



Wilby, Helen (2005) A description of a functional screening assessment developed for the acute physical setting. *British Journal of Occupational Therapy*, 68 (1). pp. 39-44.

Downloaded from: <http://insight.cumbria.ac.uk/id/eprint/4765/>

Usage of any items from the University of Cumbria's institutional repository 'Insight' must conform to the following fair usage guidelines.

Any item and its associated metadata held in the University of Cumbria's institutional repository Insight (unless stated otherwise on the metadata record) may be copied, displayed or performed, and stored in line with the JISC fair dealing guidelines (available [here](#)) for educational and not-for-profit activities

provided that

- the authors, title and full bibliographic details of the item are cited clearly when any part of the work is referred to verbally or in the written form
 - a hyperlink/URL to the original Insight record of that item is included in any citations of the work
- the content is not changed in any way
- all files required for usage of the item are kept together with the main item file.

You may not

- sell any part of an item
- refer to any part of an item without citation
- amend any item or contextualise it in a way that will impugn the creator's reputation
- remove or alter the copyright statement on an item.

The full policy can be found [here](#).

Alternatively contact the University of Cumbria Repository Editor by emailing insight@cumbria.ac.uk.

Practice Evaluation

This article provides a description of the development, process and introduction of the Structured Anchored Approach to Functional Assessment (SAAFA).¹ The approach was designed to include a person-centred and time-efficient occupational therapy functional screening assessment that would meet the needs of patients and be appropriate for use in an acute physical inpatient setting. SAAFA assessments were developed to incorporate the strengths of both quantitative and qualitative occupational therapy assessments and research methods. Taken in the round, SAAFA assessments follow a process that corresponds with the four processes of qualitative research: data gathering, analysis, interpretation and reflexivity (Miller and Crabtree 2003).

The SAAFA is a dynamic approach that continues to evolve in response to developments in theory and practice. Information from occupational therapists' reports of their day-to-day practice indicate that SAAFA assessments reflect the complexity of individual patients' functioning and lead to the development of recommendations based on pragmatic consideration of a wide range of contextual influences. Research on the SAAFA commenced in 2002.

A Description of a Functional Screening Assessment Developed for the Acute Physical Setting

Helen J Wilby

Introduction

This article describes an assessment approach developed by occupational therapists to improve the efficiency and effectiveness of the service provided to patients admitted to acute wards in a district general hospital. The 12 therapists (basic grade, senior II and senior I staff) who have worked with patients on medical, renal, oncology, surgical, neurology, neurosurgical and accident and emergency wards have been using the Structured Anchored Approach to Functional Assessment (SAAFA)¹ for the last 8 years. During this period, the approach has been taught to new members of staff and to students on practice placements.

A comprehensive account of the SAAFA is beyond the scope of this article. The paper therefore gives an overview of the approach, its development and its process, with a focus on the face-to-face interaction between patient and therapist, the quality assurance mechanisms and the

outcomes. Claims made about the SAAFA in this article are based on therapists' observations of and reflections on their everyday clinical practice.

Rationale for SAAFA development

Prior to 1997, local occupational therapy assessments of functional capacity were based on observations of patients' performance of daily living tasks (for example, washing and dressing, transfers and kitchen activities) in a variety of hospital and home-based settings and included occasional interviews with patients' relatives and use of standardised assessments of cognition. Three factors led to the development of the SAAFA.

First, therapists identified concerns about inconsistencies in assessment findings and hence the reliability of assessments. For example, a therapist might have observed a patient getting up safely out of a chair during assessment and then later observe the same patient getting up in a precarious manner when unaccompanied. Secondly, the nature of acute care was continuing to change. The length of

¹ The name 'Structured Anchored Approach to Functional Assessment' is being used as a descriptor for the purpose of the author's research: 'Structured' refers to the framework of the assessment and 'Anchored' reflects that the approach is underpinned by knowledge drawn from a range of theoretical and practical sources.

inpatient admissions was decreasing; patients appeared more unwell at the time of assessment and were leaving hospital at an earlier stage with greater levels of functional difficulty. The previous assessment process, completed over several days and requiring a high level of patient participation, seemed to be out of tune with the needs of both patients and the acute hospital setting. Thirdly, the therapists began to search the literature and started to understand how theory and evidence-based information might be applied to their practice. The first two factors indicated a need to review practice and the third provided the theory to underpin and add to the ideas of how necessary changes might be made.

Over a period of 12-18 months, the therapists experimented with their practice and reflected upon and used clinical experience to evaluate the outcomes, making further reference to the literature. The major developments that led to the emergence of the SAAFA were made during this phase. The key areas of focus during this time were:

1. Developing increased knowledge of the role of cognitive functioning (particularly attention and executive functioning) in functional performance (Rabbit 1997, Robertson et al 1997a, Rapport et al 1998, Royall et al 1998).
2. Understanding the reasons that individual functional capacity might vary (Rabbit 1997, Robertson et al 1997a, Rapport et al 1998, Royall et al 1998, Laver Fawcett 2002²).
3. Developing knowledge about various assessment methods and how they might be used in combination (Sbordone 2000, Laver Fawcett 2002, Mason 2002, Denzin and Lincoln 2003).
4. Exploring how areas 1-3 (above) might improve the predictive capacity of assessments.
5. Developing the use of narrative reasoning (Mattingly 1994), interactive reasoning (Mattingly and Fleming 1994a, Schwartzberg 2002) and pragmatic reasoning (Schell and Cervero 1993, Unsworth 2004) in assessments.
6. Using clinical experience to evaluate whether a more focused assessment of performance components at the patient's bedside might provide information previously gained during multiple observations of functional task performance.

What is the Structured Anchored Approach to Functional Assessment?

The SAAFA is an approach to functional screening assessment developed for use in the acute physical inpatient setting. The major areas of theory and research and the key authors consulted during the development of SAAFA are listed in Table 1.

² Key references that have been consulted since the initial development of SAAFA have been included.

Table 1. Major areas of theory, research (in alphabetical order) and key authors consulted during the development of the SAAFA

-
- Brain and behaviour relationships (Rabbit 1997, Robertson et al 1997a, Rapport et al 1998, Royall et al 1998)
 - Clinical reasoning and artistry in practice, professional practice and reflective practice (Schön 1983, 1987, Rogers and Holm 1991, Schell and Cervero 1993, Eraut 1994, Mattingly and Fleming 1994b, Fish 1995, Higgs and Titchen 2001a, 2001b, Schwartzberg 2002, Unsworth 2004)
 - Cognitive Disability Model (Allen 1985) and Neurofunctional Approach (Giles and Clark-Wilson 1993)
 - Constructivism (Schwandt 1994)
 - Neuroplasticity (Robertson et al 1997b, Robertson and Murre 1999)
 - Occupational performance (Reed and Sanderson 1999, Turner 2002)
 - Person-centred care (Kitwood 1997), client-centred practice (Hobson 1999, Sumsion 2000), therapeutic alliance (Safran and Muran 2000), skilled companionship (Titchen 2001) and negotiation-centred practice (Farlardeau and Durand 2002)
 - Qualitative research methodology (Lincoln and Guba 1985, Denzin and Lincoln 1994).
-

Table 2. The SAAFA assessment framework

The SAAFA process is used flexibly. Development of the assessment occurs in partnership with the patient at a level appropriate to his or her functional capacity (Kitwood 1997, Gage 1999, Hobson 1999).

- Background information on current and previous medical and functional history is collected from medical and nursing notes.
 - Face-to-face, interactive assessment (Fleming 1994) with the patient is completed at the patient's bedside on the ward often during a single meeting.
 - Information about the patient's level of functioning currently and prior to admission is collected from relevant third parties (including the patient's nearest relative or carer, hospital and community-based health care and social service staff).
 - Assessment findings are synthesised using clinical reasoning and reflection (Schön 1987, Laver Fawcett 2002). Additional information is sought to clarify issues arising from data inconsistencies (Lincoln and Guba 1985). An occupational therapy diagnosis is developed at this stage (Rogers and Holm 1991).
 - The patient's functional situation (the patient's functional capacity considered in terms of the context of his or her discharge environment) is considered to determine whether changes to the patient's level of functioning are needed and to what extent they can be achieved before recommendations are made (James 1999, Reed and Sanderson 1999).
 - Provisional findings and recommendations are discussed as appropriate with the patient and relevant third parties throughout the assessment process (Lincoln and Guba 1985, Gage 1999, Hobson 1999).
 - A written report is completed and includes the perspectives of the patient and relevant third parties and recommendations for the patient's future management.
-

The SAAFA approach includes a comprehensive and integrated assessment. SAAFA assessments are customised to meet each patient's individual needs by individual therapists using their professional 'artistry' (Schön 1987, p13) within a semi-structured framework (see Table 2). SAAFA

assessments integrate therapists' understanding of (i) the relationship between the brain and behaviour in human functioning; (ii) individual patients' stories or narratives; and (iii) contextual issues related to the patient's functional situation and the provision of health and social care.

Each assessment takes the form of a small research project; although consistent with assessment in a biomedical setting, a combination of qualitative and quantitative data collection sources is used (Miller and Crabtree 2003). Assessments generally take between 2 and 4 hours from commencement to completion of report. The assessment is not a tool that can be taken off the shelf ready to use, but with opportunity for therapists to develop proficiency in its use it is patient and therapist friendly.

Aims of SAAFA assessment

The aims of SAAFA assessments are:

1. To develop an in-depth understanding of patients' functional situations (their functional capacity considered in terms of the context of their discharge environment).
2. To complete assessments in a way that responds closely and is empathic to patients' individual functional presentations (Rogers 1980, Titchen 2001, White 2001, Schwartzberg 2002).
3. To use assessment findings as a basis for making recommendations for patients' future hospital and/or community management. This includes (i) making predictions about patients' future functional capacity (Laver Fawcett 2002); (ii) considering patients' need to make changes to their functional capacity (Reed and Sanderson 1999); and (iii) exploring patients' capacity to participate in and benefit from interventions that aim to promote an increase in functional capacity (Reed and Sanderson 1999).
4. To present 'clinically convincing' assessment findings and recommendations (Miller and Crabtree 2003, p423) in a written report (see report format in Appendix 1).
5. To consider the needs generated by and influences of the assessment context (related to the patient and acute and community health and social care agencies) throughout occupational therapy intervention (Griffiths and Schell 2002).

Areas of data gathering and parameters of SAAFA assessment

The SAAFA assessment framework was designed to be sufficiently flexible to be adapted by individual therapists for use with individual patients. The areas of data gathering include:

- Skill components (that is, physical, cognitive, psychological, spiritual and social functioning) that underpin and can be used to predict occupational performance (Hagedorn 2000).
- Task performance (specific, brief observations of engagement in activity) (Hagedorn 2000)
- Narratives (of patients and their nearest family and/or carers) (Mattingly 1994)

- Contextual factors influencing patients' functional capacity, for example patients' need and capacity to make functional change and factors influencing current health and social care provision (Kielhofner 1992, Reed and Sanderson 1999, Turner 2002).

The weight allocated to each area of assessment varies depending upon each individual patient's presentation.

The following assumptions help to define the parameters and limitations of the approach:

- The assessment approach is dynamic and continues to evolve over time in response to developments in theory and practice.
- SAAFA assessments are based on the framework outlined in Table 2. Therapists construct individualised assessments with the patient in response to the patient's individual presentation, using this framework as 'scaffolding'³ (adapted from the use of this term by Spouse 1998 and Wood 1998).
- Therapists using the SAAFA need to have an appropriate level of knowledge and skill. Therapists new to the SAAFA are therefore advised to work with or receive supervision or support from a therapist experienced in its use.
- Person-centred practice is regarded as an integral part of this approach and is assumed to be the responsibility of each therapist. Consent from assessment participants needs to be sought as required prior to and during each assessment.
- It remains the responsibility of the assessing therapist (and his or her supervisor) to assure the quality of assessment findings.

Using and evaluating SAAFA assessments

Assessment with the patient

Therapists use themselves as the assessment tool (Lincoln and Guba 1985, Fleming and Mattingly 1994a) during face-to-face contact with the patient. This requires the therapist simultaneously to be involved in the interaction with the patient and to monitor the progress of the assessment and manage its course (Safran and Muran 2000). The therapist aims to tune into factors about the patient's functioning that are meaningful to the patient and develops the assessment at an appropriate pace, based on the cues that the patient is giving either verbally or through his or her behaviours (Kitwood 1997, Titchen 2001). This means that the therapist aims to explore aspects of the patient's functioning as they become relevant and meaningful during the course of the assessment. The therapist aims to learn about the patient's level of functioning from all the patient's responses and by using a variety of the therapist's senses (Fleming and Mattingly 1994a).

³ The term 'scaffolding' is used here to describe the support that the framework of the assessment provides for the assessing therapist. This framework is not adhered to rigidly but offers reference points for the progression of individual assessments.

During the course of the assessment, the therapist collects assessment data from a variety of sources (Miller and Crabtree 2003), different for each patient, of interview, observation, examination, standardised and non-standardised tests to complete the assessment (Reed and Sanderson 1999, Laver Fawcett 2002). The timing and mix of these assessment methods (Miller and Crabtree 2003) is determined by the therapist in response to the patient's presentation on a moment-to-moment basis, drawing on the therapist's knowledge of the patient's pathology, knowledge from personal experience and knowledge of the craft of occupational therapy (Higgs and Andresen 2001).

The demands made upon the patient during assessment are adjusted according to each patient's individual functional presentation. Frequently, the therapist creates opportunities to observe the patient's task performance (for example, inviting the patient to walk a short distance, pour a glass of cordial or comb his or her hair) during assessment. Assessment of cognitive functioning is made by integrating findings from all assessment data including history of preadmission functioning, observations made during all aspects of assessment with the patient and information gained from use of standardised and non-standardised assessments (Groth-Marnat 2000). The Mini Mental State Examination (Folstein et al 1975) is frequently used. Assessment findings are interpreted and synthesised both during and after data gathering (Schön 1983, Fleming and Mattingly 1994a).

Quality assurance

The therapists who have used the SAAFA perceive that the strength of SAAFA assessments lies in their flexibility, with the capacity for each therapist to customise each assessment to each individual patient. However, it is recognised that this strength may be undermined unless sufficient rigour is employed to assure the 'trustworthiness'⁴ of assessment findings. These issues were taken into account during the design of the SAAFA and are considered for each assessment. Mechanisms to assure the trustworthiness of assessments are therefore built into the SAAFA.

The quality of assessments is dependent upon the expertise and clinical reasoning of the therapist. The therapy team therefore emphasises the need for therapists new to the SAAFA to be supported in developing knowledge and skills in its use (Lave and Wenger 1991, Wenger 1998). Therapists frequently discuss their assessments and reasoning with colleagues and also seek occupational therapy second opinions (Lincoln and Guba 1985, Fleming and Mattingly 1994b).

Adherence to the framework of the assessment has also been identified as a mechanism aimed at increasing the trustworthiness of assessments. Omission of assessment components can reduce the trustworthiness of assessments for some patients. Completion of the SAAFA assessment in its entirety is recommended for every patient unless this is deemed clinically inappropriate by the assessing therapist using his or her clinical reasoning skills. The assessment was designed so that assessment data are gathered from a variety

of sources and using a variety of methods (Lincoln and Guba 1985). In this way, opportunities to obtain relevant and sufficient information from a variety of perspectives are increased and data can be compared and contrasted.⁵ Data collection continues until the therapist perceives that data 'saturation' (Strauss and Corbin 1998, p136) has been achieved.⁶

The process of data analysis using reflection and clinical reasoning is continued until 'crystallisation'⁷ leads to a coherent and integrated understanding of findings (Richardson 2003). Reflexivity, or dynamic awareness of the therapist's impact on the assessment, is an important part of this analysis (Finlay and Gough 2003). Inconsistencies or contradictions in assessment findings are taken to be reflective of an inadequate or incomplete understanding of the patient's functional situation and warrant further data collection and/or analysis (as in 'negative case analysis'⁸ described by Lincoln and Guba 1985). Assessment findings can be replicated by following the assessing therapist's audit trail (Lincoln and Guba 1985).

Outcomes

Since SAAFA assessments were introduced, the therapists have evaluated their usefulness in the following ways:

1. By comparing descriptions of and predictions made about patients' functional capacity in occupational therapy reports with actual performance on discharge as reported when patients are readmitted
2. By comparing assessment findings across therapists and by seeking occupational therapy second opinions
3. Through peer discussion about case presentations, clinical reasoning and report writing
4. By comparing patients' responses to SAAFA assessments with responses to the previous assessment method.

These continuing evaluations indicate that SAAFA assessments are more efficient and of greater quality than those that they replaced. The therapists judge that SAAFA assessments are more person-centred, as described by Kitwood (1997) and Gage (1999). The therapists aim to

⁴ 'Trustworthiness': the extent to which assessment findings are worth taking into account (from Lincoln and Guba 1985, p290).

⁵ Issues associated with using mixed data collection methods that do not always yield easily comparable data are recognised (Mason 2002). Unfortunately, discussion of these issues is beyond the scope of this article.

⁶ Data 'saturation' is achieved when the collection of further data seems counterproductive and when new data does not add to the current understanding (Strauss and Corbin 1998).

⁷ Richardson (2003) used the term 'crystallisation' to represent the way in which understanding is developed about complex and multifaceted issues (such as human functioning). Richardson recognised that individual researchers (therapists) variously influence their research findings and through crystallisation develop a deeper and more complex view of their subject (the patient's functional situation). Examples in parentheses have been added by the author.

⁸ 'Negative case analysis' is a process of seeking additional data to confirm or refute a hypothesis until the hypothesis accounts for all additional data (Lincoln and Guba 1985).

tailor assessments to each patient's functional presentation and level. They also work to develop a partnership with the patient and, hence, create an assessment that has meaning for and relevance to the patient. Patients now rarely ask, 'Have I passed [the assessment]?' The therapists perceive that using SAAFA assessments they gain a greater understanding of patients' functional capacities and are more accurately able to predict functional performance beyond the ward environment.

The number of inconsistencies in assessment findings is believed to have been significantly reduced. The therapists perceive that SAAFA assessments support the development of more appropriate recommendations for rehabilitation, care provision or other management options. Clinical observations indicate that assessment findings are stable across therapists and over time. Assessments are completed in a way that is more responsive to the faster pace and nature of current acute inpatient care. Additionally, a number of therapists and students have stated that doing SAAFA assessments has supported the development of their clinical reasoning skills.

Current use and research

The SAAFA is presently used by a group of therapists at a single site. Research to investigate the SAAFA commenced 3 years ago. This article has been written in part fulfilment of the first aim of the research, which is to describe the development and process of SAAFA assessments. This phase of the research is continuing and a qualitative phenomenological study is presently being undertaken to explore therapists' experiences and perceptions of using SAAFA assessments. The focus of this study is to elucidate the details of therapists' practice using the SAAFA and provide insights into the clinical reasoning used in SAAFA assessments.

Acknowledgements

Particular thanks go to the author's colleagues, and especially to Eileen Noble, who co-developed and explored the use of SAAFA, and also to Dr Diane Cox, for her support and academic guidance during the last 2 years.

Thank you also to the two reviewers of this article for their considerations and constructive comments.

This article was completed as part of the author's MPhil/PhD studies.

References

- Allen C (1985) *Occupational therapy for psychiatric diseases: measurement of cognitive disabilities*. Boston: Little, Brown.
- Denzin NK, Lincoln YS, eds (1994) *Handbook of qualitative research*. London, Sage.
- Denzin NK, Lincoln YS (2003) Introduction: the discipline and practice of qualitative research. In: NK Denzin, YS Lincoln, eds. *Strategies of qualitative inquiry*. London: Sage, 1-45.
- Eraut M (1994) *Developing professional knowledge and competence*. London: Falmer Press.
- Falardeau M, Durand MJ (2002) Negotiation centred versus client centred: which approach should be used? *Canadian Journal of Occupational Therapy*, June, 135-42.
- Finlay L, Gough B (2003) Prologue. In: L Finlay, B Gough, eds. *Reflexivity: a practical guide for researchers in health and social sciences*. Oxford: Blackwell Science.
- Fish D (1995) *Quality mentoring for student teachers: a principled approach to practice*. London: David Fulton.
- Fleming MH (1994) The therapist with the three-track mind. In: C Mattingly, MH Fleming, eds. *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis, 119-36.
- Fleming MH, Mattingly C (1994a) Action and inquiry: reasoned action and active reasoning. In: C Mattingly, MH Fleming, eds. *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis, 316-42.
- Fleming MH, Mattingly C (1994b) Giving language to practice. In: C Mattingly, MH Fleming, eds. *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis, 3-21.
- Folstein M, Folstein S, McHugh PR (1975) Mini-Mental State: a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189-98.
- Gage M (1999) Physical disabilities: meeting the challenges of client-centred practice. In: T Sumsion, ed. *Client-centred practice in occupational therapy: a guide to implementation*. London: Churchill Livingstone, 89-102.
- Giles GM, Clark-Wilson J (1993) *Brain injury rehabilitation: a neurofunctional approach*. London: Chapman and Hall.
- Griffiths S, Schell D (2002) Professional context. In: A Turner, M Foster, S Johnson, eds. *Occupational therapy and physical dysfunction: principles, skills and practice*. London: Churchill Livingstone, 211-52.
- Groth-Marnat G (2000) Introduction to neuropsychological assessment. In: G Groth-Marnat, ed. *Neuropsychological assessment in clinical practice: a guide to test interpretation and integration*. New York: John Wiley, 3-25.
- Hagedorn R (2000) *Tools for practice in occupational therapy: a structured approach to core skills and processes*. London: Churchill Livingstone.
- Higgs J, Andresen L (2001) The knower, the knowing and the known: threads in the woven tapestry of knowledge. In: J Higgs, A Titchen, eds. *Practice knowledge and expertise in the health professions*. Oxford: Butterworth Heinemann, 10-21.
- Higgs J, Titchen A, eds (2001a) *Practice knowledge and expertise in the health professions*. Oxford: Butterworth Heinemann.
- Higgs J, Titchen A (2001b) *Professional practice in health, education and the creative arts*. London: Blackwell Science.
- Hobson SJG (1999) Using a client-centred approach with persons with cognitive impairment. In: T Sumsion, ed. *Client-centred practice in occupational therapy: a guide to implementation*. London: Churchill Livingstone, 51-60.
- James G (1999) The clinical reasoning process. *British Journal of Therapy and Rehabilitation*, 6(8), 368.
- Kielhofner G (1992) *Conceptual foundations of occupational therapy*. Philadelphia: FA Davis.
- Kitwood T (1997) *Dementia reconsidered: the person comes first*. Buckingham: Open University Press.
- Lave J, Wenger E (1991) *Situated learning: legitimate peripheral participation*. Cambridge: Cambridge University Press.
- Laver Fawcett A (2002) Assessment. In: A Turner, M Foster, S Johnson, eds. *Occupational therapy and physical dysfunction: principles, skills and practice*. London: Churchill Livingstone, 107-44.
- Lincoln YS, Guba EG (1985) *Naturalistic inquiry*. London: Sage.
- Mason J (2002) *Qualitative researching*. London: Sage.

- Mattingly C (1994) The narrative nature of clinical reasoning. In: C Mattingly, MH Fleming, eds. *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis, 239-69.
- Mattingly C, Fleming MH (1994a) Interactive reasoning: collaborating with the person. In: C Mattingly, MH Fleming, eds. *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis, 178-96.
- Mattingly C, Fleming MH (1994b) *Clinical reasoning: forms of inquiry in a therapeutic practice*. Philadelphia: FA Davis.
- Miller WL, Crabtree BF (2003) Clinical research. In: NK Denzin, YS Lincoln, eds. *Strategies of qualitative inquiry*. London: Sage, 397-434.
- Rabbit P (1997) Introduction: methodologies and models in the study of executive function. In: P Rabbit, ed. *Methodology of frontal and executive function*. Hove: Psychology Press, 1-38.
- Rapport LJ, Hanks RA, Millis SR, Deshpande SA (1998) Executive functioning and predictors of falls in the rehabilitation setting. *Archives of Physical Medicine and Rehabilitation*, 79, 629-33.
- Reed KL, Sanderson SN (1999) *Concepts of occupational therapy*. Baltimore, MD: Lippincott, Williams and Wilkins.
- Richardson L (2003) Writing: a method of inquiry. In: NK Denzin, YS Lincoln, eds. *Collecting and interpreting qualitative material*. London: Sage, 499-541.
- Robertson IH, Manly T, Andrade J, Baddeley BT, Yiend J (1997a) Oops: performance correlates of everyday attentional failures in traumatic brain injured and normal subjects. *Neuropsychologica*, 35(6), 747-58.
- Robertson IH, Ridgeway V, Greenfield E, Parr A (1997b) Motor recovery after stroke depends on intact sustained attention: a 2-year follow-up study. *Neuropsychology*, 11(2), 290-95.
- Robertson IH, Murre JM (1999) Rehabilitation of brain damage: brain plasticity and principles of guided recovery. *Psychological Bulletin*, 125(5), 544-55.
- Rogers CR (1980) *A way of being*. New York: Houghton Mifflin.
- Rogers JC, Holm MB (1991) Occupational therapy diagnostic reasoning: a component of clinical reasoning. *American Journal of Occupational Therapy*, 45(11), 1045-53.
- Royall DR, Cabello M, Polk MJ (1998) Executive dyscontrol: an important factor affecting level of care received by older retirees. *Journal of the American Geriatric Society*, 46(12), 1519-24.
- Safran JD, Muran JC (2000) *The therapeutic alliance: a relational treatment guide*. New York: Guilford Press.
- Sbordone RJ (2000) The assessment interview in clinical neuropsychology. In: G Groth-Marnat, ed. *Neuropsychological assessment in clinical practice: a guide to test interpretation and integration*. New York, John Wiley, 94-126.
- Schell BA, Cervero RM (1993) Clinical reasoning in occupational therapy: an integrative review. *American Journal of Occupational Therapy*, 47(7), 605-10.
- Schön DA (1983) *The reflective practitioner: how professional think in action*. London: Temple Smith.
- Schön DA (1987) *Educating the reflective practitioner*. San Francisco: Jossey-Bass.
- Schwandt TA (1994) Constructivist, interpretivist approaches to human inquiry. In: NK Denzin, YS Lincoln, eds. *Handbook of qualitative research*. London: Sage.
- Schwartzberg S (2002) *Interactive reasoning in the practice of occupational therapy*. Upper Saddle River, NJ: Pearson Education.
- Spouse J (1998) Scaffolding student learning in clinical practice. *Nurse Education Today*, 18, 259-66.
- Strauss A, Corbin J (1998) *Basics of qualitative research: techniques and procedures for developing grounded theory*. London: Sage.
- Sumsion T (2000) A revised occupational therapy definition of client-centred practice. *British Journal of Occupational Therapy*, 63(70), 304-309.
- Titchen A (2001) Skilled companionship in professional practice. In: J Higgs, A Titchen, eds. *Practice knowledge and expertise in the health professions*. Oxford: Butterworth Heinemann, 69-79.
- Turner A (2002) Occupation for therapy. In: A Turner, M Foster, S Johnson, eds. *Occupational therapy and physical dysfunction: principles, skills and practice*. London: Churchill Livingstone, 25-46.
- Unsworth C (2004) Clinical reasoning: how do pragmatic reasoning, worldview and client-centredness fit? *British Journal of Occupational Therapy*, 67(1), 10-19.
- Wenger E (1998) *Communities of practice: learning, meaning, and identity*. Cambridge: Cambridge University Press.
- White K (2001) Professional craft knowledge and ethical decision-making. In: J Higgs, A Titchen, eds. *Practice knowledge and expertise in the health professions*. Oxford: Butterworth Heinemann, 142-48.
- Wood D (1998) *How children think and learn: the social contexts of cognitive development*. Oxford: Blackwell.

Author

Helen J Wilby, MA, BA, DipCOT, Senior Lecturer, St Martin's College, Bowerham Road, Lancaster LA1 3JD. Email: h.wilby@ucsm.ac.uk

Appendix 1. Format for reporting functional screening assessment (adapted for individual patients)

Summary

Preadmission history

- Functional overview
- Home environment/Support networks

Current functional performance

- Selective movement/Postural attitude
- Cognitive functioning/Affective presentation
- Activities of daily living

Considerations regarding rehabilitation/future management/ care needs/discharge planning

Recommendations