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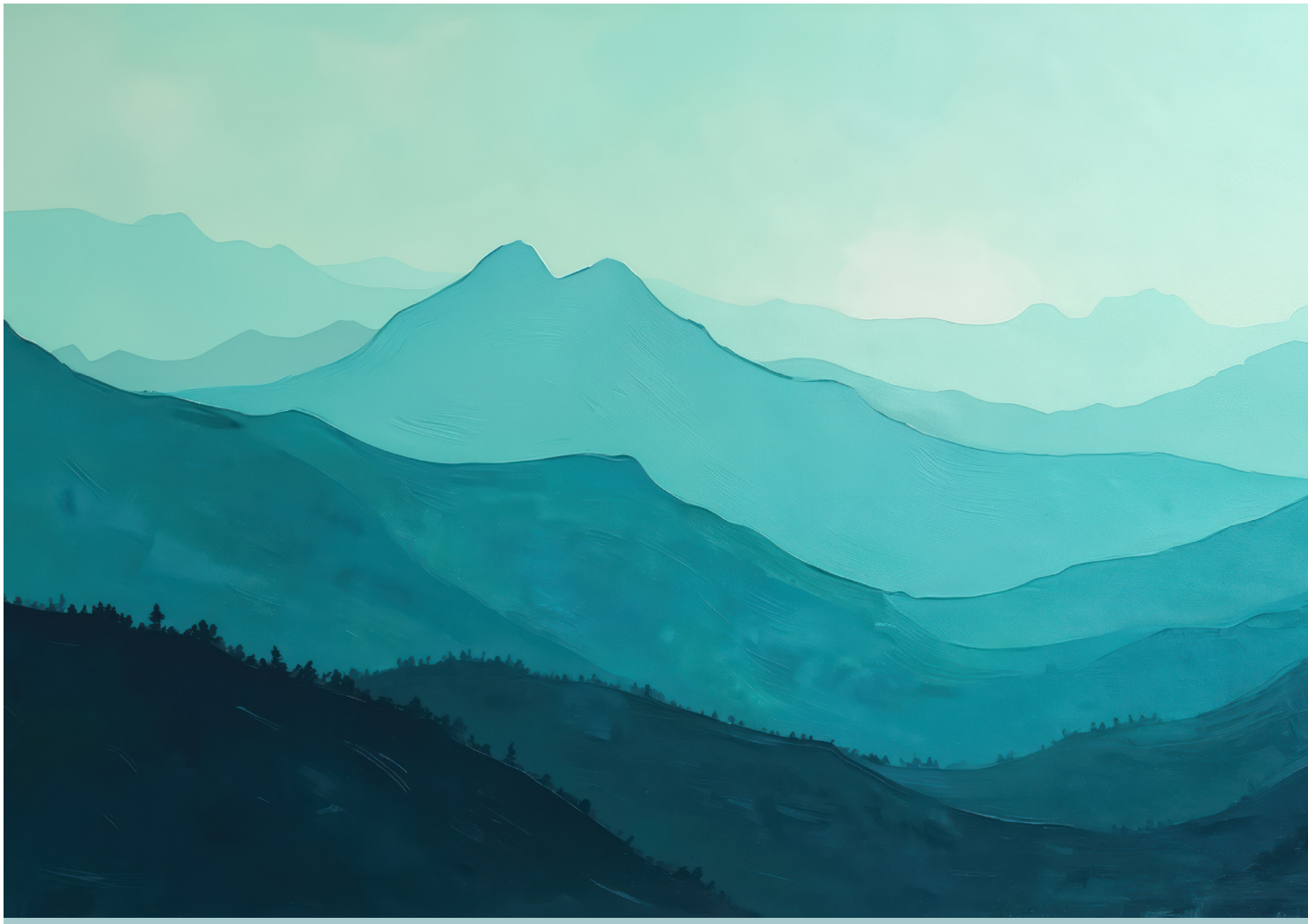
The PRACTIC Goalsetting Interview (PGSI)



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PRACTIC Goalsetting Interview (PGSI)

The PGSI was inspired by the Bangor Goal-Setting Interview (BGSI), originally developed by Clare, L., et al. (2019). "Individual goal-oriented cognitive rehabilitation to improve everyday functioning for people with early-stage dementia: A multicentre randomised controlled trial (the GREAT trial)." International journal of geriatric psychiatry 34(5): 709–721. The PGSI has been validated in a study among home care recipients (*Ref. 1). When the PGSI is used together with the model TIME as part of the assessment, research shows better goal attainment and reduced frailty among home-dwelling patients compared to the use of the PGSI alone (*Ref. 2).

*Ref 1: Væringstad A., et al. Development of the PRACTIC Goal-Setting Interview (PGSI) for frail community-dwelling patients. Feasibility, interrater reliability and content validity—A Mixed Methods Study. Patient preference and adherence (submitted) 2025.

*Ref 2; Væringstad A., et al. Preventing and Approaching Crises for frail community-dwelling patients Through Innovative Care (PRACTIC) – a cluster randomised controlled trial BMJ Open (submitted) 2025.

The Research Centre for Age-Related Functional Decline and Disease, Innlandet Hospital Trust, Ottestad, Norway (2022).
Developed by A. Væringstad, Ø. Kirkevold, J. Myhre, I. H. Feiring, S. Bergh & B. Lichtwarck.

The PRACTIC Goalsetting Interview contributes to identify individual goals, and in a quick and simple way assesses the individual's goal achievements both before and after interventions.

PGSI can be used to identify common goals defined by the patient, next of kin and staff in the home care services.

Date:.....

Interviewer:

.....

☐ Baseline ☐ 12 weeks ☐ 24 weeks

Step 1: Identify areas to work with

Talk to the person, next of kin, and the staff in the homecare services about what is important for them, and what could be better in the person's situation (see the manual for examples of possible areas to work on):

Step 2: Define the first SMART goal

Agree on the specific SMART goal: Specific, Measurable, Achievable, Realistic, and Time limited

Goal statement 1:

Description of current attainment (view of the person and next of kin about the current performance):

Description of current attainment (view of the staff in the homecare services about the current performance, if relevant):

Step 2: Define the second SMART goal (if desired)

Agree on the specific SMART goal: Specific, Measurable, Achievable, Realistic, and Time limited

Goal statement 2:

Description of current attainment (view of the person and next of kin about the current performance):

Description of current attainment (view of the staff in the homecare services about the current performance, if relevant):

Step 2: Define the third SMART goal (if desired)

Agree on the specific SMART goal: Specific, Measurable, Achievable, Realistic, and Time limited

Goal statement 3:

Description of current attainment (view of the person and next of kin about the current performance):

Description of current attainment (view of the staff in the home care services about the current performance, if relevant):

Step 3 and 4: Ratings of readiness to change and goal attainment

Use the Visual Rating Scales to explain and complete the ratings. Write down the ratings here.

Readiness to change: the person's perception of his/her readiness to change to achieve the goal (from 1–10)
1 = not ready to work with the goal 10 = extremely ready to work with the goal

Attainment: how the person/the staff are currently performing in relation to the goal (from 1–10)
1 = cannot do or am not doing successfully 10 = can do and am doing very succesfully

	Person / Next of kin	Staff in home care service
Goal 1		
Readiness to change /motivation		Not relevant
Attainment at baseline		
Attainment at 12 weeks		
Attainment at 24 weeks		
Goal 2 (if desired)		
Readiness to change /motivation		Not relevant
Attainment at baseline		
Attainment at 12 weeks		
Attainment at 24 weeks		
Goal 3 (if desired)		
Readiness to change /motivation		Not relevant
Attainment at baseline		
Attainment at 12 weeks		
Attainment at 24 weeks		

Appendix 1: Visual Rating Scale

Visual Rating Scale: Readiness to change

1 2 3 4 5 6 7 8 9 10

👎 Not at all ready to work on the goal

Extremely ready to work on the goal 👍

Visual Rating Scale: Attainment

1 2 3 4 5 6 7 8 9 10

☹ Cannot do / am not doing successfully

Can do and am doing very successfully ☺

Appendix 2: Manual

This document provides an overview of the goal-setting process using the PRACTIC Goal-Setting Interview (PGSI). PGSI is inspired by the Bangor Goal-Setting Interview (BGSI), Clare, and the BGSI manual, by Clare, L. et al., The University of Exeter, Exeter, United Kingdom, 2016. The PGSI has been validated in a study among home care recipients (*Ref.1, page 2). When the PGSI is used together with the model TIME as part of the assessment, research shows better goal attainment and reduced frailty among home-dwelling patients compared to the use of the PGSI alone (*Ref. 2, page 2).

PRACTIC goalsetting interview (PGSI)

Background

PGSI is a goal-setting interview inspired by the Bangor Goal-Setting Interview (BGSI) (https://psychology.exeter.ac.uk/reach/publications/). PGSI helps identify individual goals and quickly and easily assesses the individual's goal achievement, both before and after interventions. This makes changes visible. PGSI can be used to establish common goals set by the patient, relatives, and the services surrounding the individual.

Identifying goals can be beneficial when there is a need or desire to achieve a change. Goals are brief descriptions of actions or activities that the individual, relatives, and service providers wish to undertake, achieve, or improve. The goals represent something that can change to improve the current situation, regardless of how unsatisfactory or challenging it may be. In this way, goals can provide a sense of control over the situation. Working towards inspiring yet realistic goals is motivating. A specific goal will more significantly commit the individual, relatives, and caregivers to work towards achieving the goals. This contributes to more sustained effort and better execution of the activities.

PGSI is conducted as a conversation between the interviewer (e.g., the research assistant) and those being interviewed. PGSI is administered in four steps (described in more detail below). The steps primarily reflect the stages of a problem-solving process.

The initial assessment is step 1 and 2

You should always start interviewing the person and his/her next of kin. Staff from the home care service must be present to identify common and realistic goals

PGSI Step 1 – Identify areas to work on

In a detailed conversation about the current situation, identify *areas* for improvements within *e.g.*:

1. Manage at home
2. Maintain contact with family and friends
3. Participate in meaningful and enjoyable activities
4. Health problems (physical and mental health)
5. Behaviour and psychological symptoms in dementia (BPSD)
6. Other areas

The conversation in step 1 should focus on what is important for the person, and more general areas before specific goals are defined in step 2.

Begin with an open question for the actual areas. If necessary, you may follow up with more specific prompts. The interviewer may initiate discussions using the following general opening questions:

- Is there something you would like to start doing, resume doing, or do more of, eventually with help?
- Are there things you would like to manage better, eventually with help?
- Are there things that are challenging to do, with or without help, because of your difficulties (use the person's own way of describing this, e.g., poor memory)?
- How do you cope with your difficulties?

PGSI – Step 2 – Setting SMART goals and assigning goal attainment descriptors.

Based on the area identified in step 1 you should describe the problem and the current situation, something that makes it possible to define better what the person will achieve in terms of changes and goals. The person has the opportunity to set up to three goals.

Ensure that any activity or task selected as the basis for a goal is one that the person has the capacity and potential to undertake, either unaided or once appropriate additional resources have been put in place.

Consider what steps and actions are involved in any activities or tasks, how they might form the basis for selected goals, what skills are required to carry them out, and how this relates to the person's, relative's, and staff's intrinsic capacity. This will make it possible to identify where there is a mismatch between the current and the desired situation and what extra support is needed to address this mismatch.

It is then possible to define the goal statement. Goal statements are brief declarations about a behaviour or response that the person, next of kin, or staff wish to carry out or achieve (e.g., 'Be able to go for a 15 minutes' walk twice a week'). They should normally be statements about **observable, measurable behaviour or activities**, and not about feelings or wishes. It is important that goals are **realistic and potentially achievable** within the time period that you define as relevant. This may involve developing a broadly expressed objective into a precise and focused goal, conforming to SMART principles. This means the goal should be: **S**pecific, **M**easurable, **A**ttainable, **R**ealistic and **T**ime Limited

Goal attainment descriptors: Specify what needs to happen to agree that the goal has been fully achieved.

PGSI – Step 3 and 4 – Rating of readiness to change (initial) and goal attainments (initial and postintervention), and assigning attainment descriptors.

This section is to record the person's views about how motivated he/she is to achieve the goal (completed at the initial appointment only) and how he/she is currently performing in relation to the identified goal (completed at the initial appointment and at the follow-up appointments).

Readiness to change ratings: Ask the person (eventually supported by the next of kin) to rate how ready he/she is to make changes or receive interventions or help in relation to these problems to improve the situation. This rating provides a check on whether the identified goal is relevant and realistic. The **readiness to change ratings** can range from 1 (not ready to work on the goal) to 10 (extremely ready to work on the goal).

Goal attainment ratings: To assess the extent and direction of progress, the attainment rating is completed at the initial visit and repeated at subsequent time-points. The initial goal attainment is usually low. The timing of the follow-up assessments is usually 12 and 24 weeks. The **attainment ratings** can range from 1 (cannot do or am not doing successfully) to 10 (can do and am doing very successfully). A progress score can be calculated for the goals by comparing initial and follow-up ratings.

Next of kin and the person rate the goal attainment together in one scoring. The staff from the home care service rates the goal attainment based on their own observations. If the person is unable to rate the goal attainment, the next of kin can rate the goal attainment based on their observations. To help explain the scales and complete the ratings you can use a visual representation of the rating scales (see attachment 1).

Avoid goals where the baseline attainment rating is high and/or motivation to work on the goal is low.

Appendix 3: "Things you would like to do" – handout

To aid discussion about potential goals you can use the handout provided. You can either go through it together with the person, next of kin, or staff, or leave it for them to look at before your next visit.

THINGS YOU WOULD LIKE TO DO

Difficulties in remembering and thinking can impact on daily life in various ways. There are different things that people may want to change to make their lives more enjoyable. You may think of these ideas for things to improve as 'goals'.

We would like to invite you to come up with some goals that you would like to achieve. A goal might be something that you currently find difficult to do and wish you could do more easily, or without getting frustrated. It might be something that you are currently not doing and would like to do more of, or it might be something new that you would like to learn how to do.

Here are some goals that other people have wanted to achieve:

- ✔ *I would like to be without pain most of the day*
- ✔ *I would like to go to the day care centre three days a week*
- ✔ *I would like to go for a 15-20 minutes walk twice a week*
- ✔ *I would like to have home care every day*
- ✔ *I would like to eat supper every day*
- ✔ *I would like to take a shower every day*
- ✔ *I would like to have a conversation with someone from the home care service twice a week*

The questions overleaf may help you to think about what you would like to change...

Think about your day-to-day routine
What do you find difficult to do around the home because of health problems?
What would you like to start doing, or learn how to do, in your day-to-day life, either alone or by help from others?
Think about your pastime and leisure activities
How do your health problems affect your enjoyment of doing your pastimes and leisure activities?
What pastimes or leisure activities would you like to do more of, or start doing, either alone or by help from others?
Think about your friends and family
How do your health problems affect your ability to talk to and spend time with friends and family members?
What changes would you like to make so that you can enjoy talking and spending more time with people more, either alone or by help from others?

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