

**GUIDE FOR USE OF ASSESSMENT FORM:** This is a guide to direct the user toward the type of information that should be put into each box. The goal is to use Clinical Reasoning to guide selection through application of a mixture of didactic knowledge to enhance assessment outcome and drive treatment toward successful outcomes.

**PRELIMINARY HYPOTHESIS**

**1. What Impairments do you expect?**

Impairments are the specific problems that occur at the level of the body functions and structures. The impairments need to be SPECIFIC. Too often, a therapist stops at the level of MULTI SYSTEM impairments and does not take the extra step in the assessment to identify the SINGLE-SYSTEM impairment. Take a look at examples below:

Multi System Impairment	Associated Single System Impairments
<b>STRENGTH</b>	Loss of closed-chain knee extension Limited sustained closed-chain triceps in closed chain tasks Limited muscular endurance Inability to consistently develop muscular power needed for task completion Muscular Power Muscular Endurance Open Chain Closed Chain Eccentric, Concentric, isometric Loss of control of scapular stabilizers for open chain movement
<b>BALANCE</b>	Loss of gaze fixation Limited automatic postural righting reactions Delayed stepping strategies Overly reliant on visual input Diminished distal proprioception and somatosensation both feet Absent ankle strategies with early and ineffective stepping reactions

The key is to ask “what about [multi system] impairment is the real problem (remember- we are attempting to answer the question “why” and need specific limitations to guide our treatments. This is a first step!)

**Why?**

The “Why?” question is asking “Why do you think this will be a problem?” and the answer should link the hypothesized impairment to the pathophysiology and the information in the case.

**2. What activity limitations do you expect to see? Why?**

According to the ICF Model, Activity Limitations are the tasks that are difficult. This could be reaching overhead to a cabinet, going up steps reciprocally, sitting for driving, transfers, gait, etc. The activity limitations are tightly connected to the impairments. This information comes from the chart

information, any information we have from the patient prior to beginning the evaluation, former PT notes or MD notes and hypothesized impairments related to the known medical history/pathophysiology.

To “what degree?” means the most probable level of assistance they will need (this guides you in deciding which tests are most relevant- if they are total assist to sit, a BERG is not appropriate) and this information is gained from the available information if you have it, if you don’t then “hypothesized educated-guess” will work. Then the “why” asks you to clarify why you think this (it was in the chart, based off of the location of the surgical intervention, etc.)

### **3. Medications**

This section is pretty self-explanatory. It requires attention to be given to the medications and consider the impact they could have on the assessment and findings and prognosis.

#### ***SUBJECTIVE QUESTIONS:***

Too often, the assessment is full of talk and limited action. This section is designed to encourage questions that are absolutely necessary. Though it is possible there will situations where 8 questions just won’t cut it, this section is designed to challenge the learner to prioritize what is really important and use information from the case to round out the information.

#### ***SCREENS:***

The following systems need to be considered for screen or full examination:

- Cardiovascular/pulmonary/aerobic capacity
- Endocrine
- Cranial Nerves
- GI/Urinary/Reproductive
- Integumentary/circulation
- Balance
- Gait
- Joint integrity
- Cognition
- Motor function
- Pain
- Sensory
- Muscle performance
- Coordination
- Posture
- Range of motion
- Reflexes
- Skeletal integrity

It is possible some of these could be “screened out/partially screened” by using information from the case to decide there is no need for attention to this topic OR subjective questions could be used to clear many of these. I.E. “Have you had any changes in your breathing, activity tolerance, swallowing, hearing, mood...etc”.

When you do the SCREEN, identify what part of the screen you will do , or write “all” indicating all parts will be done. For example, a patient with a Right MCA with need only a screen of the RIGHT UE and LE

strength/sensation, but the left side will need a full examination. So sometimes, PART of the body could be screened out, leaving the targeted site for full examination.

### **Why?**

Again, the user should be able to use sound literature knowledge, case information and/or synthesize information from didactic learning and known pathophysiology to justify the choice to screen vs. examine fully.

### **EXAMINATIONS:**

See list above. This is the same list that needs to be examined to decide which needs a full examination. Remember, sections of the body can be split between examination and screen and this is indicated by the type of health condition/diagnosis. Ideally all systems listed will be covered and indicated to what degree (partially/screened out, screen, examination)

The **Why?** continues to represent the clinical reasoning component that connects the decision to the reason based on best available information, knowledge, etc.

### **FUNCTIONAL TASKS:**

This is directed by the patient and the patient's expressed limited activities and needs to fully participate as they desire in all areas of their life. The **Why?** is the reasoning the user uses to make the decision to include stated functional task into the examination.

### **OUTCOME MEASURES:**

Outcome Measures are too often utilized which don't fit the diagnosis, stage of recovery, level of mobility, setting or goals of the patient. This section is meant to allow clinical reasoning to be applied to selecting the most relevant outcome measures based on the presentation, setting and likely goals.

Here, the **Why?** will encourage the use to correlate tests with documented literature related to this outcome measure (patient populations, settings, etc) as well as show the ability to choose OM's which will allow the patient to show progress with during the episode of care. A test where the patient performs well will not be applicable as a discharge performance measure and a test which is more discriminative will not show progress has been made. Specific selection is encouraged. Correlation with ICF level ensures that there are a variety of OM's that reflect the level of recovery and care that is being provided. (i.e. outpatient setting needs PARTICIPATION level OM's and impairment level OM's are not appropriate (ROM, MAS). But, in the acute setting, it may be appropriate to use ROM as an outcome measure for a TKE, but an ABC would not, as they patient has not experienced the outside world with the TKR yet and could not answer the questions)

### **EDUCATIONAL NEEDS:**

Identify the stakeholder(s) who need education and the type of education they need **AT THE TIME OF THE EXAMINATION** and why it is needed. This will guide the user to contain their education to information that is pertinent at the initial examination, versus going to education that is not needed now, but may be later on during the course of the episode of care or at discharge.

### **WHAT IS THE ROLE OF THEPT FOR THIS PATIENT?**

For each topic listed on the left side, identify the plan the PT may have (remember, it is a hypothesis) and the resources you will need to do this. It is appropriate here to consider what you will need at the

initial examination as well as through the episode of care and at discharge. This information will assist in writing the PLAN section of the initial examination.

## **GUIDE FOR USE OF PROGRESSION FORM:**

### **Main Impairment:**

This is where the primary impairment limiting the goal/task is listed. This should be expressed in language consistent with SINGLE SYSTEM impairments. The form is set for their to be one main one, but an additional form has been added to the sample list that has space for three primary impairments. This allows for the therapist to include multi impairments within the treatment planning when progression toward a goal. See samples.

### **Beginning Status:**

Here, the current status is indicated. I.E. elevation to 45 degrees only before pain or ambulates 25 feet with min assist and quad cane. The goal (the end right box) will be the goal for this beginning status.

### **Progress Intervention:**

There is space for 8 stages to be identified. This can be shortened or expanded depending on the complexity of the patient, however, 8 seems to fit many patients.

There is a top row (it is blank) and a bottom row (it has two squares and an arrow). Let's talk about the top row first.

For each column entitled "Progress Intervention" , the top box is reserved for identification of the goal of that stage of the progression. The terms in this box should reflect general characteristics such as "reduce inflammation" (as would be the case in an acute surgical patient, you'd first want to reduce inflammation, before introducing active movement) or "increase resting postural tone" as a pre-requisite for dynamic movement. It is the PRIORITY for the plan of care. What comes first.

In the box below this, the actual specific type of treatment/intervention that will be utilized is indicated. The arrow is the starting point. This indicates where you think you might start. Then, the two boxes up and down correlate with your plan for progression. If you do what is indicated at the arrow and they are successful, then you'd do the next line up, then the next line up. BUT... if they could not tolerate what you planned for the arrow, then you would modify and reduce the intensity as is indicated for the line below and maybe even lesser intensity with the bottom box.

When the patient achieves the intervention indicated at the arrow, then both levels above, they are theoretically ready for the next box to the right- they are ready to be progressed. This occurs through all 8 boxes. The ultimate goal being to utilize motor control and motor learning theories to progress the patient from the left side (the beginning status) through the necessary and intentional steps toward the goal (the far right box). The top boxes would identify at what point the patient was ready for things such as strengthening, then power, then multiplanar movement, the open environments and then dual tasking, then task variability in occupationally simulated environments. In theory, the last box right before the goal should look like the goal with only slight modifications. The box just before the goal should not be 'strengthening the LE with open chain exercises" and the next box, the goal, be "return to basketball game at rec center".

This progression forces the user to plan, strategically and prioritize what has to occur to reach the stated goal. In theory, this IS A FLOW sheet. If this was filled out, someone could follow it and know when to progress along the path. Current flow sheets fail to progress toward functional goals.

**FUNCTIONAL GOAL (correlates with main impairment and beginning status)**

**This is the ultimate FUNCTIONAL goal that is limited by the stated impairment(s) as indicated on the far left.**

This progression forces the uses to correlate functional goals with noted limiting impairments to assist in guiding targeted treatment to address the specific needs of the patient. This with the end goal in mind.