

Stroke Physiotherapy Assessment

Patient name: Mr McTAVISH CHI: aged 54	Handover from acute service: on holiday abroad at time of onset: presented with dense left sided weakness, sensory loss, homonymous hemianopia & visiospatial inattention. Limited stroke specific rehabilitation to date as was managed in general ward for 3 weeks abroad before being repatriated
Consent to treatment: consent obtained verbally	Stroke date & classification: Right TACS, CT showed large right hemisphere infarct
Cognition, perception & vision *denotes spasticity risk factor	
Consider: memory; orientation to time, place & person; inattention or neglect*; visual impairment* *denotes spasticity risk factor left homonymous hemianopia; left visual inattention spasticity risk factors present	
Upper Limb	
Consider: ROM; strength; tone; sensation*; proprioception*; swelling; coordination; pain; shoulder subluxation; spasticity *denotes spasticity risk factor shoulder 1/2 flexion & 1/3 ext rotation both limited by pain; elbow full & pain-free passive ROM; wrist limited combined wrist & finger extension due to shortening in long finger flexors & increased tone noted Grade 0 muscle strength throughout upper limb low tone shoulder with moderately increased tone distally Tactile sensation absent throughout Proprioception absent Shoulder pain & subluxation present spasticity risk factors present	
Lower Limb	
Consider: ROM; strength; tone; sensation*; proprioception*; swelling; coordination; pain; compensations; spasticity *denotes spasticity risk factor Grade 3 muscle strength hip flexion, hip extension & knee extension; grade 2 muscle strength distal to knee low tone hip with moderately increased tone distally Gross touch sensation intact proximally Proprioception intact	
Posture	
Consider: symmetry; midline orientation; trunk rotation; pelvic tilt lateral & ant/post; curvature; activity; compensations in sitting & standing low tone throughout left trunk; lacks midline orientation; evidence of fixing through right upper limb & trunk causing asymmetry & bias to right	
Balance	
Consider: static; dynamic; sitting & standing reduced sitting balance due to postural asymmetry & compensations lacks standing balance	
Indoor Mobility/Gait	
Consider: pattern; stance phase; swing phase; exercise tolerance & aids Previously fully independent with no aids both indoors & outdoors; currently dependent on full hoist for all transfers	
Stairs	
Consider: internal or external; number; pattern; rails; exercise tolerance; assistance or prompting required currently unable	

SignatureName.....Date

Transfer/Positioning	Assistance/Equipment	Comments
Sit to stand	currently unable	only to be attempted within physiotherapy at present
Bed transfers & positioning	full hoist for all transfers	requires assistance to achieve midline posture in lying with upper limb supported on pillows to improve attention & position
Seating requirements & positioning	standard static chair or wheelchair with appropriate postural support from pillows	requires assistance to achieve equal weight bearing & pillow support for upper limb position

Problems	Goals	Plan
incomplete assessment	establish full physical baseline using objective outcome measurement in order to set collaborative and meaningful goals of rehabilitation	ongoing assessment and physical management in discussion with patient, carer & MDT
Abnormal muscle tone & presence of spasticity risk factors	seek to normalise muscle tone using positioning & handling techniques; limit the establishment & potential negative impact of compensations resulting from abnormal muscle tone;	consistent MDT use of therapeutic handling to normalise tone; provision of appropriate support to aid alignment; provision of regular posture & position changes to ensure regular movement of muscles and joints through range; complete/ refer for additional spasticity assessment & management; education of patient & carer in rationale behind strategies
Sensory loss	increase sensory input & awareness; limit adverse impact of sensory loss through positioning & support; manage risk of trauma resulting from sensory loss	Provision of appropriate tactile sensory feedback; full MDT & family carer involvement; ensure correct foot alignment prior to weight bearing
Left sided muscle weakness	limit negative impact of compensatory strategies developed as result of weakness & loss of function, especially in upper limb; progressive lower limb strengthening	consistent MDT management of upper limb with therapeutic handling, passive movement & positioning; lower limb strengthening including weight bearing; facilitation of active participation & self management; support & promote flexibility in weak muscles & mobility of affected joints; maintain optimal alignment during movement/exercise
left visual deficits	increase awareness to & attention to visual loss	use of appropriate positioning to ensure stimulation to both sides; encourage use of scanning to compensate for loss in visual field; encourage MDT & family carer to provide stimulus on left to increase attention
hemiplegic shoulder pain	reduce the impact of compensations resulting from shoulder pain; reduce the pain; prevent chronicity of shoulder pain; maintain shoulder girdle & scapular mobility	MDT management of shoulder pain including MSK assessment; implementation of appropriate movement & handling techniques; provision of exercise programme; consideration of external supports; consideration of appropriate analgesia; education for self management
reduced mobility & associated dependence in transfers	reduce dependence in transfers & mobility maintaining safety and reducing negative impact of compensatory strategies	provide appropriate support for transfers in keeping with ability and functional rehabilitation goals & potential impact of compensatory strategies

SignatureName.....Date