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The *why, what* and *how* of goal planning in stroke rehabilitation

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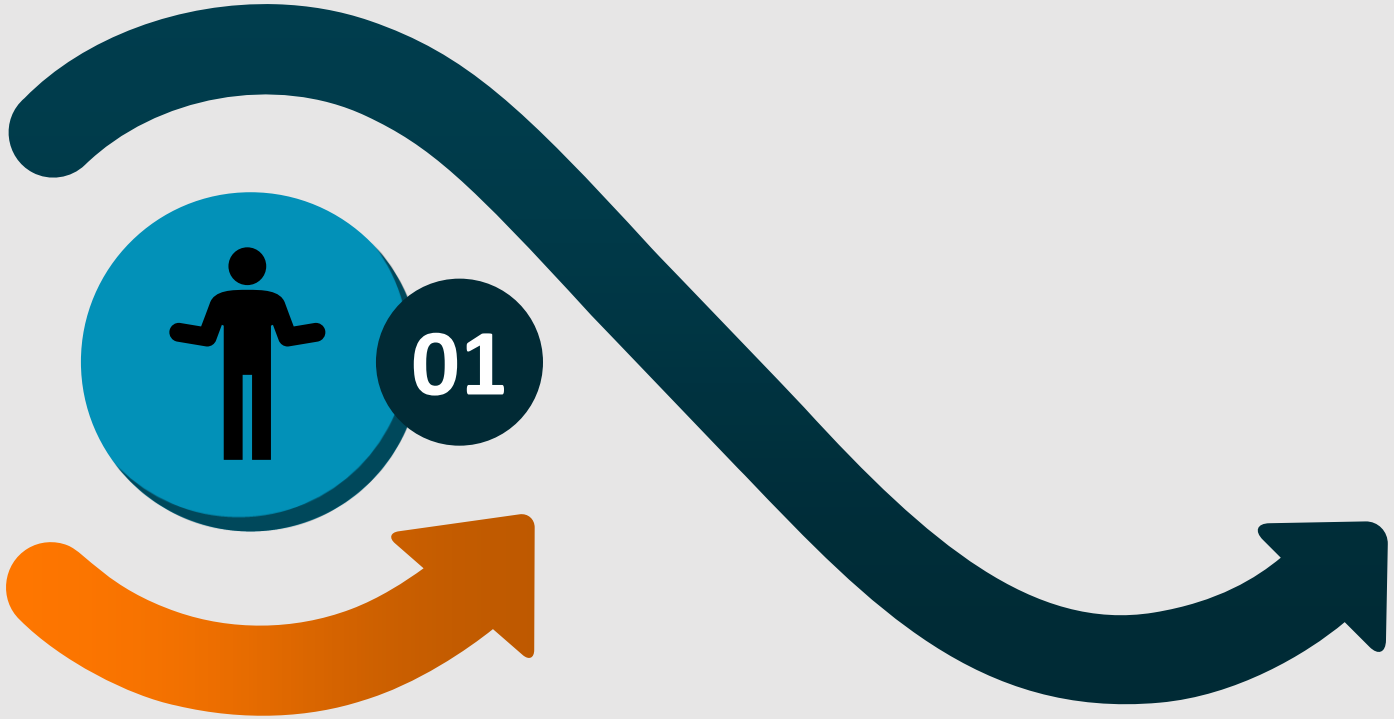
AUT CENTRE FOR PERSON CENTRED RESEARCH

Three inter-related purposes
guide our work:

1. Rethinking rehabilitation
2. Embedding person-centredness
3. Making a difference

Goal planning in stroke rehabilitation

Goal planning in stroke rehabilitation



WHY?

Goal planning in rehabilitation

"The essence of rehabilitation"

"The cornerstone of effective rehabilitation"

"One of the skills that most specifically characterises professionals involved in rehabilitation"

"A prerequisite for interdisciplinary teamwork"

There is evidence to support the implementation of stroke specific inpatient and community rehabilitation services. The benefit arises when well organised teams, work with the patient and family/whānau to achieve goals.

STROKE FOUNDATION•NZ

New Zealand Stroke Rehabilitation: A Strategy

Part A: Recommendations for the provision of best practice rehabilitation for stroke patients

UMMARY

Stroke Network (NSN) and Ministry
and outcomes of stroke rehabilitation
with stroke and their families/whānau.
s out what constitutes best practice
document will be produced which will

mentation strategies ("how to do").

There is evidence to support the implementation of stroke specific inpatient and community rehabilitation services. The benefit arises when well organised teams, work with the patient and family/whānau to achieve goals. This benefit occurs both with inpatient and community services.

The benefit derives from:

- Offering timely rehabilit
- Co-located organised i
- Well organised dedicated stroke r teams with regular team meetings
- Skilled stroke rehabilitation ther
- Goal setting in discussion with the patient/whānau and the interdisciplinary stroke rehabilitation team
- Sufficient rehabilitation intensity to achieve maximum recovery
- Options for community rehabilitation including (but not limited to) early supported discharge
- Staff and patient/family/whānau education
- Services to smooth transition back into the community, including return to work & driving, and
- Regular meetings with patient and family/whānau.

Goal setting in discussion with the patient/whānau and the interdisciplinary stroke rehabilitation team

Purposes of goal planning in rehabilitation

- Multiple (possibly conflicting) purposes
  1. To improve patient outcomes
  2. To enhance patient autonomy
  3. To evaluate outcomes
  4. To respond to contractual / legislative / professional requirements

- One approach is unlikely to achieve all this

(Levack et al. 2006)

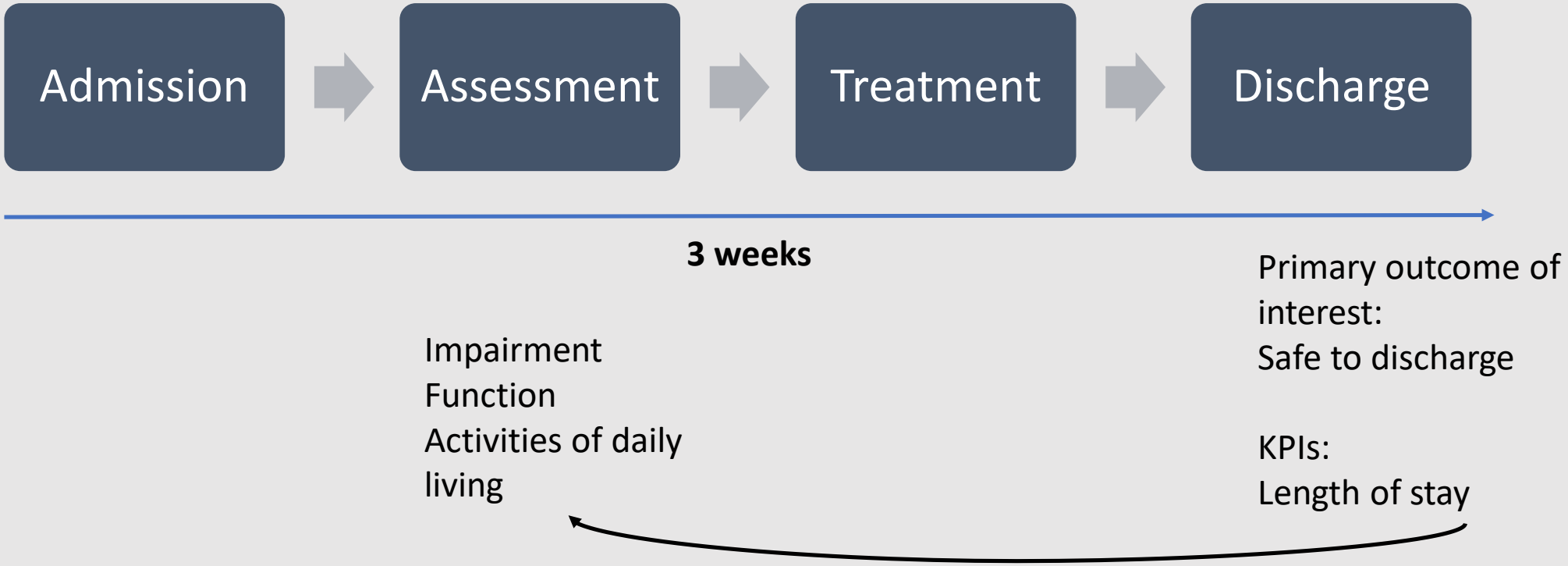
So….

- What should be our primary driver for goal planning in stroke rehabilitation?
- How might that inform…
  - What types of goals we set?
  - How we do it?

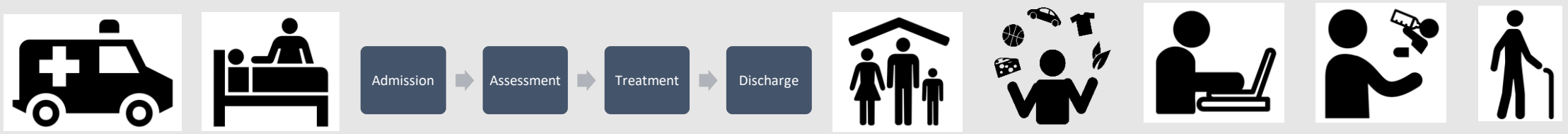
Stroke rehabilitation in context

- Despite knowledge advance re: effective prevention, treatment and rehabilitation in stroke
  - Efficacy ≠ real world effectiveness
  - The long-term burden of stroke remains significant and is growing
- For many people, rehabilitation requires
  - Intensive effort over long periods of time
  - Sustained engagement is key
- Services largely targeted at acute/subacute phase
  - A strong rhetoric of ‘self-management’ beyond that

Where we tend to focus our energy



But, for the person with stroke…



A life time

?

Primary outcome of interest:
Long term health and well-being

KPIs:
Living a healthful and meaningful life

A shift necessary?

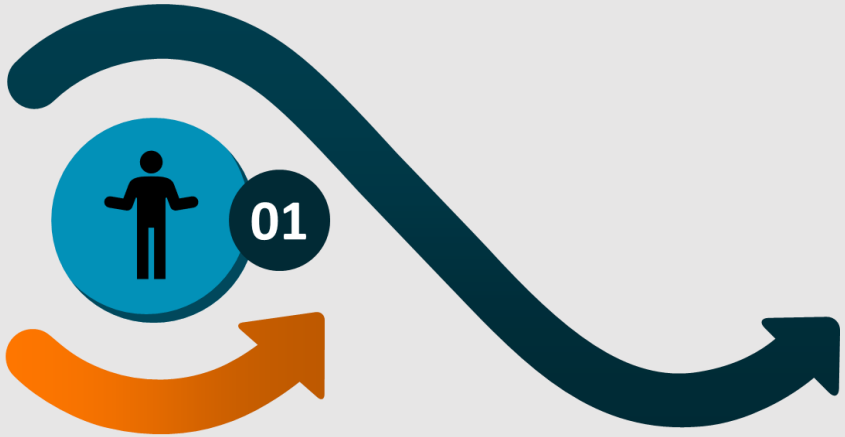
Acute event	→	Long term condition
Self-management	→	Co-creating health

Our primary driver for goal planning in stroke rehabilitation?

- To what extent could our goal planning processes:
  a) Support sustained engagement in a process of recovery?
  b) Build capability for long-term health and well-being?

- And in doing so…. have therapeutic potential in their own right?

Goal planning in stroke rehabilitation



WHY?

To:

a) create the context for sustained engagement

b) build capability for future health and well-being

Goal planning in stroke rehabilitation

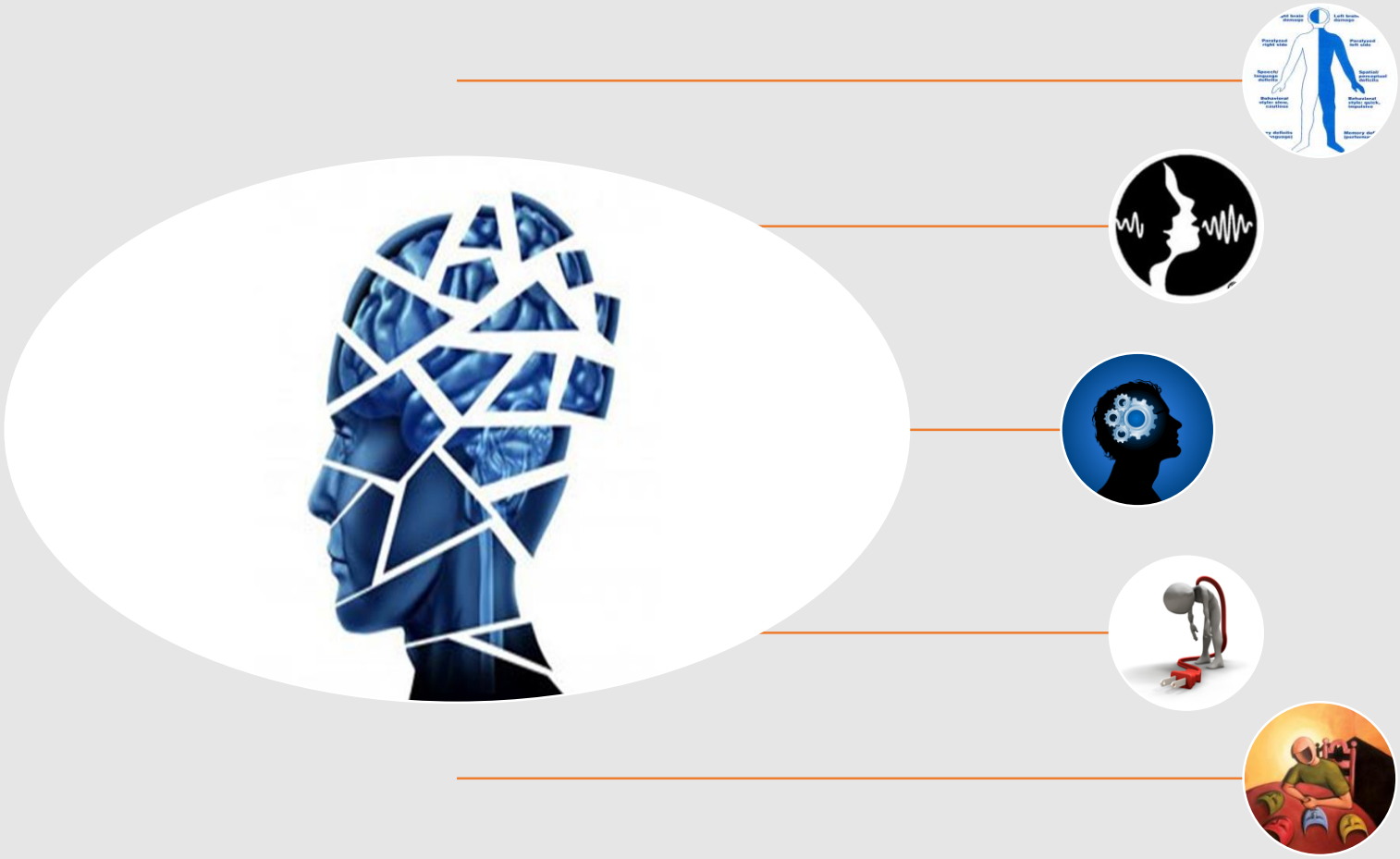
A helpful starting point?

Self-regulation Theory

- Most human behaviour is goal-directed
- People strive towards multiple goals
- **Success in achieving desired goals is determined by one's own skill in regulating cognition, emotions and behaviour**
- Progress or failure in goal attainment has affective or emotional consequences
- Goal attainment, motivation and affect closely related and will interact

(Siegert, McPherson & Taylor, 2004)

Consider this in the context of stroke



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- **Goal attainment, motivation and affect closely related and will interact**

(Siegert, McPherson & Taylor, 2004)

So….

- If we want to:
  a) create the context for sustained engagement
  b) build capability for future health and well-being

- Our goal planning processes need to support self-regulatory skill development

SMART goals – prevails as the dominant approach?

- S – Specific
- M – Measurable
- A – Achievable
- R – R
- T – T

Evidence for SMART?
Surprisingly weak - except for ‘specific’

Challenging the principles of SMART

- S – Specific
- M – Measurable
- A – Achievable
- R – Realistic
- T – Timebound

Do goals need to be (A) achievable?
…or does progress towards a demanding goal (while not necessarily attaining it) bring about positive outcomes and help patients/clients become more involved in the process?

Do goals need to be (R) realistic?
…or do aspirational goals play an important part in sustaining motivation to keep striving and working at rehabilitation?

Do Goals need to be (T) timebound?
…or does a fixation on short term achievement impact negatively on long term recovery and adaptation?

SMART goals

- S – Specific
- M – Measurable
- A – Achievable
- R – R
- T – Ti

Do not necessarily….
…create the context for sustained engagement
…build capability for future health and well-being

Why?

- Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  - Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’

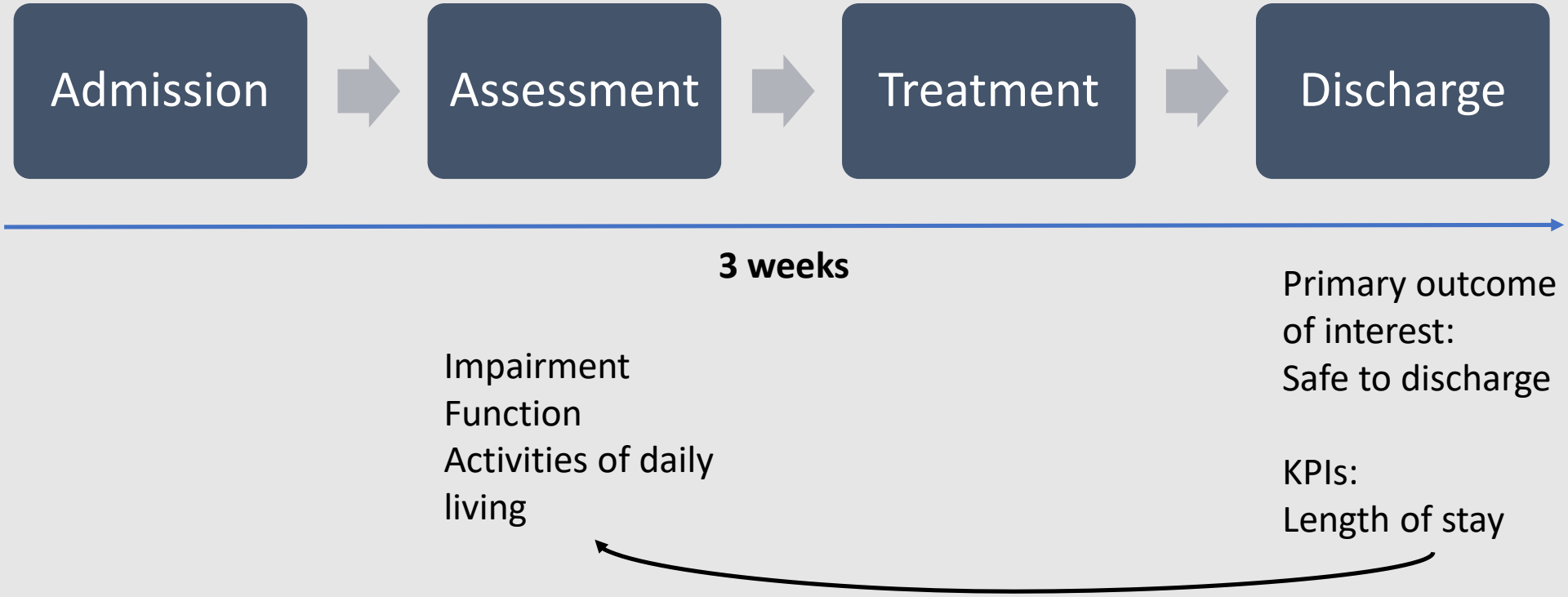
I remember the first time the therapist at the hospital talked about setting goals, I said something about tramping again, perhaps swimming, perhaps even playing golf again. She said – “what about getting up in the morning and getting dressed?” – and I thought hell’s teeth, we’re on a different page here and my heart sank a bit.

(Person w Stroke)

Why?

- Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  - Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’
- Specific to a discrete episode of care – frequently just a small part of the patients rehabilitation journey

e.g.


Admission
Assessment
Treatment
Discharge
3 weeks
Primary outcome of interest:
Safe to discharge
KPIs:
Length of stay
Impairment
Function
Activities of daily living

Why?

- Tend to reflect disciplinary-specific or service-centred goals, versus personally meaningful goals
  - Focus on ‘realistic’ and ‘achievable’ versus ‘hope’ and ‘challenge’
- Specific to a discrete episode of care – frequently just a small part of the patients rehabilitation journey
- Emphasis on goal characteristics (not goal-directed behaviour)
  - Unlikely to build self-regulatory skill

SMART goals

- S – Specific
- M – Measurable
- A – Achievable
- R – R
- T – Ti

But, if not SMART, then what?

Person-centred rehabilitation

Engagement

DISABILITY AND REHABILITATION
https://doi.org/10.1080/09638288.2018.1561952

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

OPEN ACCESS Check for updates

Person centered care in neurorehabilitation: a secondary analysis

Zealand

ome of the complexities of

ARTICLE HISTORY
Received 1

Goal planning

litation 2009; 23: 296-309

study of self-regulation informed goal setting

Therapeutic relationship

Disability & Rehabilitation, 2012; Early Online: 1–5
© 2012 Informa UK, Ltd.
ISSN 0963-8288 print/ISSN 1464-5165 online
DOI: 10.3109/09638288.2012.670044

PERSPECTIVES IN REHABILITATION

Human technologies in rehabilitat our clients

Nicola M. Kayes & Kathryn M. McPherson

Person Centred Research Centre, Health and Rehabilitation

Purpose: It is often observed that different rehabilitation practitioners carrying out the same intervention can have a quite different impact on outcome. The relationship or connection between the practitioner and patient, referred to here as the therapeutic alliance (TA), is receiving growing attention as potentially contributing to the disparate response to treatment observed. In this paper, we discuss what we currently know about the TA in rehabilitation and its impact on engagement (and what do we not know) and consider the ramifications of not knowing. *Key Messages*: The TA is increasingly identified as an important determinant of engagement in, and health outcome following, rehabilitation. However, research identifying its core components is limited, with very little exploring *how* practitioners might develop a more positive TA with patients. Further, what we do know/understand is limited by inadequate measurement tools. Research aiming to better understand the key ingredients of the TA that contribute to outcome and its role in rehabilitation is urgently required. *Conclusions*: Arguably, if we fail to advance knowledge in this field and seek answers to some of the questions we have raised, we may fail to tap into the true potential of the TA as a covariate of rehabilitation outcome.

Keywords: Connection, collaboration, partnership, therapeutic relationship, therapeutic alliance

Introduction

All too often, what is found to be efficacious in research fa to translate to an effective strategy in real world rehabilitati practice [1–3]. It has also been observed that different pra titioners carrying out the *same* intervention can have a quite *different* impact on patient perceptions of the quality of care [4,5], and indeed outcomes [6,7]. These findings highlight that while *what* we do is important, aspects of *who* we are, and *how* we work with our clients may be crucial.

Original Article

CLINICAL REHABILITATION

Co-constructing stroke rehabilitat study exploring h engagement can engagement

Felicity AS Bright[1], Nicol Christine Cummins[1], Linc and Kathryn M McPherso

Abstract

Objective: To explore how pract influence patient care and engagem

Design: A qualitative study using t focus groups and observations.

Setting: Inpatient and community

Subjects: Eleven people experiencin

Interventions: Not applicable.

Results: The practitioner's engag When patients considered practiti practitioners were not engaged, th engagement was important but co patient. Disengagement was taboo outcomes, or when having an emo influenced the other, suggesting it v

Conclusions: Practitioner engagen disengagement was reported by mo

Keywords

Patient participation, attitude of he

Date received: 20 October 2016; accepted:

physiotherapist perceptions of factors associated with treatment success and found that the majority perceived the therapeutic relationship and patient resources to be more important than the treatment itself [13]. Dahlgreen et al. [14] interviewed a group of physiotherapists regarding their

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informa healthcare

RESEARCH PAPER

Bridging the goal intention–action gap in rehabilitation: a study of *if-then* implementation intentions in neurorehabilitation

Paula Kersten[1], Kathryn M. McPherson[2], Nicola M. Kayes[1], Alice Theadom[1,3], and Alana McCambridge[2]

[1]*Person Centred Research Centre, School of Rehabilitation and Occupation Studies, AUT University, Auckland, New Zealand,* [2]*Movement Neuroscience Laboratory, Department of Sport and Exercise Science, University of Auckland, Auckland, New Zealand, and* [3]*The National Institute for Stroke and Applied Neurosciences, School of Rehabilitation and Occupation Studies, AUT University, Auckland, New Zealand*

Abstract

Purpose: To test the feasibility and acceptability of an implementation intention strategy (*if-then* plans) increasingly used in health psychology to bridge the goal intention–action gap in rehabilitation with people with neurological conditions who are experiencing difficulties with mobility. *Methods*: Twenty people with multiple sclerosis (MS) and stroke, randomised to an experimental and control group, set up to three mobility related goals with a physiotherapist. The experimental group also formulated *if-then* plans for every goal. *Data collection*: Focus groups and interviews with participants and therapists; Patient Activation Measure (PAM), 10-m walk test, Rivermead Mobility Index, self-efficacy, subjective health status, quality of life. *Results*: Qualitative data highlighted one main theme: *Rehabilitation in context*, encapsulating the usefulness of the *if-then* strategy in thinking about the patient in the context of complexity, the usefulness of home-based rehabilitation, and the perceived need for a few more sessions. Changes in walking speed were in the expected direction for both groups; PAM scores improved over 3 months in both groups. *Conclusion*: *If-then* plans were feasible and acceptable in bridging the goal intention–action gap in rehabilitation with people with MS and stroke, who are experiencing difficulties with mobility. This approach can now be adapted and trialled further in a definitive study.

Keywords

Adults, goals, intentions, multiple sclerosis, neuro-rehabilitation, stroke

History

Received 27 September 2013
Revised 11 August 2014
Accepted 12 August 2014
Published online 28 August 2014

➤ Implications for Rehabilitation

- Goal planning in rehabilitation necessitates specific strategies that help people engage in goal-related tasks.
- *If-then* plans aim to support people to deal more effectively with self-regulatory problems that might undermine goal striving and have been found to be effective in health promotion and health behaviour change.
- This feasibility study with people with a stroke and multiple sclerosis has demonstrated that *if-then* plans are feasible and acceptable to patients and physiotherapists in supporting goal-directed behaviour.

Behavioural strategies

Introduction

Goal planning in rehabilitation is now well-accepted practice. However, many questions remain about the best way this should be done; whether the resources needed to do this are outweighed by the benefits achieved; whether the approach is generalisable to people with cognitive problems, and whether setting goals influences goal-directed behaviour [1–5]. It may seem that setting long-term goals and specifying the targeted goal-directed behaviour (i.e. explicitly stating an intention) in itself is sufficient to support a person to engage in rehabilitation, or a self-managed rehabilitation programme. In fact, there is increasing evidence that even in healthy populations, having intentions to work towards a goal only moderately predicts the actual goal-directed behaviour (28% of variance explained) [6]. In other words, often the very best intentions to do something (e.g. eating healthier, doing more exercise) do not translate into the desired action.

The behaviour change literature refers to this conundrum as the "'intention–behaviour gap'" [6]. This gap can occur when people fail to get started (i.e. they don't do any exercises they planned), get derailed (i.e. they began with the exercise programme but gave up), or as a result of negative states (i.e. low mood or low levels of confidence impact on exercising) [4,7,8]. Various reasons for this

Hope

APHASIOLOGY, 2012, *iFirst*, 1–18

Psychology Press
Taylor & Francis Group

SR Research Group
litation Research Centre,

Hope in people with aphasia

F. A. S. Bright[1], N. M. Kayes[1], C. M. McCann[2], and K. M. McPherson[1]

[1]Person Centred Research Centre, Health and Rehabilitation Research Institute, AUT University, Auckland 1142, New Zealand
[2]Department of Psychology Speech Science, The University of Auckland, Auckland 1142, New Zealand

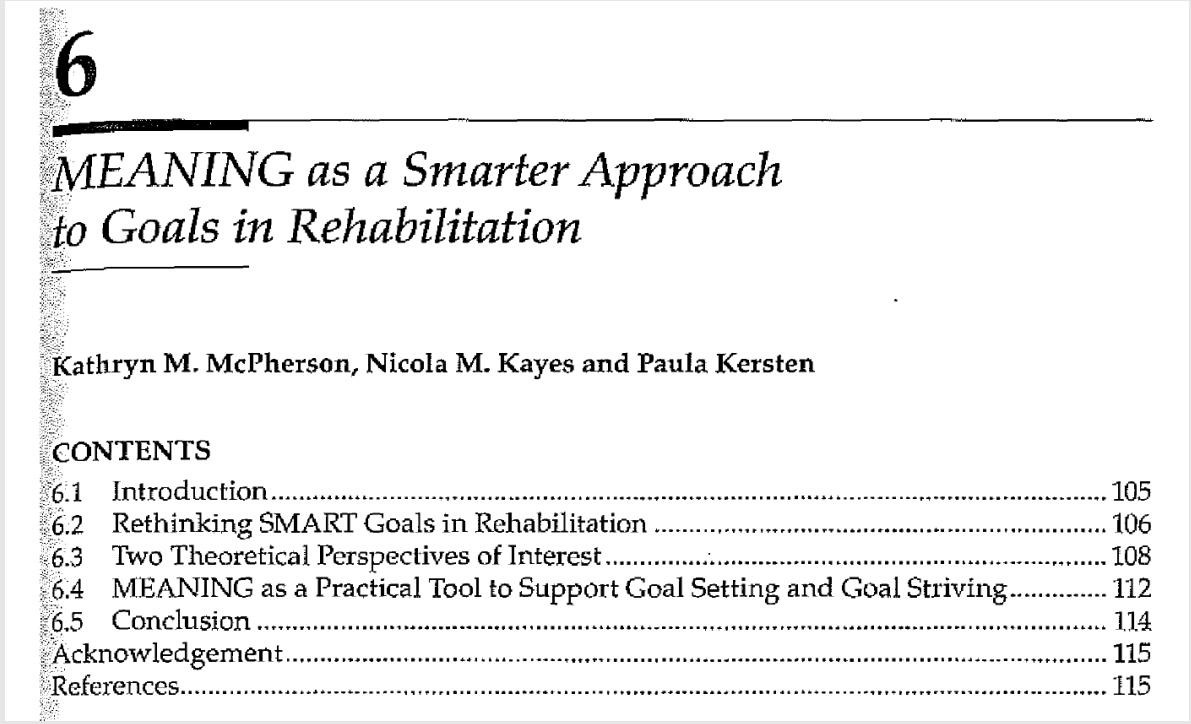
Background: Hope is considered to be important for health, recovery, and rehabilitation outcomes in a range of healthcare populations. Little is known about hope in people following stroke, and even less is known about hope in people with aphasia following stroke as they are commonly excluded from research in this field.
Aims: This study aimed to explore how hope was experienced by people with aphasia following stroke during the post-acute period of rehabilitation, and to identify factors influencing the experience of hope.
Methods & Procedures: This study utilised an Interpretive Description methodology. Data were collected through semi-structured interviews with five people with aphasia. Supported conversation techniques were used to facilitate full contribution of participants. Data were analysed using a number of approaches—coding, thematic analysis, narrative construction, diagramming, and memoing.
Outcomes & Results: Hope was experienced in two ways. *Simply 'having' hope* was a broad but passive sense of hope which appeared to be the primary, constant form of hope. *Actively hoping* was an active, future-oriented form of hope that was experienced intermittently by participants. The experience of hope appeared dynamic and complex and seemingly influenced by three primary factors: uncertainty about the future; viewing hope as double-sided; and a sense of disruption. These were in turn influenced by a person's past experiences, present reality and perceived future.
Conclusions: Hope is considered important by people with aphasia. It appears related to how people engage in rehabilitation and may be influenced by clinicians. As such, it is a concept that therapists should be aware of. Suggestions for how clinicians may consider and address hope are provided and discussed.

Keywords: Hope; Aphasia; Rehabilitation; Stroke.

Hope is said to be important in rehabilitation and living with illness or injury (Barker & Brauer, 2005; Bluvol, 2003; Dorsett, 2010; Gum, Snyder, & Duncan, 2006; Lohne & Severinsson, 2004; Nekolaichuk, Jevne, & Maguire, 1999; Simpson, 2004; Soundy et al., 2010). It is commonly considered a multi-dimensional construct (Dufault & Martocchio, 1985; Farran & Popovich, 1990; Morse & Doberneck, 1995;

Meaningful goals

- A personalised approach to goal planning
- Explicitly targeted at building self-regulatory skill and capability
- An intervention vs. a means to an end



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MEANING as a Smarter Approach to Goals in Rehabilitation

Kathryn M. McPherson, Nicola M. Kayes and Paula Kersten

CONTENTS

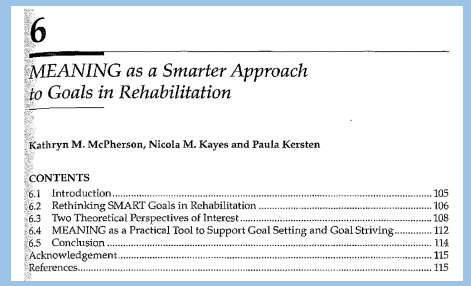
Goal planning in stroke rehabilitation

To:

a) create the context for sustained engagement

b) build capability for future health and well-being

Move beyond SMART to Meaningful goals



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MEANING as a Smarter Approach to Goals in Rehabilitation

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Goal planning in stroke rehabilitation

Goal MAP

Identifying what matters most	Anchor concrete actions, goals, tasks of therapy to what matters most	Planning to support implementation of goals into action
Meaning M	Anchor A	Planning P
The why?	The what?	The how?

Step 1: Meaning

- Prioritising therapeutic relationship
- Knowing what matters as the context for goal-related activity is a powerful tool
- The most adaptive form of self-regulatory behaviour relate to the ability to:
  - select concrete, manageable goals (lower order tasks)
  - that are linked to personally meaningful (higher-order) representations

Emmons (1996)

The critical points?

- Focus on
  - Getting to know
  - Broader hopes and aspirations
- Encourage people to move beyond impairment or to articulate vague goals in more detail
  - E.g. “I just want to walk again”, “I just want to get better”
- Helping people to move beyond the ‘what’ to the ‘why’?
  - E.g. “I just want to drive again”

Step 2. Anchor

- Anchor goals, tasks and activities (explicitly) to what matters most
  - A tool for making sense of therapy
- Negotiate levels of progress towards attainment
  - Links to mood/motivation/sense of self
- Modelling a strategy for the clients continued use

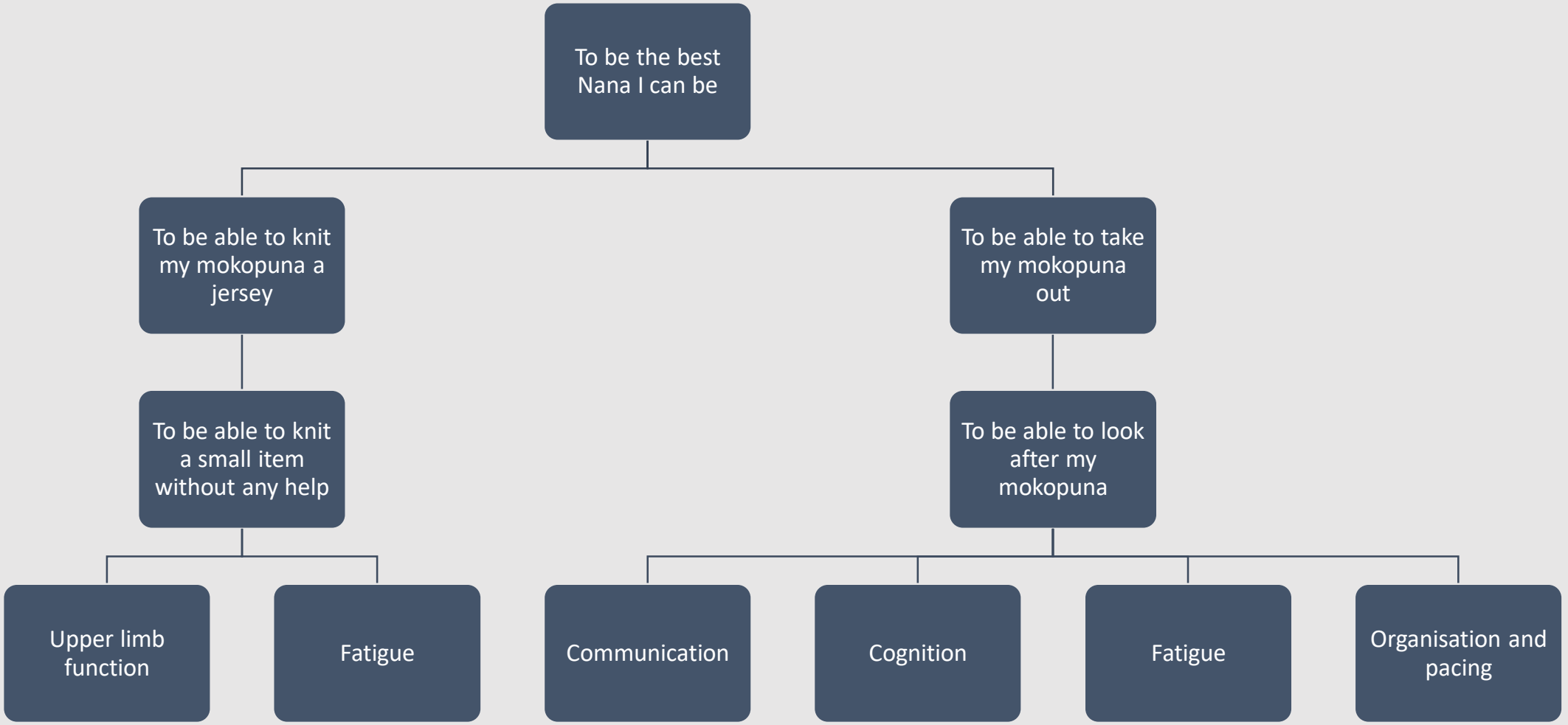
Higher order hopes

Broad
Abstract
Conceptual
Linked to desired self-image

Concrete
Manageable
Lead to achievement of higher order goals

Lower order goals

(Siegert, McPherson & Taylor, 2004; Emmons, 1996)


To be the best Nana I can be
To be able to knit my mokopuna a jersey
To be able to take my mokopuna out
To be able to knit a small item without any help
To be able to look after my mokopuna
Upper limb function
Fatigue
Communication
Cognition
Fatigue
Organisation and pacing

Negotiating levels of goal progress

To be the best nana I can be		
Fantastic outcome	Able to knit my mokopuna a jersey	Able to take my mokopuna out for a treat
Great/ better than expected	Able to hold a knitting needle and make a small item without any help	Able to look after my mokopuna for an afternoon
Expected outcome	Able to hold a knitting needle and make some stitches with a little bit of help	Able to enjoy having my mokopuna come for a visit
Current level	I can't hold a knitting needle	I can only cope with having my mokopuna around for a few minutes and I don't enjoy it
If things got worse	Not able to do anything for or with my mokopuna	

The critical points?

- Explicitly link broader hope to the tasks and goals of rehabilitation
- Negotiate goal levels to allow for a sense of progress and experience of success
- Use the clients words where possible

Step 3. Planning

- Action and coping plans to support goal-related activity
- We all have good intentions – some of mine…
  - I'm going to exercise more
  - I'm going to eat breakfast
  - I'm going to manage my work-life balance better
- BUT often a gap between what we intend to do – and what we actually do
  - The Intention-Behaviour Gap

Intention-behaviour continuity

- Continuity between intentions and action only holds when:
  - The behaviour in question is discrete not repetitive;
  - The behaviour is fully under the control of the individual;
  - The costs and benefits of the behaviour occur at the same point in time allowing for equal temporal weighting

(Hall et al 2008)

Planning for action

- Translating intentions into action needs explicit management

  Gollwitzer and Sheeran (and others)

- Rehearsal of ‘specific’ plans = more likely the intention will be implemented
  - ‘If-then’ plans

If-then plans

Failing to get started (Action plan)	*If* it is 9am on Tuesday or Thursday, *then* I will walk to the end of my street & back
Getting derailed (Coping plan)	*If* it is raining when I am meaning to go for a walk, *then* I will drive to the local shopping mall and walk from the supermarket to my favourite clothes shop and back again
Negative states (Coping plan)	*If* I start to feel anxious about going for a walk, *then* I will remind myself that in the past walking has made me feel good

Goal MAP in summary

Identifying what matters most	Anchor concrete actions, goals, tasks of therapy to what matters most	Planning to support implementation of goals into action
Meaning M	Anchor A	Planning P
The why?	The what?	The how?

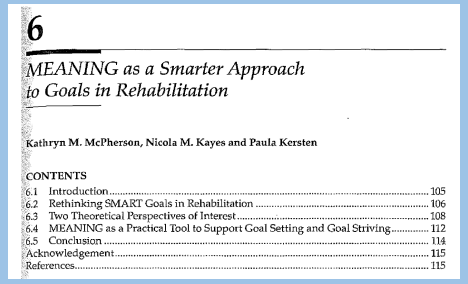
Goal planning in stroke rehabilitation

To:

a) create the context for sustained engagement

b) build capability for future health and well-being

Move beyond SMART to Meaningful goals



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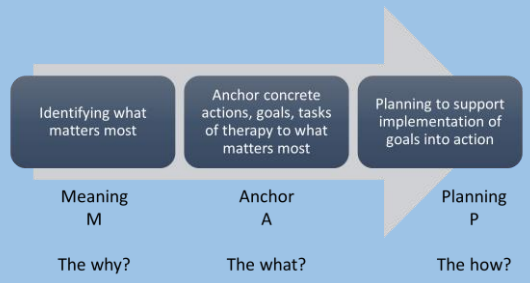

AUT CENTRE FOR PERSON CENTRED RESEARCH

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Always in conversation . Engaging with diversity . Connecting as people . Pushing the boundaries