Standardised methods for setting person centred goals in stroke patients with communication impairment

Clinician Mini-Manual

Version 1

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Translational Public Health and Evaluation Division

Stroke and Ageing Research Group

Monash University

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Acknowledgements

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TYPES OF COMMUNICATION IMPAIRMENTS

Communication can be affected by multiple different aetiologies and can be affected across different modalities.

Note: different terms are sometimes used in the conditions noted below (e.g. dysphasia for aphasia). These terms are interchangeable, however the most common/preferred term for the impairment is listed below.

Aphasia: is a disorder that results from damage to the language areas of the brain. Language can be affected in expression (written and/or verbal) and/or understanding (reading and/or auditory). Aphasia varies greatly in presentation from person to person, however the two broad categories of aphasia are fluent and nonfluent. (1)

Apraxia of speech: is a motor planning difficulty, making it challenging to sequence movements for producing speech. Some symptoms include difficulty pronouncing words (particularly longer words), difficulties with repetition, and articulatory groping for the right sound. (2)

Cognitive-communication: is a problem with communication that is caused by a cognitive deficit rather than a language/speech deficit. Some symptoms include difficulty with attention, memory, understanding jokes, using inference or following directions. (3)

Dysarthria: is a muscular control difficulty resulting in impaired articulation. Symptoms can include slurred speech, slow speech, and impaired intelligibility. (4)

Dysphonia: is a disorder affecting the sound quality of the voice (5). Symptoms can include quiet, breathy, strained, or hoarse vocal quality.

Other considerations:

Cultural and Linguistic Diversity: Clearly, having English as an additional language is not a communication impairment. However it is important to be aware of with your patients in order to achieve the best communication. Consider when and how they learnt English, what is their primary language, what language is spoken the most at home/in the community, which language can they read/write/talk in. Keep in mind that it may be a different language for each modality. Will the pictures and concepts make sense from the perspective of their cultural background? (e.g. the image of the toilet it may be different in their culture). NB: use an interpreter to support your goal setting session if necessary. (6)

Hearing impairment: is a partial or total inability to hear (7). Some people may support this difficulty with sign language, cochlear implants, hearing aids, or hearing amplifiers. NB: if your patient uses sign language (Auslan), use an interpreter to support your goal setting session.

Vision impairment: is a partial or total inability to see clearly secondary to low vision, eye movement deficit, visual field impairment, and/or perceptual deficit. (8) Some people may support this difficulty with corrective surgery/laser, glasses, or contact lenses.

SUPPORTING COMMUNICATION

Auditory comprehension difficulty: Use short, simple sentences emphasising key words. Silence is good and allows the patient time to comprehend. Point to the picture and verbalise the written word above the picture. Gesture with your hands or objects if necessary to support understanding (e.g. return to driving – gesture with your hands a steering wheel). Use writing if patient is able to read, to further emphasise key words.

Reading comprehension difficulty: point to the picture associated with the word and verbalise the written words for the patient. Move through them with enough time for the patient to understand each goal item. You may need to describe each item as picture identification may also be affected. An example is "blood pressure – if you have high blood pressure we could work on lowering your blood pressure".

Written expression difficulty: let the patient point to items they want to work on. If the patient wants to write allow them pen and paper and time to write down what they want to say. Check back with the patient that you have understood and that they have written the word they wanted to (e.g. this word says home – would you like to get some information on help at home?).

Verbal expression difficulty: allow the patient time to work out what they want to say. For patients with severe difficulties establish their yes/no. This may be pointing to a yes/no board, head nod/shake, squeezing hand once for no and twice for yes. Whatever is the best strategy for that patient, it is good to know prior to your goal setting session. During goal setting ask clarifying questions (e.g. are you talking about public transport?).

Cognitive-communication difficulty: Consider how is their memory? Or attention? You may need to repeat the task instructions for completing goal setting throughout your session. You may need to take breaks and redirect their attention back to the goal setting menu at various times.

Dysarthria: if their speech is very difficult to understand the patient could try writing, drawing, pointing, or typing. Clarify that you have understood the patient ("you said you would like to work on not falling – is that correct?"). At times speech is easier to understand when people slow down. You can ask the patient to slow down.

Dysphonia: if they are so quiet that you are having trouble hearing them, ask them to use a loud voice. Ensure the background noise is reduced as much as possible (e.g. turn off the TV/radio, close the door if there is noise from outside) and you are sitting face-to-face, close to the person. If you continue to have trouble hearing them, use an amplifier/microphone if you have one available. If you don't have an amplifier/microphone, then you could ask the patient to try writing, drawing, pointing, or typing.

Vision impaired: If they have reading glasses ensure they have them on for the goal setting session. People with vision impairment typically rely heavily on verbal information – consider how much verbal information you can provide at a certain time for their memory.

Hearing impaired: If they have hearing aids make sure the batteries are working and the hearing aids are inserted properly. If they do not have hearing aids would they benefit from a hearing amplifier? People with a hearing impairment typically rely heavily on visual information – consider how you change between tasks not disorientating the patient.

COMMUNICATION STRATEGIES

Guidelines (9)

- Goals for recovery should be client-centred, clearly communicated and documented so that both the stroke survivor (and their families/carers) and other members of the rehabilitation team are aware of goals set.
- Use alternative means of communication (such as gesture, drawing, writing, use of augmentative and alternative communication devices) as appropriate.
- Promoting access and inclusion by providing aphasia-friendly formats.

Strategies

- Speak slowly, using a natural tone of voice
- Use supportive gestures
- Allow extra time
- Use yes/no questions (e.g. “would you like to improve your walking?”)
- Use close ended questions (e.g. “did you point to ‘shower’ or ‘cooking’?”)
- Present one idea at a time
- Check understanding and validate responses (e.g. “you said you would like to return to driving, is that correct?”)
- Adapt environment using face-to-face interviews with little background noise
- Provide appropriate writing tools and paper for drawing or writing to communicate as needed
- Point to pictures across the whole page monitoring for visual inattention/neglect
- Consider using a Visual Analogue Scale
- Include family/carers where appropriate
- If the patient has an augmentative and alternative communication device set up include this during goal setting (e.g. pt uses: iPad to type messages, communication board, or speech generating device)
- Use colours to support understanding (e.g. yellow background for survivor’s goal)
- Collaborate with your Speech Pathologist on what are the best strategies to support the individual as each person will require slightly different strategies.
- Check they have their glasses/hearing aids if applicable.

You can rephrase goal setting to make it easier for the patient to understand. Here are some examples:

  - What would you like to achieve?
  - What did you used to do which is now difficult?
  - What would you like to return to doing?
  - What do you want to work on?
  - What do you need to do in order to get home/work/hobbies?

EXAMPLE SCRIPT

On arrival into patient's room greet the patient, state your name, your profession, and your visit purpose. Allow breaks between chunks of information. Take the patient into a quiet therapy space or turn off background noise (e.g. TV) if you are restricted to the patient's room. Show the patient the goal setting menu and either ask the patient to read aloud the goal setting instructions or read them to the patient.

Remember: Abstract concepts are difficult to understand. Words which can be visualised are easier (e.g. driving vs stroke prevention).

"Hello Spencer, my name is Estelle. I am from occupational therapy.

Today I want to find out what you would like to work on while you're in rehabilitation.

We call this goal setting. A goal is something that you want to improve for yourself. I have a booklet (show goal setting menu) with different areas that we can work on improving. Not all of the areas will be relevant to you.

I would like you to look at the items. Then choose three, four, or five areas which you would like to improve.

These could be things you used to do which are now difficult, or things you would like to achieve. We will then discuss ways to help you achieve your goals.

The goal items are arranged into five groups.

These are your health, your mind and body, everyday activities, out and about, and healthcare and support (point to areas as reading out headings).

Look through the items and point to three to five areas that you would like to improve."

TROUBLE SHOOTING

- Are they pointing to every picture without choosing one?
    - Stop the patient (if necessary with hand up gesturing a stop sign) and model response you would like (e.g. you point to a picture e.g. 'healthy eating' then point to yourself "one of the things I would like to do is eat more healthy food" point back to picture. Allow a break of a few seconds then point to patient "what would you like to improve?" if needed gesture 'what' with hands up and shoulder shrug.
- Have they chosen multiple options?
    - Write down all the options they have chosen onto a whiteboard/piece of paper so only the options they have chosen are in front of them. This reduces visual distractions. Then ask the patient to identify their top 3 priority goals from their list.
    - Or if you're going through and they are saying yes to every item then write 1, 2, 3 on a whiteboard and say "only 3 goals". Then go through each item with yes/no board and when the patient says/points to yes then write that item under a number. Once you have 3 items written down and they proceed to say 'yes' to a fourth item, indicate your 3 written items and say "which one is least important?" (Showing the level of importance page if needed). Rub out the one they indicate and write the new item in or move past the new item if that was the least important. This way you will always have only 3 goals.
- Are they unable to point/verbalise?
    - Is the patient staring at the page without making a choice? If they look engaged in the page allow the patient time, they may be deciding on their answer. If you have allowed extra time and the patient continues to not make an attempt to choose an option go through each item with the yes/no board. Model the response you want (e.g. a yes or no). When modelling verbalise the response and point to which item you are talking about (e.g. point to 'yes' as you say '"yes" and do a head nod (yes). This is called total communication.)
- Fatigue monitoring
    - People with communication impairment will inevitably require more time to complete goal setting. Allow this extra time so the session doesn't feel rushed. Monitor for fatigue. Communicating can be exhausting for patients and the goal setting may need to be split over sessions to support the patient to make decisions and for the clinician to provide ongoing patient centred care.
- How to use family members as support
    - Family members can be a wonderful support for people with communication impairment, however they can also take over the session from the patient. When a family member is present in the session continue to ask the patient questions directly – make eye contact, use their name so they know you expect them to answer the question and not their family. Use the family as support (e.g. "you have said you want to return to cooking, is this something your family can help with?")

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APPENDIX 1A GOAL SETTING MENU

FLIP STYLE

Please print the menu on A4 paper, in colour and laminate prior to your goal setting session.

Goal setting instructions

A goal is something that you **want to improve**.

Setting goals helps with recovery after a stroke.

Instructions

1. Look at the list of items

2. Choose **1 to 5** items that you would like to improve

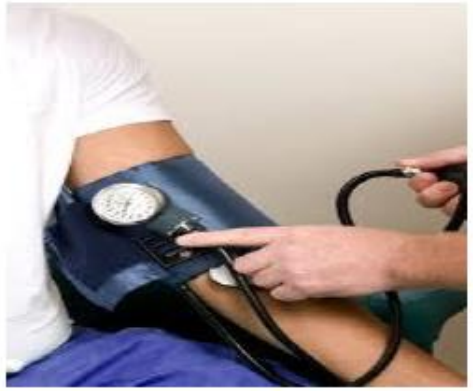
You can discuss

- What you want to improve
- Ways to help achieve your goals
- How to monitor progress
- Changing your goals when your needs change

You can talk, write, draw, point, type, and ask questions.

Your health

□ Blood Pressure



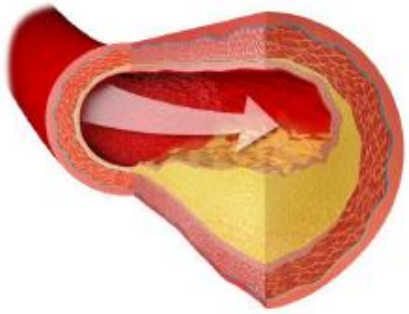
□ Diabetes

□ Healthy Eating

□ Exercise

□ Medication

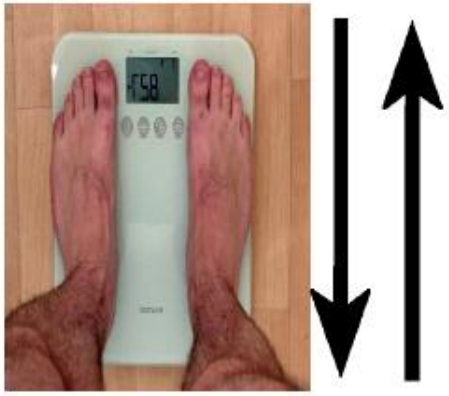
□ Cholesterol



Your health

□ Drink less alcohol

□ Change weight



□ Quit smoking

Your mind and body

□ Moving

□ Pain

□ Memory

□ Falls

□ Tired

□ Swallowing

Your mind and body

□ Bladder and bowels

□ Mood

□ Communication

□ Seeing

Everyday activities

□ Shower

□ Toilet

□ Dressing

□ Eating

□ Gardening

□ Technology

Everyday activities

□ Cooking

□ Housework

□ Washing

□ Money

□ Other activities

□ Reading

Out and About

□ Public Transport

□ Driving

□ Work

□ Leisure

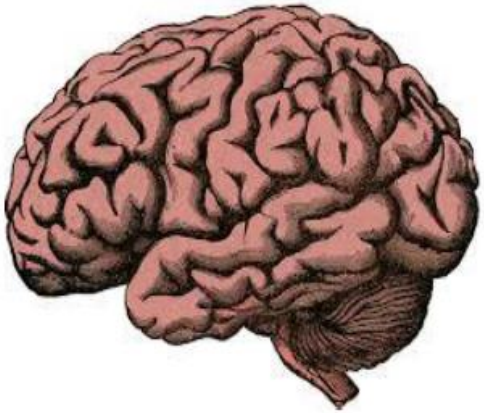
□ Relationships

□ Healthcare decisions

Healthcare and Support

□ Health information

□ Preventing stroke



□ Life after stroke

□ Support groups

□ Health professionals

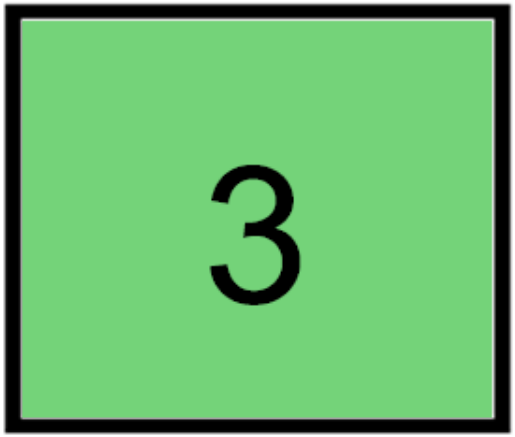
□ Home help

Yes

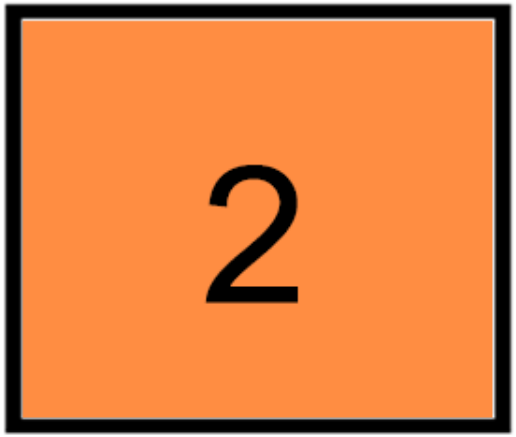
No

Level of importance

□ **Very** important



□ **Sort of** important



□ **A little** important

□ Help?

□ Where?

□ How long or often?

□ How well?

□ By when?

APPENDIX 1B GOAL SETTING MENU

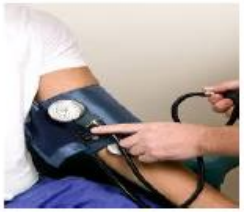
A3 STYLE

Please print the first two pages on A3 paper, in colour and laminate prior to your goal setting session.

Please print the following four pages on A4 paper, in colour and laminate prior to your goal setting session.

Your health

□ Blood Pressure



□ Diabetes

□ Healthy Eating

□ Exercise

□ Medication

□ Cholesterol

□ Drink less alcohol

□ Change weight

□ Quit smoking

Your mind and body

□ Moving

□ Falls

□ Bladder and bowels

□ Pain

□ Tired

□ Mood

□ Memory

□ Swallowing

□ Communication

□ Seeing

Everyday activities

□ Shower

□ Toilet

□ Dressing

□ Eating

□ Gardening

□ Technology

□ Cooking

□ Housework

□ Washing

□ Money

□ Other activities

□ Reading

Out and about

□ Public transport

□ Driving

□ Work

□ Leisure

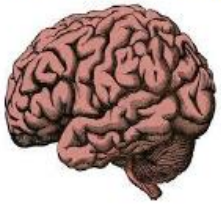
□ Relationships

□ Healthcare decisions

Healthcare and Support

□ Health information

□ Preventing stroke



□ Life after stroke

□ Support groups

□ Health professionals

□ Home help

Goal setting instructions

A goal is something that you **want to improve**.

Setting goals helps with recovery after a stroke.

Instructions

1. Look at the list of items

2. Choose **1 to 5** items that you would like to improve

You can discuss

- What you want to improve
- Ways to help achieve your goals
- How to monitor progress
- Changing your goals when your needs change

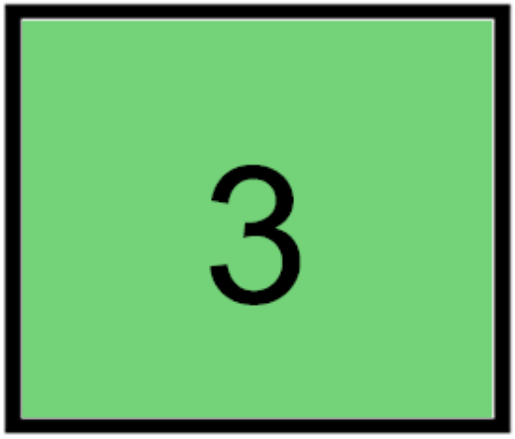
You can talk, write, draw, point, type, and ask questions.

Yes

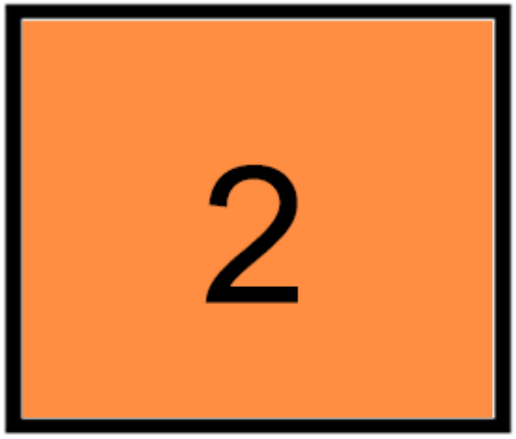
No

Level of importance

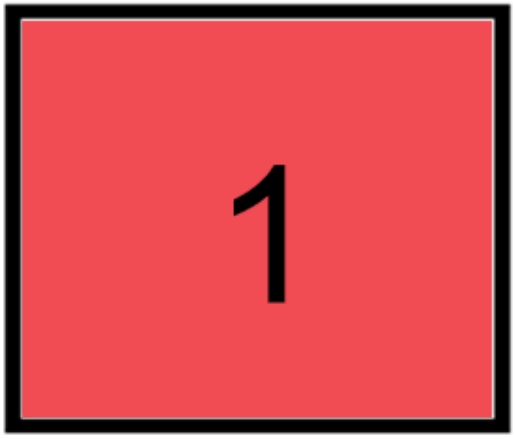
□ **Very** important



□ **Sort of** important



□ **A little** important



□ Help?

□ Where?

□ How long or often?

□ How well?

□ By when?

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 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_____

Goal

This goal is important to me

How to **measure** goal

-
-
-
-
-
-
-

Strategies to achieve goal

-
-
-
-
-
-
-
-
-

I want to achieve this goal by _____

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 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_____

Goal

This goal is important to me

How to **measure** goal

-
-
-
-
-
-
-

Strategies to achieve goal

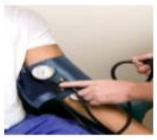
-
-
-
-
-
-
-
-
-

I want to achieve this goal by _____

APPENDIX 3. WORKED EXAMPLE USING TEMPLATES

Your health

☑ Blood Pressure



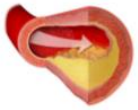
☐ Diabetes

☐ Healthy Eating

☐ Exercise

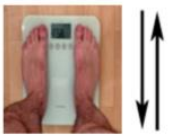
☐ Medication

☐ Cholesterol



☐ Drink less alcohol

☐ Change weight



☐ Quit smoking

Your mind and body

☑ Moving

☐ Falls

☐ Bladder and bowels

☐ Pain

☐ Tired

☐ Mood

☐ Memory

☐ Swallowing

☑ Communication

☐ Seeing

Everyday activities

☐ Shower

☐ Toilet

☐ Dressing

☐ Eating

☐ Gardening

☐ Technology

☐ Cooking

☐ Housework

☐ Washing

☐ Money

☐ Other activities

☐ Reading

Out and about

☐ Public transport

☐ Driving

☐ Work

☐ Leisure

☐ Relationships

☐ Healthcare decisions

Healthcare and Support

☐ Health information

☐ Preventing stroke

☐ Life after stroke

☐ Support groups

☐ Health professionals

☐ Home help

DISCHARGE GOAL SETTING TEMPLATE

Instructions: Survivors should 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 15 / 07 / 18

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

Goal 1

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

This goal is **very** important to me

How to **measure** goal

- Able to walk independently
- within my own home between rooms
- during the day
- without the need for a walker
- consistently (more than 75% of the time)

Strategies to achieve goal

- Monday, Wednesday, and Friday

  Walk between rooms with my walker, with my daughter Willow
- From Thursday 12th July to Wednesday 1st August

  Tuesday and Thursday

  10-minute walk without my walker around my house

  With Willow
- From Thursday 2nd August to Thursday 9th August

  Tuesday, Thursday, and Saturday

  10-minute walk without my walker around my house

  Without Willow

I want to achieve this goal by **Thursday 9th August 2018**

Goal 2

Reduce my blood pressure

This goal is **moderately** important to me

How to **measure** goal

- Blood Pressure of 130/90
- measured with manual blood pressure monitor cuff and stethoscope
- on right arm by the nurse at doctor's clinic
- at monthly appointment

Strategies to achieve goal

- In the morning each day

  Take my antihypertensive medication with food
- Go for a 20 minute walk most days
- Avoid salt in my dinner
- Purchase an automatic blood pressure machine

  Take my blood pressure between visits to my doctor

I want to achieve this goal by **Thursday August 9th 2018**

Goal 3

To be able to **express my needs**

This goal is **very** important to me

How to **measure** goal

- To order coffee for myself and my husband Matt
- when we go to the local café
- and be understood by the café attendant
- with correct coffees received from the order

Strategies to achieve goal

- Attend communication group on Thursdays

  at Community Rehabilitation centre.

- Every day

  Practice ordering coffee at home with Matt each day.

  "I would like one flat white with no sugar

  and one cappuccino with one sugar"

- Tuesdays

  Go to Coffee Club

  Order my flat white coffee

  Matt can assist if needed

I want to achieve this goal by **Thursday August 9th**