116 Practice-Based Evidence. How Well do We Collect Routine Clinical Data and What do Rehab Practitioners Think About the Process? A Service Evaluation

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ABSTRACT

Background: The international collaboration of the Common Data Elements (CDE) group recommend best outcome measures for research in paediatric ABI population (McCauley et al., 2012). Routinely collected clinical data on children can be flawed, uncertain, proximate and sparse 'FUPS' (Wolpert & Rutter, 2018).

Recolo UK Ltd provides community-based neuropsychological rehabilitation for children, young people and young adults. Associates collect data from their assessments and reviews to identify impairments and monitor outcome, using measures recommended by CDE (Gosling, 2015).

Aims to ask: Are the gaps in the clinical dataset? Why? What are barriers and challenges to data collection?

Method: Two phases: frequency counts of data and practitioner interviews. Clients have a wide range of age (0–18 yrs), brain injury type and severity. In clinical practice, associates assessed 267 children with brain injury and their families.

Measures: a) PedsQL, FAD, BRIEF, SDQ, CASP. b) Interview scripts.

Procedure: a) Frequency analysis of questionnaires collected 2013–2019; b) Six associates recruited as 'participants' for semi-structured interview. A purposive sampling method was adopted. Thematic Analysis (Braun & Clarke, 2006) performed.

Results: a) There are large gaps in the database. The totals completed measures at baseline ranges from n = 163–41 (PEDS-FIM-parent; PEDSQL core-child). Most commonly reviewed once were PEDS-FIM, PEDS-QL, and SDQ (n = 35, 34, 28 respectively). b) Five key themes were identified from the interview scripts: impact of outcome measures on clients; construct of outcome measurement; culture of goal setting; helpful aspects of outcome measurement; barriers to data collection.

Conclusions: There were gaps in data collection. The interviews describe barriers and facilitators to data collection. Recommendations are given to address the issues by increasing knowledge and skills, improving the technology and including nomothetic (goals) and idiographic (questionnaire) outcomes.

117 How Good are our Goals? Understanding SMARTness in a Paediatric Neuropsychological Rehabilitation Service

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ABSTRACT

Background and aims: Goal setting is a key ingredient in rehabilitation with children and young people (Ylvisaker, 1998). It should be a core competency of any member of a rehabilitation team (Wade, 2009). Goals in rehabilitation should be SMART (Specific, Measurable, Achievable, Realistic and Timed).

This study employed a service evaluation in order to: 1. Examine reliability of goal quality rating items according to established SMART criteria; and 2. Identify goals associated with poorer 'SMARTness' to inform goal setting and audit practice.

Method: As part of a service evaluation cycle, a project was undertaken to evaluate the quality of a sample (n = 100) of anonymised paediatric neuropsychological rehabilitation goals. The text of each goal was rated by four senior practitioners within the service according to criteria set within a goals questionnaire (Grant & Ponsford, 2014). Five items relating to SMARTness were used, with a highest possible score 20.

Results: SMART tool total scores were normally distributed (mean = 12.36; sd = 3.19; range 5–20). Calculation using all five items provided a 'good' inter-rater reliability (ICC = 0.824). Items on the tool attracting low IRR included 'does the goal assess criteria that are process oriented?' (ICC = 0.288). 77% of the goal sample had 'high' to 'excellent' IRR. 68% of these goals (n = 53) were rated as having a high level of SMARTness. 32% (n = 24) were rated as low in SMARTness. Goals with low IRR included those with: generalised wording, e.g. 'to attend all Southend Utd activities as they are planned'; ambiguous goal difficulty, e.g. 'to sit my exams (first mocks then GCSEs) in a way that helps me do my best whilst managing energy levels well'; and poorly defined tasks, e.g. 'mum to be receiving appropriate therapy for depression by X.' Goals rated reliably low on SMARTness had poor goal specificity, e.g. 'to find out good things about my brain, what I do and to like myself.'

Conclusions: Rehabilitation practitioners can use this tool to quantify SMARTness of rehabilitation goals set with children, young people and their families. Not all individual items on the tool have adequate reliability and require modification. It is yet to be determined how SMARTness of goals relate to their meaningfulness to the client or their achievement in rehabilitation.