Assessment and intervention in the acute care setting is a continuum of components, beginning before the initial patient contact and continuing through each treatment session. The six elements are not always followed in a linear fashion and may flow from one element to the next and back again. Each element is critical to the SAFE and therapeutic management of acutely ill patients.

This chapter is designed to give the reader suggestions for each of the six elements in the continuum of acute care. Most of the ideas described in the six elements are practical tips from experienced therapists working in the acute care hospital and intensive care unit.

As you read this chapter take the information and apply it to your own experiences and work place, making modifications as necessary.

**Six Elements in the Continuum of Acute Care**

I. Review Medical Information

II. Observe the Patient and the Environment

III. Initiate Patient Contact

IV. Assess Body Functions and Structures

V. Assess Functional Activities

VI. Intervention
I. Review Medical Information

The first element in the continuum of acute care begins even before the patient is seen. In preparation for the assessment, and to ensure safety, the therapist gathers important information. You must have a good understanding of the disease process and know what impact your treatment may have on any other medical conditions. Talk with the nurse if you have any questions regarding your patient’s medical care or any planned procedures that may interfere with your treatment schedule. Before entering the patient’s environment, be sure to do the following:

Review the medical records
Medical records include the medical history, daily vital signs, medications given, reports of test results, recommendations, and daily notes from nurses, doctors and therapists. Most importantly, for the therapist, the chart also contains doctor’s orders, allowing the therapist to initiate treatment. In acute care settings, a patient’s status can change quickly and, therefore, therapists should review the medical chart prior to each patient contact for updates as well as changes in orders. When reviewing medical records, pay close attention to the details. Look for inconsistencies or conflicting information. Follow up with the medical staff to seek clarification and answer any questions.

Look for the following in the patient’s chart:
- new or revised orders
- diagnosis and past medical history
- any specific precautions which may affect treatment
- specific contraindications or precautions related to the medical condition
- recent progress notes
- prior level of function and living situation
- recent tests or lab results and their implications
- changes in medications and possible side effects
- significant changes in vital signs
II. Observe the Patient and the Environment

The second element in the continuum of acute care begins with specific observations of the patient and the patient’s environment. This is extremely important for the safety of the patient and for proper patient care. Interaction with the patient is not required during this element. Observations begin before the more formal assessment begins and continues throughout each therapy session.

Sharpen your observation skills. Look carefully for any clues to help determine problem areas that affect your patient’s level of functioning. You should always scan the environment for any new information related to patient care. The better you are at observing, the better your decisions will be regarding safety, therapeutic intervention, recommendations and discharge planning.

Observations of the Environment

Is the patient’s room located near the nurse’s station?
Nursing will generally select rooms near the nurse’s station for confused patients or patients who require frequent monitoring.

Are there signs or postings?
Signs and postings are important ways to gather information. Signs at the door or next to the bed help share information between all team members. For example, if a patient has specific precautions related to infection control or aspiration, signs will be posted where they are easy for everyone to see. Pay close attention to these signs for the safe and proper care of the patient.

What medical equipment is in the room?
Observe all medical equipment, monitors, lines and their placement. Note readings on the monitors before you begin. Make sure that lines hooked to monitors, IVs or catheters have enough length to allow you to move your patient. Notice whether there are seizure pads on the bed rails.

What is the placement of the bed in the room?
The orientation of the bed in the room will determine if your patient has the involved side or the less involved side toward the door. Depending on your assessment, you may request to make a change. Although a fearful patient may feel reassured being able to see the door by having their less involved side toward the door and be less inclined to climb out of bed, positioning the bed so the involved side is toward the door can help patients become more aware of that side. When the involved side faces the door, nurses and family members are more likely to approach the patient’s weak side as they enter the room.

Are the lights on in the room? Are the window shades open or closed?
How the room is lit can provide clues to the patient’s status. Many patients have sensitivity to light and prefer to keep the room darkened. Depressed patients may also prefer a darkened room. Check with the patient before brightening the room.
What is on the bedside table?
Observe the articles on the bedside table. Glasses, hearing aides, dentures, books and even the type of drink or food (and what has been eaten or not eaten) give the therapist more information about the patient and the patient’s interests. If you need the table during the assessment, keep it close by.

Are there flowers, plants, get well cards or balloons in the room?
Therapists must determine what type of caregiver assistance is necessary and available should the patient be discharged to home. Cards and flowers indicate someone (family and/or friends) is involved in the patient’s life who may be a potential caregiver if someone is needed. This information will be extremely important during discharge planning.

Observations of the Patient

Before entering the room, is the patient’s door open?
If so, walk by and observe what the patient is doing.
Is the patient staring into space?
Is the patient picking at clothing, calling out, slumped in bed or positioned with a leg over the side rail?

Observations of such behaviors can provide important information before initiating patient contact and can alert you to the possibility of mentation, risk to fall or inability to follow directions.

Are there any indications of medical procedures such as a tracheotomy, chest tubes, sternal bandages, craniotomy incisions, shunts, or IVs?
If so, follow proper medical guidelines. Always consult with the nurse if you have any questions.

Are there restraints? If so, why?
Consult the medical chart or ask the nurse why the restraints were ordered. Follow your hospitals policies and procedures and be sure all restraints are in place once your treatment has been completed.

Does the patient appear anxious, uncomfortable or distressed?
Signs related to anxiety or discomfort may be obvious or subtle. The patient may be pale or sweating. Agitation (moving the head from side to side) may be medication induced or secondary to communication challenges, pain or confusion. Incontinence, skin irritation, wounds and poor or prolonged bed positioning can all contribute to agitation. Remember: the low functioning stroke survivor cannot tell you these things, so you need to think of all the potential irritants, both internal and external. Many patients have premorbid pain from arthritis, chronic back pain, fibromyalgia or other conditions. Discuss with the nurse or physician to see if the medications taken by the patient at home have been ordered.

Is the patient experiencing nausea?
Look to see if there is an emesis basin near by. If so, they may have a reaction or sensitivity to medication. Keep the basin, towels, a moist wash cloth and the call light within reach during therapy.
Does the patient look overly fatigued?
Fatigue may be related to the patient’s medical condition, medications or busy schedule. Some patients have their nights and days reversed and are fatigued because they spent the entire night in the emergency room at the time of admission. Many team members will be making their initial contact during the first 24 hours to assess the patient. Had another discipline just been there for their initial assessment? If so, you may want to reschedule and allow the patient to rest before beginning your session.

What is the patient doing as you enter the room?
Specific observations can provide critical information as you proceed with your more formal assessment of strength, motor planning, vision, language skills, cognition, perception and level of functional activities.

For example, if the patient is eating their meal, observe the following:
• Is the patient eating independently or is assistance necessary?
• If so, what level of assistance?
• Is the patient using one or both upper extremities?
• Can the patient grip the utensils? (Observe finger flexion and extension).
• Can the patient bring the utensil or glass to their mouth? (Observe elbow flexion, supination, wrist extension).
III. Initiate Patient Contact

As you initiate contact with your patient, continue your observations and follow hospital protocols. Most hospitals require the therapist to knock on the door and identify themselves by name and discipline before entering the room.

Practice SAFE guidelines throughout the session. Remember the four guidelines for safety during your assessment.

- Sharpen your observation skills
- Acquire necessary handling skills
- Follow medical guidelines
- Enhance the environment

Sharpen Your Observation Skills

- Check the patient’s wristband for proper identification.
- Continue to observe the patient’s general appearance and level of alertness.
- Observe rate and pattern of breathing.
- Observe color of skin and palpate skin temperature.

Acquire the Necessary Handling Skills

- Put the patient at ease.
- Follow guidelines for therapeutic use of self.
- Use critical listening skills.
- Develop trust and rapport to help the patient feel safe.
- Know your own abilities and limitations, what you can and can’t do safely related to patient care, and, if needed, ask for assistance when mobilizing the patient.

Follow Medical Guidelines and Procedures

- Have a good understanding of the disease process.
- Know the impact the treatment may have on any other medical conditions.
- Be aware of any contraindications or precautions.
- Check with nursing staff before disconnecting any lines or monitors.
- Practice universal precautions.
- Wash your hands before you begin; use gloves if necessary.
- Get patient consent before beginning treatment.
Enhance the Environment

- Bring any necessary equipment (assessment tools, gait belt) with you.
- Place the call light within your reach, in case you need assistance.
- Use good body mechanics; change the height of the bed, if necessary.
- Position necessary items within reach; once your patient is sitting or standing, you do not want to leave their side to get something you’ve forgotten.

A patient’s level of impairment and functional status can change as the result of your influence or other factors including the disease process, medications or fatigue. Some therapists find it helpful to visualize what they will do during the therapy session. This gives them a chance to practice before including the patient.

Orientation to time and place

Each time you see your patient, assess their orientation to time and place. An increase in confusion or disorientation could indicate a change in medical status. Methods for determining a patient’s cognitive status can vary, using more or less formal assessments. Establish rapport and begin with simple, easy questions. “I just need to ask you a few questions. Can you tell me where you are?”

Therapists often develop their own particular ‘style’ for gathering this information, asking the patient to respond to a list of questions or, making it less formal, as a part of normal conversation. Get well cards or family photos in the room may help in asking questions related to orientation. For example, asking, “Do you know who this is?” Whether you follow an evaluation form, item by item, or glean the information in a less formal manner, it is important that your assessment is thorough and complete.

Whether your questions are a part of normal conversation or a more formal assessment, remember the following:

- Follow guidelines for therapeutic use of self.
- Put the patient at ease.
- Help the patient feel safe.
- Develop trust and rapport with the patient.
- Use good critical listening skills.
- Try to finish with an easy question.
- Ending on a positive note is important and helps calm the patient.
IV. Assess Body Functions and Body Structures

The assessment of body functions and structures, the fourth element in the continuum of acute care, establishes a baseline for possible impairments of ROM, motor control and sensation that may affect the patient’s ability to perform functional activities. Always follow the guidelines established at your facility for assessing and recording impairments related to ROM, strength, muscle tone and sensory status. For a complete list of descriptions and codes for body functions and structures included in the ICF, refer to the text “International Classification of Functioning, Disability and Health.”

Tips for the Initial Assessment of Body Functions and Structures

Be prepared to adjust the length of your initial assessment.

Your session may be shortened due to factors including:

- Patient’s level of fatigue.
- Scheduling of laboratory or clinical tests.
- Interruptions due to medical management by nurses or physicians.

Prioritize your assessments

Determine which assessments are most urgent and necessary for making discharge recommendations. Therapists working in the acute care setting often combine sensory, ROM and motor function assessments during their initial evaluation, moving seamlessly from one to the next. Combining assessments helps with efficiency of time and provides an impression of the patient’s functional potential.

Organize the environment

Come prepared with the necessary equipment or tools to complete each assessment. Position the bedside table for better efficiency. Adjust the lights, bedding, pillows and bed rails, as needed.

Raise the height of the bed

Raising the height of the bed improves eye contact with your patient. A raised bed also provides better ergonomics for you, protecting your back. Be sure to explain to your patient that you are going to raise the bed, so your patient isn’t startled or surprised.

Work distal to proximal

Your patient will be less anxious if you begin with the hands and feet instead of the trunk, pelvis and shoulders. For example, when testing sensation or ROM of the upper extremity, start with the hands. Your patient will have a better idea of what to expect as you work more proximally.

Begin with the less involved side

Begin your assessment with the less involved side. This allows you to establish a baseline of ‘normal’ for your patient before assessing impairment of the involved side. In addition, it will help your patient better understand what to expect as you move to the involved side.
Observe your patient as you move to the involved side
As you complete your assessment of the less involved side and move to the involved side, continue your observations. Note your patient's ability to turn their head and track visually. Is there any inattention or disregard indicating a possible visual field deficit?

Observe the involved limb before moving it
Look for changes in color, feel the temperature of the skin and note any swelling or edema. Compare your observations with the less involved side. (Once you begin to move the extremity, note any changes.)

Use firm (never forceful) handling
Support the weight of the limb firmly, with a flat or open hand. Do not squeeze the limb or use force. Move the limb slowly. Go only to the point of resistance. Stop if your patient displays any signs of discomfort.

Use less formal assessments
When patients don’t understand what to do, it may be appropriate to use less formal assessments to determine sensory status or motor function.

For example, if your patient has difficulty following directions re: movement of the limbs, it may be appropriate to observe impairments by asking your patient to “Squeeze my hand” or “Bend your legs.” How your patient responds gives immediate information re: motor function, ROM and ability to follow commands. If your patient is unable to understand verbal instructions, demonstrate the movement for your patient while repeating the verbal cues. Some patients do better with tactile cues. Try passively moving the limb. This may help your patient initiate movement.

Use real life situations to assess impairments
Is the television on? Ask your patient to turn it off during the assessment. Observe their ability to hear you, follow directions, visually find an object and then manipulate it. As you observe, assess active range of motion (AROM), strength against gravity and problem solving abilities.

Ask your patient to report any pain or discomfort
Explain to your patient, “If anything hurts, or if you have any discomfort, let me know.” Observe facial expressions and look for signs (anticipation of pain, wincing or withdrawing). If pain is present, stop. Ask your patient to describe it and try to determine the source of the pain.
Tips for Assessing Sensation
Assessing your patient’s awareness and perception of incoming stimulation to the involved side is an important prognostic indicator for functional recovery as well as safety. Sensory tests may include light touch, deep pressure or kinesthesia.

When testing your patient’s sensory awareness, allow the limb to rest comfortably on the bed. Keep verbal instructions to a minimum (patients often respond to the verbal cue instead of the touch). Allow your patient to keep their eyes open until you’ve established that they understand your directions. Once your patient comprehends your instructions, ask your patient to close their eyes.

The validity of sensory tests may be compromised by lethargy, medications that sedate the patient or communication deficits. In this case, less formal tests will quickly give you information regarding possible sensory impairments. Note your patient’s response as you touch their involved side to get their attention. It is also important to observe sensory awareness of the involved side during functional activities such as bed mobility and self-care. Is your patient aware of the involved limb?

Tips for Assessing Motor Function: ROM, Strength and Muscle Tone
Follow recommended protocols when measuring ROM, strength and muscle tone with your patient. At times, it may be difficult to get an accurate assessment if cognitive, perceptual, language or sensory impairment is present.

Note the position of your patient during the assessment
Your patient’s position (supine, sidelying or sitting) can influence strength (gravity eliminated vs. against gravity) and muscle tone. Modify the position of your patient, as necessary, to maximize your patient’s response. For economy of endurance, start in supine, progress to sidelying and then sitting.

Begin with active ROM
Your patient’s ability to do active ROM (of either extremity) will allow you to observe ROM, strength (against gravity or with gravity eliminated, depending on the position of the limb), coordination and motor control. Note movement that is purposeful as well as non-purposeful. Describe the movement. Is there involuntary movement influenced by atypical muscle tone? If so, do not assign a muscle grade; instead describe what movement your patient can or cannot do. Describe how the tone interferes with function.

Determine the consistency of your patient’s response
Can your patient do the movement more than once? Does the muscle become fatigued? Are there fluctuations in tone? After two or three repetitions, does the pattern of movement change? Describe the inconsistency of movement.

Note patterns of substitution
Stroke survivors often substitute motion when weakness or irregular muscle tone is present. Some patients may move in a synergy pattern. Describe the pattern of movement.

Note limitation in ROM
If limitations are observed during active ROM, try to determine the cause. Limited ROM may be premorbid (look for obvious scars, check your patient’s medical history), environmental (sheets, hospital gowns, clothing, and catheter lines may restrict movement) or a result of body functions and structures (swelling of the limb, muscle tone, shortened ligaments or connective tissue tightness).
V. Assess Functional Activities

The assessment of your patient’s functional status defines the fifth element in the continuum of acute care. Key activities such as mobility and self-care are assessed, allowing you to make safe and accurate recommendations for patient discharge from the hospital. If formal assessments are used, such as the FIM™, the Barthel Index or others, follow the protocols specific to each tool.

In order to maintain safety during the assessment of bed mobility, transfers, dressing, grooming and hygiene, the therapist often gives suggestions, verbal cues and/or physical assistance as necessary. As the therapist intervenes (and is no longer just an observer), the assessment becomes more dynamic. Dynamic assessment allows the therapist to make modifications to the patient and the environment at the time of the evaluation, resulting in safer care and, at the same time, preparing for intervention strategies.

Tips for the Assessment of Mobility

Bed mobility: scooting side to side
Scooting in bed is important to assess as it typically precedes the functions of rolling and coming to a sitting position. Therapists often see patients attempt to scoot in bed.

- Position your patient in supine.
- Observe the movements of the head, trunk and limbs as you ask your patient to “scoot over” in bed.

If assistance is required:
- Position the involved leg in hip and knee flexion.
- Stabilize one or both feet, as needed.
- Ask your patient to bridge, putting weight through both feet.
- Encourage your patient to use the less involved leg.
- Note the amount of assistance required.

For step-by-step handling methods, turn to the chapter on “Practice Labs.”

Bed mobility: rolling
The assessment of rolling gives the therapist an indication of potential for a higher skill level. The ability to roll in bed is necessary to change position during bed rest (preventing pressure sores) and precedes coming into a sitting position at the side of the bed.

You can assess rolling in isolation (i.e., rolling for the sake of rolling) by asking your patient to roll to one side and then to the other. Or, you can assess rolling within the context of a functional activity by asking your patient to sit up. In either case, your observations of your patient’s ability to roll will be entered into your assessment.
Bed mobility: rolling (cont.)

- Position your patient in supine.
- Prepare your patient to roll toward the involved side first. This allows for use of the less involved arm on the opposite bed rail to help roll into a sidelying position.
- Safely position the involved upper extremity forward, to avoid impingement at the glenohumeral joint. Make sure the involved arm is not pinned under your patient’s trunk.
- Prepare the environment. Position any IV lines, drains, pumps and oxygen tubing as needed. Position the call light for the nurse within your reach.
- If your goal is to have your patient move into a sitting position at the edge of the bed, be sure to place bedside tables or a chair in a safe place with easy access.
- Next, have your patient roll toward the less involved side.

If assistance is required:

- Protect the involved arm as your patient attempts to roll toward the less involved side. Do not allow the involved arm to be “left behind.”
- Some patients avoid rolling completely onto their involved side. This may be due to decreased awareness of the involved side.
- Some patients have difficulty rolling over the greater trochanter to get fully onto the involved side. Assist as necessary.

For step-by-step handling methods, turn to the chapter on “Practice Labs.”

Bed mobility: sidelying to sitting

The activity of getting to the edge of the bed provides a wealth of information about your patient’s body awareness, strength, coordination, tone and ability to follow instructions.

Ask your patient to tell you or demonstrate how they would get out of bed at home prior to their stroke. Use tactile and verbal cues to assist your patient for safety. Observe the involved side for any active movements this familiar activity might elicit.

Even a high level patient may have difficulty changing position from supine to sitting, especially for the first time. Always take your time, allowing your patient to change positions as gradually as possible. This can prevent or decrease the initial vertigo and/or nausea that some individuals experience following a stroke. Watch for sweating and/or changes in skin color or facial expression that may be early signs of nausea. Say to your patient: “Please let me know if you have any dizziness or nausea at any time during this assessment.”

If a patient stops participating or becomes more dependent or requires more assistance with the task, it might be time to stop and have your patient lie back down. Remember, you still have quite a bit of work to do to get your patient repositioned well in the bed. If possible, have your patient actively participate throughout the session.
If during the assessment, you determine your patient to be unsafe, neglecting their involved upper extremity, or unable to motor plan for the activity, safely assist them back into a supine position. Determine if there was anything you could have done differently to be more successful. Begin again, if your patient has enough endurance, and guide them through supine to sidelying to sitting, instructing your patient on proper techniques to promote the return of function and safety. Often acute stroke survivors have only enough endurance to do the task once. Therefore, remember what went well and what could be improved during the next session.

_For step-by-step handling methods, turn to the chapter on “Practice Labs.”_

**Sitting at the edge of the bed**
First assess whether your patient is ready to attempt sitting at the edge of the bed. This ability depends on trunk control, endurance, hemodynamic issues and the amount of assistance required.

Once your patient is sitting at the edge of the bed, position yourself on your patient’s involved side. Lower the bed and position your patient’s feet flat on the floor, in a weightbearing position.

Determine your patient’s sitting balance and center of gravity. Is your patient pushing to one side or backward? Can they find or maintain a midline position? Note any pain, dizziness, nausea or double vision.

There are many ways to assess dynamic sitting balance, but it must be assessed carefully and methodically. Assess dynamic sitting balance by having your patient weight shift toward each side, beginning with the less involved side. Allow your patient to bear weight on an extended arm or forearm.

Most patients will brace with the less involved arm, broadening the base of support. Changing or narrowing a patient’s base of support will challenge dynamic sitting balance and trunk control. To narrow their base of support, ask your patient to “Touch the top of your head” and observe trunk activity and balance.

If your patient is functioning at a higher level, challenge your patient with more information to the upper trunk and observe how your patient responds to outside forces. Ask them to “Hold the position” or say “Don’t let me push you over.”

An excellent way to observe and assess dynamic sitting balance is to have your patient do something functionally. Ask them to reach for an object such as the hairbrush. Begin by holding the object near midline and increase the challenge by moving it further away. Position the object higher or lower and note your patient’s response.

Environmental factors must also be considered when assessing your patient’s sitting posture and balance. Soft surfaces (such as an air mattress) do not provide the same support as firm surfaces, often making it more difficult for patients to shift or change position.

If at any time your patient becomes dizzy, tired or unable to participate, have them return to a supine position.
Sit to stand
In order to determine if your patient is ready to attempt sit to stand, assess the following:

- ability to sit at the edge of the bed
- midline orientation
- trunk control
- awareness of the involved side
- ability to follow verbal cues or gestures
- ability to feel the floor under their feet

Determine your own handling skills and your ability to stand a patient safely by yourself. Never attempt to stand a patient if you are unsure of your own ability. It is common for the therapist to ask for assistance from another therapist, nurse or assistant during the first attempt at standing.

Prepare the environment. Position the call light for the nurse close to you. Be aware of all IV lines, catheter lines, cardiac monitors or any equipment or monitors attached to your patient. Have your patient wear non-skid slippers or shoes. Have your patient stand next to the bed rail or a heavy, stable surface.

Many hospitals require their therapists to use a gait belt when standing a patient. If you use a gait belt, first check for precautions. Has your patient had abdominal surgery? Does your patient use an ostomy bag? Make sure the gait belt fits snugly. If it becomes loose during your task, adjust it as needed.

Observe the patient’s size, facial expression and behavior. Is your patient fatigued or agitated? Tell your patient “Please let me know if you have any dizziness or nausea at any time.”

If you are assessing sit to stand for the first time, you may have only one chance due to the patient’s fatigue. One sit to stand is often all they can do, and a second attempt may be too much for the acute stroke survivor.

- Position yourself on the involved side.
- Have a second person assist, if needed.
- Observe how your patient prepares to come from sit to stand. What is the base of support? How are the feet positioned?
- From these observations, determine whether or not to proceed.

Continue your assessment.

- Identify how your patient shifts weight.
- Identify activation of trunk, hip and knee control.
- Note upper extremity and hand placement.
- Observe any compensatory strategies your patient may use.
- Observe changes in skin color, perspiration, facial expression.
- If, at any time you are unsure, have your patient return to a sitting position.
- Have your patient stand. Assist as necessary.

For step-by-step handling methods, turn to the chapter on “Practice Labs.”
Standing
Stand securely on your patient’s involved side. Be prepared to block the involved knee, as needed. Place your hands securely on your patient’s trunk, placing one hand around the trunk and onto the hip of the less involved side. Your other hand may be at the involved hip, sternum or gait belt, as needed.

Strive for midline, bearing weight over both legs. Encourage bilateral hip extension by having your patient look at an object in the room. Maintain close contact at the trunk and pelvis.

Next, gently have your patient shift weight onto their involved leg and then back to midline. Be prepared to brace the knee. Assess the length of time your patient is able to stand and the amount of assistance required.

Standing is dependent on the strength, balance and endurance of the patient and the therapist. Have your patient return to sitting if you are tired.
Tips for the Assessment of Self-Care

The assessment of functional activities during self-care identifies the patient’s ability to perform the actual tasks of dressing, grooming, hygiene and feeding. These functional tasks are inherently more complex, requiring many systems to work simultaneously. During the self-care assessment, you will be observing problems related to trunk control, upper and lower extremity strength, coordination, sensation, motor planning, visual perception, cognition, communication, memory and attention.

Precautions

Check for any precautions and follow medical guidelines before beginning the assessment of self-care activities. Here are a few common precautions seen in the acute care hospital.

- Brushing teeth: aspiration precautions
- Combing/brushing hair: surgical incisions on scalp (staples or sutures)
- Shaving: anticoagulants (unless an electric shaver is used)
- Washing face: nasogastric (ng) or oxygen tube
- Washing limbs/trunk: IVs, EKG leads, surgical incisions
- Upper extremity dressing: sternal precautions, precautions related to pacemakers

The order in which the various functional tasks are performed will be determined by the results of your previous assessments as well as any known precautions.

Begin your assessment with grooming and then continue with dressing. The assessment of grooming and hygiene can take place bedside, sitting at the edge of the bed or, for higher level patients, in standing at the sink. When moving from one position to the next, follow the guidelines established in the previous section on “Tips for the Assessment of Mobility.”

Whether you are assessing dressing, grooming, hygiene or feeding, bring along all the supplies you will need and review all relevant precautions. Assess the amount of assistance required and identify all impairments that affect the patient’s functional ability during self-care.

While your patient attempts functional activities:

- Note any environmental modifications or adaptive devices used.
- Note any compensatory techniques used.
- Note deficits in judgment or safety awareness.
- Note the use of one or both upper extremities, ability to grasp and reach for objects.
- Describe the quality of movement, strength and range of motion of both upper extremities.
- Observe motor planning abilities.
VI. Intervention

During the sixth and final element in the continuum of acute care, the therapist transitions from assessment to intervention while continuing to follow each of the previous guidelines. The plan of intervention is specific to each stroke survivor, determined by the problem areas identified during the assessment.

*Please turn to the next chapter, “Guidelines to Intervention in the Acute Care Setting” for more information on intervention of the stroke survivor in the acute care setting.*