Adult Social Care

Best Practice Guidance for Outcomes

Assessing people's needs **and strengths,** to determine what their aspirations are, being able to support them to meet these aspirations through their care and support.

Using the **S.M.A.R.T** methodology we can support realistic outcomes for people which they can use to further their independence.

S – SPECIFIC

What exactly are we going to do? With/for whom? What is the specific outcome for the individual?

This must be well defined and clear and at the end of this intervention be what will have changed for the person.

It's easier to accomplish a specific goal than a general one; e.g. "re-join my old lunch club and attend twice a week".

M – MEASURABLE

There should be concrete criteria for measuring progress toward the attainment of outcomes.

How will you know when the outcome has been achieved? How will you measure progress towards the outcome?

A – ATTAINABLE/ACHIEVABLE

When people (not just a professional) identify outcomes that are really important to them (e.g. be able to cook a Sunday lunch) they are more likely to develop the attitudes and ability to reach them.

Can we realistically get this done in the time frame/within available resources?

Outcomes should not be beyond the person's or the service's capabilities.

R – REALISTIC

Outcomes should represent an objective that people are willing and able to work towards. They should also be set at a sufficiently high level that they represent real progress.

Is the outcome relevant and proportionate? Is it within reach and possible?

T – TIMELY/TIME LIMITED

Outcomes should be grounded within a time frame (e.g. by the end of the week/month/year I will be able to button my own cardigan).

DOs AND DONTs OF RECORDING OUTCOMES

DO - make them responsive to an individual's needs.

DO - make them person centred and developed with as much participation as possible by the individual.

DO - involve the individual's family and friends in agreeing outcomes. Sensitively negotiate any conflicting or opposing views using professional judgement.

DO - remember that an individual's definition of independence may be very different to yours.

DO - make sure you have a clear understanding of the individual's priorities and what aspects of their life they feel are central to feeling independent.

DO - revisit the outcomes at agreed timescales, e.g. at six weekly review or annual review.

DO - review the person's needs if progress towards the goals is not met.

DON'T - confuse specific tasks as SMART outcomes, e.g. "Refer to speech therapist" is not an outcome - that is a task.

DON'T - misunderstand the person's own aspirations and what they feel would make them feel more independent otherwise there is a risk they will become demoralised when they are not being helped to achieve their personal outcomes.

DON'T - use terminology like 'ongoing' and 'ASAP' or "Achieve full potential". How will you know? How will you measure this?

DON'T - make outcomes too general, too vague or immeasurable.

DON'T - use expressions that are too broad or too vague and not SMART, e.g. "Is healthy", "Is safe"

Sources: **www.scie.org.uk** and **www.east-ayrshire.gov.uk**

If information is used from previous assessments/reviews/support plans this must be clearly identified where the information is from, who completed the assessment and why it is now still relevant.