to express my needs	**Timeframe** 4 weeks	**Importance** 3	**Difficulty** 3
Baseline (no change or worse)	**-2**	Has not been able to order the coffees with or without assistance from her husband.		
Partially achieved	**-1**	Has ordered the coffees but has needed some assistance from her husband in order to be fully understood (e.g. clarification of order).		
SMART goal	**0**	**To order coffee for herself and her husband when they go to the local café and be understood by the café attendant with correct coffees received from the order.**		
Somewhat better than expected	**+1**	Successfully ordered the coffees on her own using clear and fluent language and was easily understood.		
Much better than expected	**+2**	Successfully ordered the coffees on her own and was easily understood and had a brief conversation with the café attendant.		

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 4		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

Survivor goal 5		**Timeframe**	**Importance**	**Difficulty**
Baseline (no change or worse)	**-2**			
Partially achieved	**-1**			
SMART goal	**0**			
Somewhat better than expected	**+1**			
Much better than expected	**+2**			

*Agreed strategies are to be recorded on the client summary sheet

<table>
<tr><th colspan="3">Client Summary Sheet</th></tr>
<tr><th>Goals</th><th colspan="2">Strategies to Achieve Goals</th></tr>
<tr><td>Goal 1:
To be able to walk around my house without the walker.</td><td rowspan="2">Supervised practice of walking between rooms without the walker with my daughter 3 times a week.
Going for a 10-minute walk with walker 2 times a day in street in the first 2 weeks then building up to 3 times a day in the next 2 weeks.</td><td>Timeframe
4 Weeks</td></tr>
<tr><td>Measurable Goal:
Able to walk within own home between rooms during the day without the need for a walker consistently (>75% of the time).</td><td>Importance
□ A little
□ Moderate
√ Very</td></tr>
<tr><td>Goal 2:
Reduce my blood pressure.</td><td rowspan="2">Take my antihypertensive medication as prescribed.
Purchase an automatic BP machine to monitor BP between visits to my doctor.
Go for a 20 minute walk most days.
Will not add salt to my evening meal.</td><td>Timeframe
4 Weeks</td></tr>
<tr><td>Measurable Goal:
Reduce BP to 130/90 measured with manual BP monitor cuff and stethoscope, on right upper limb by nurse at GP clinic at regular monthly review.</td><td>Importance
□ A little
√ Moderate
□ Very</td></tr>
<tr><td>Goal 3:
To be able to express my needs.</td><td rowspan="2">Attend communication group weekly at Community Rehabilitation centre.
Practice ordering coffee at home with husband each day.
Attend local café weekly and practice ordering with assistance from husband with a gradual reduction in the amount of assistance provided.</td><td>Timeframe
4 Weeks</td></tr>
<tr><td>Measurable Goal:
To order coffee for herself and her husband when they go to the local café and be understood by the café attendant with correct coffees received from the order.</td><td>Importance
□ A little
□ Moderate
√ Very</td></tr>
<tr><td>Goal 4:</td><td rowspan="2"></td><td>Timeframe</td></tr>
<tr><td>Measurable Goal:</td><td>Importance
□ A little
□ Moderate
□ Very</td></tr>
<tr><td>Goal 5:</td><td rowspan="2"></td><td>Timeframe</td></tr>
<tr><td>Measurable Goal:</td><td>Importance
□ A little
□ Moderate
□ Very</td></tr>
<tr><td colspan="3">Agreed Reviews: Frequency of self-review / reflection towards meeting the goal and/or planned follow-up with health professional</td></tr>
<tr><td colspan="3">Self-review (+/- family or carer): Self review with husband and daughter weekly.
Health practitioner review: Weekly Speech Pathology appointments. GP review in 4 weeks.</td></tr>
</table>