

Clinical Task Instruction

SKILL SHARED TASK

S-AD03: Assess dressing and provide basic/bridging intervention

Scope and objectives of clinical task

This CTI will enable the health professional to:

- assess the client's ability to safely and effectively dress and undress themselves in sitting
- develop and implement an appropriate plan to address common dressing deficits including providing standard education on the use of adapted clothing, one handed techniques and dressing equipment.

VERSION CONTROL

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This Clinical Task Instruction (CTI) has been developed by the Allied Health Professions' Office of Queensland (AHPOQ) using information from locally developed clinical procedures, practicing clinicians, and published evidence where available and applicable

This CTI should be used under a skill sharing framework implemented at the work unit level. The framework is available at:

<https://www.health.qld.gov.au/ahwac/html/calderdale-framework.asp>

Skill sharing can only be implemented in a health service that possesses robust clinical governance processes including an approved and documented scope of skill sharing within the service model, work-based training and competency assessment, ongoing supervision and collaborative practice between skill share-trained practitioners and health professional/s with expertise in the task. A health professional must complete work-based training including a supervised practice period and demonstrate competence prior to providing the task as part of his/her scope of practice. When trained, the skill share-trained health professional is independently responsible for implementing the CTI including determining when to deliver the task, safely and effectively performing task activities, interpreting outcomes and integrating information into the care plan. Competency in this skill shared task does not alter health professionals' responsibility to work within their scope of practice at all times, and to collaborate with or refer to other health professionals if the client's needs extend beyond that scope. Consequently, in a service model skill sharing can augment but not completely replace delivery of the task by profession/s with task expertise.

Please check <https://www.health.qld.gov.au/ahwac/html/clintaskinstructions.asp> for the latest version of this CTI.

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Requisite training, knowledge, skills and experience

Training

- Mandatory training requirements relevant to Queensland Health/HHS clinical roles are assumed knowledge for this CTI.
- If not part of mandatory requirements complete patient manual handling techniques, including the use of walk belts, and sit to stand transfers.
- This CTI is written for client's performing the task in a seated position. If the local implementation of the CTI will include client's standing during the task, the skill share-trained health professional should have completed training in, or have demonstrated competence in, facilitating and assessing safe standing balance e.g. CTI S-MT05: Standing balance assessment. A standing balance assessment should be conducted prior to commencing the task. The standing balance assessment should include standing with eyes closed, head back, arms to head, reaching and standing on one leg as components of the task. This variant should be noted in the Performance Criteria Checklist.
- Competence in the following CTIs or demonstrated professional equivalence:
 - CTI S-MT07: Standing transfer assessment

Clinical knowledge

To deliver this clinical task a health professional is **required** to possess the following theoretical knowledge:

- conditions that commonly make dressing difficult including pain, surgical restrictions, muscle weakness/tightness, neurological conditions, poor vision and altered cognition, perception and/or sensation. This should include conditions identified in the indications and limitations section of this CTI.
- socially acceptable patterns of dressing e.g. modesty, personal/cultural and spiritual preferences
- steps and elements of functional dressing including duration of the task, orientation of clothing items and donning/doffing
- common adaptations to support functional dressing including pacing, adapted clothing, one handed dressing techniques and dressing equipment e.g. long handled reacher, button hooks, sock aids, shoe horns, elastic shoe laces, and Velcro® fasteners.

The knowledge requirements will be met by the following activities:

- review of the Learning Resource
- receive instruction from the lead health professional in the training phase
- read and discuss the following references/resources with the lead health professional at the commencement of the training phase:
 - local falls risk screening and mitigation strategies, programs and/or processes
 - local equipment hire/purchase protocols, processes and schemes e.g. the Department of Veterans Affairs (DVA) and Medical Aids Subsidy Scheme (MASS)
 - local equipment supplier details and relevant processes, including type of equipment, pricing and delivery processes.

Skills or experience

The following skills or experience are not specifically identified in the task procedure but support the safe and effective performance of the task or the efficiency of the training process and are:

- **required** by a health professional in order to deliver this task:
 - competence in the use of mobile oxygen and/or any required monitoring equipment relevant to the local care setting e.g. blood pressure, oxygen saturation or heart rate.
- **relevant but not mandatory** for a health professional to possess in order to deliver this task:
 - experience working with clients in rehabilitation settings, including supporting the retraining of functional tasks.

Indications and limitations for use of skill shared task

The skill share-trained health professional shall use their independent clinical judgement to determine the situations in which he/she delivers this clinical task. The following recommended indications and limitations are provided as a guide to the use of the CTI but the health professional is responsible for applying clinical reasoning and understanding of the potential risks and benefits of providing the task in each clinical situation.

Indications

- The client has been identified as having dressing problems. This may be via referral, subjective history taking, medical record or direct observation e.g. observed difficulty putting on and/or orientating cardigan/jacket, buttons mismatched or undone or inability to put shoes on.
- The client is medically stable and there is no medical prohibition to participating in dressing e.g. the medical record indicates that the client has no restrictions to sitting up and vital signs are within expected limits, or the client is living in the community and is not acutely unwell.

Limitations

- Limitations listed in CTI S-MT07 apply.
- If the skill share-trained health professional is **not** required to complete CTI S-MT07 i.e. where standing transfer assessment is within their existing expertise and scope of practice, then:
 - as part of the training process, review the limitations listed in the CTI above
 - consider existing skills, knowledge and experience in the tasks
 - in collaboration with the lead health professional, determine and document bespoke limitations to this task relevant to the individual's scope of practice.

For example, teams may determine that physiotherapists with task expertise in standing transfer assessment and balance may include client groups in the scope of this CTI that would be otherwise excluded such as clients with an amputation or those who are non-weight bearing.

- Additional limitations include the following:
 - The client is known to require full assistance to dress. The client currently receives support from family or service providers for dressing and there has been no change in physical or cognitive function to indicate a need for re-assessment.
 - The client is unable to sit upright without support or demonstrates poor sitting balance. This may include actual or near loss of balance when eyes are closed, reaching behind, leaning to the side or

reaching towards the ground or behind. This may be due to reduced muscle strength, involuntary movements, vestibular issues or visuospatial perceptual problems. Sitting balance may also be impacted by medical/surgical restrictions, poor trunk/head control, structural deformity, contractures, spasticity, vestibular problems, uncontrolled hypotension. Sitting balance problems may be associated with a head injury, spinal cord injury, motor neurone disease, cerebral palsy or a range of other conditions.

- The client requires more than one assist to stand from sitting. Sit to stand is required for lower limb dressing e.g. to pull undergarments up. If the client cannot perform lower limb dressing as part of the skill shared task, upper limb dressing/undressing assessment may still be undertaken. If required, the client may need assistance for lower limb dressing to complete the task.
- Significant bilateral upper limb weakness or reduced range of motion. At a minimum the client must be able to grasp and move clothing to the required position with at least one hand and arm.
- The client has ideation apraxia. This is a condition in which an individual is unable to plan movements related to interaction with objects e.g. trying to put shoes on hands, putting soap on a toothbrush or buttering bread prior to placing in the toaster.
- The client shows signs of fatigue and/or drowsiness. Schedule the assessment at a time that coincides with an increased level of alertness or at a time when dressing is required e.g. after showering. If symptoms are moderate to severe, cease the task.
- The client complains of pain at rest and/or that is aggravated by movement. Consider scheduling the assessment to a time that coincides with analgesia and support the client to avoid aggravating movements during the task through cueing or manual guidance. If symptoms are moderate to severe, cease the task.
- The client has ataxia or freezing. If symptoms are mild, monitor balance and limb placement closely during the task. If symptoms are moderate to severe, cease the task.
- The client has orthopaedic, surgical or medical restrictions. These will be documented via protocols, theatre notes, or medical orders e.g. weight bearing status (non, touch, partial, full), total hip replacement precautions, mobilise within range of a movement brace only, sternotomy precautions for upper limb weight bearing or a history of shoulder dislocation or surgery. The client with restrictions must be cleared to undertake the task by the medical team or through a protocol/care pathway and any restrictions must be adhered to during the task. If restrictions are unable to be maintained during the task, it should be ceased. If restrictions are unclear, consult with the treating team.
- The client has a significant cognitive deficit e.g. an inability to follow instructions for safety, is disorientated in the bathroom environment or is known to demonstrate impulsive, unpredictable or aggressive behaviour.
- The client reports significant concerns and/or anxiety with being assessed during dressing or does not consent to being observed during dressing. This may be due to modesty or cultural concerns and/or gender of the health professional performing the task. Discuss the concerns with the client and provide further information on the purpose of the task. Determine if the client consents to proceed or develop a management plan for dressing assessment. This may include the use of simulation of the dressing activity or assessment by a health professional of a different gender.

Safety & quality

Client

The skill share-trained health professional shall identify and monitor the following risks and precautions that are specifically relevant to this clinical task:

- As dressing requires good dynamic balance, close supervision of the client is required at all times. If the client requires assistance with standing up/sitting down, arrange this prior to commencing the task. Do not leave the client unattended whilst partially dressed.
- Appropriate footwear should be worn prior to the client standing up to mobilise i.e. well-fitting enclosed shoes with good traction or grip socks.
- The client has transient, limited or reduced sensation and/or proprioception e.g. spinal cord compression/injury, peripheral neuropathy or neurological disease. Monitor for clothing adjustment and placement during the task to avoid entrapment in the clothing. The prolonged wear of twisted and/or tight clothing may reduce circulation and increase the risk of pressure injury.
- The client has a wound and/or oedema of the limbs. If a wound dressing is present, ensure it is intact prior to commencing the dressing task. If oedema or increased sensitivity is present, ensure that clothing is loose fitting. A management plan should be in place to address wounds and/or oedema e.g. wound dressings, bandaging or compression garment.
- The client requires or is currently receiving oxygen. Discuss the task with a relevant health professional from the treating team prior to commencing the task e.g. nurse, doctor. The skill share-trained health professional must be competent in the use of mobile oxygen and any monitoring equipment if required to undertake the task. Observe the client's ability to manage their oxygen requirements whilst dressing, noting shortness of breath, fatigue management and placement of oxygen tubing.
- If the client is unsafe or unable to complete the task, cease the assessment and provide assistance to dress the client for modesty.

Equipment, aids and appliances

- The client should be assessed using their usual dressing aids and/or appliances. If their usual aid, appliance or product is not available a similar trial/loan item should be provided. Items may include a dressing stick, shoe horn, button hook, ankle foot orthosis (AFO), prosthetic limb/s, splint/s, compression garments, glasses, hearing aids, wigs, incontinence products, stoma and indwelling catheter (IDC) bags or personal alarms.
- Ensure all equipment is clean and in good working order as per local infection control and equipment maintenance protocols. Refer to the manufacturer's guidelines for specific maintenance requirements for dressing aids e.g. check rubber grips have not perished, rubber stoppers are in place on dressing sticks, the coating over the dressing stick hook has not perished, long handled shoe horn is not cracked/split and button hook components are working.

Environment

- As this task assesses the client's ability to dress/undress, it should be performed in a private area to maintain the client's modesty.
- If the task is being undertaken in the bathroom, check the floor is dry and clean prior to the client standing up to put on underwear/pants. This includes wiping up excess water and/or talcum powder.

Performance of Clinical Task

1. Preparation

- Use information collected from the medical chart to determine the client's dressing ability including the use of any modified techniques and/or aids or required assistance as per the *Guide to conducting a dressing history* in the Learning Resource and the client is medically cleared to undertake the task.
- Ensure the client has clothing available for the dressing assessment e.g. underwear, day clothes and footwear.

2. Introduce task and seek consent

- The health professional checks three forms of client identification: full name, date of birth, **plus one** of the following: hospital UR number, Medicare number, or address.
- The health professional introduces the task and seeks informed consent according to the Queensland Health Guide to Informed Decision-making in Health Care 2nd edition (2017).
- As the task involves observation of dressing, client consent should include information on the need to be observed and details on how privacy and dignity will be maintained.

3. Positioning

- The client's position during the task should be:
 - sitting, in a safe, private location such as the bathroom or the bedroom, with feet flat on the floor e.g. on a mobile commode, on a shower chair or on the side of the bed.
- The health professional's position during the task should be:
 - standing to the side of the client and slightly in front to monitor the client during the task and provide hands on assistance if required. If the client has a weaker/affected side, assistance is usually provided on this side.
 - If required, an assistant should stand on the affected side (where relevant) and in a position so as not to obstruct the observation of the client's performance. If a client requires more than one light assist, review the "Limitations" section of this CTI.

4. Task procedure

- The task comprises the following steps:
 1. Explain and demonstrate (where applicable) the task to the client.
 2. Check the client has understood the task and provide an opportunity to ask questions.
 3. Obtain or confirm information from the client (or carer) with regard to:
 - a) current physical capability and/or issues relevant to dressing including equipment requirements, personal preferences, and problems or concerns
 - b) the ability to sit and stand including balance history i.e. falls history, ability to stand/mobilise, assistance required, aid used and medical/surgical restrictions
 - c) assistance required for sitting, sit to stand and standing

On the basis of the information provided, determine if the task will progress to include the observation of dressing performance.

4. Observe the client in sitting. If the client is unable to sit unsupported, cease the task e.g. cannot sit without back or arm support, or has excessive postural sway, leaning or listing. Document all observations and refer to a health professional with expertise in the task for further assessment.
5. Assess the client standing up and sitting down. Determine if the task will include both upper and lower limb dressing/undressing. If the client is seen immediately after showering and requires more than one assist to dress the lower limbs, arrange this assistance prior to commencing the task.
6. Ask the client to undress and dress themselves including the use of equipment, see the “Safety and quality” section above. Evaluate dressing performance using *Dressing assessment – observations* and *Table 1: Clinical reasoning guide to common observations and adaptive strategies* in the Learning Resource. Assist the client to complete the dressing task if required, noting any verbal prompting and/or physical assistance/manual guidance provided.

Note: If the client is seen immediately after showering and is undressed at commencement of the task, the skill share-trained health professional will assess dressing and then may choose to ask the client to demonstrate the components of undressing through simulation of the activity, rather than actually undressing and then dressing again. If problems are noted when simulating undressing, the client can be requested to demonstrate the full activity in this or a subsequent session. The health professional should consider client fatigue, pain and tolerance in determining the extent of the dressing/undressing tasks covered in a single occasion of service, particularly if coupled with showering or other activities.

7. Determine if the client would benefit from a basic/bridging intervention/s to improve dressing performance. Refer to *Table 1: Clinical reasoning guide to common observations and adaptive strategies for dressing* and *Table 2: Dressing equipment* in the Learning Resource.
8. Select appropriate basic/bridging intervention/s considering the client’s goals, impact on independence, safety and timeliness of task performance.
9. Discuss and develop a plan with the client (and/or carer if relevant) for intervention/s e.g. assistance, adapted clothing, one-handed techniques and/or dressing equipment. If recommending equipment, include features, maintenance requirements, risks, cost and proposed benefits for independence.
10. Implement the plan by providing education, including demonstration (if required), for each intervention. Observe the client using the prescribed environment, technique and/or equipment. Provide cueing and manual guidance if required for safety and training effectiveness. Make any adjustments to the plan to improve performance.
11. Determine if the client requires further review and/or rehabilitation.

5. Monitoring performance and tolerance during the task

- Common errors and compensation strategies to be monitored and corrected during the task include:
 - the client does not complete the task in a usual order. If sequencing problems are noted provide the client with an opportunity to self-correct. If the client does not self-correct prompt the client with the correct order and/or provide assistance.
 - the client has orientation problems e.g. difficulty orientating clothing front to back, inside out, or orientating the body to the clothing such as placing arms into pants or feet into shirt sleeves. If orientation problems are noted provide the client with an opportunity to self-correct. If the client does

not self-correct prompt the client with the correct orientation placement/position of clothing or body and/or provide assistance.

- buttons are not aligned. Provide the client with an opportunity to self-correct. If the client does not self-correct prompt the client with the correct order and/or provide assistance.
- the client gets stuck in clothing e.g. due to not/partially unfastening buttons, zippers or laces/fasteners. Provide a verbal prompt and/or assistance to return to the previous dressing step.
- Monitor for adverse reactions and implement appropriate mitigation strategies as outlined in the “Safety and quality” section above.

6. Progression

- The client may require further assessment if dressing goals change or factors impacting dressing change e.g. acute exacerbation of Chronic Obstructive Pulmonary Disease resolves, change in weight bearing status, a new fall, hospital admission, change in assistance available, acute injury to the limbs, illness or surgery.

7. Document

- Document the outcomes of the task as part of the skill share-trained health professional’s entry in the relevant clinical record, consistent with documentation standards and local procedures, commenting on the clients ability to complete the task and specifics of task performance including:
 - the environment the task was undertaken e.g. hospital ward bathroom, client’s bedroom/bathroom
 - the client’s position during the task e.g. sitting on a chair, side of bed, commode chair
 - ability to initiate and complete the task in a timely manner
 - ability to plan the task including correct use of any required equipment
 - specifics of task performance including planning for the task, ability to orientate clothing, perform the task in an appropriate order, recognise items, problem solve and effectiveness
 - safety during the task and the client’s awareness of the potential dangers
 - aspects of the task that required the use of redirection/verbal cueing, manual guidance or assistance
 - a recommendation for ongoing dressing/undressing performance e.g. independent, requires equipment, supervision and/or assistance. If supervision and/or assistance are provided this should also be described e.g. cueing, manual guidance, environmental set-up or symptom monitoring.
 - if equipment training and/or a rehabilitation goal are relevant record a plan to achieve this e.g. provision of standard education for long handled dressing aids or adapted clothing, education on one handed dressing techniques and/or pacing or the commencement of a rehabilitation program.
 - any basic/bridging intervention/s that were provided as part of the session, including the outcome for each intervention i.e. change in performance and recommendation for ongoing use.
- The skill shared task should be identified in the documentation as “delivered by skill share-trained (*insert profession*) implementing CTI S-AD03: Assess dressing and provide basic/bridging intervention” or similar wording.

References and supporting documents

- Australian Commission on Safety and Quality in Healthcare (2012). Safety and Quality Improvement Guide Standard 8: Preventing and managing pressure injuries. Sydney ACSQHC, 2012. Available at: https://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard8_Oct_2012_WEB.pdf
- Queensland Health (2017). Guide to Informed Decision-making in Health Care (2nd edition): https://www.health.qld.gov.au/_data/assets/pdf_file/0019/143074/ic-guide.pdf
- Examples of client handouts:
 - Cairns and Hinterland Hospital and Health Service: Long Handed Aids (n.d.). Available at: https://qheps.health.qld.gov.au/_data/assets/pdf_file/0029/660494/ot-long-handled-aids-2018.pdf
 - Cairns and Hinterland Hospital and Health Service (n.d.). One handed tips. Available at: http://qheps.health.qld.gov.au/cairns/docs/ot_one_hand_tech.pdf
 - Darling Downs Hospital and Health Service, State of Queensland (2017). Fact Sheet 987.v2 - Long handled self care assistive devices. Available at: <http://qheps.health.qld.gov.au/darlingdowns/pdf/fact/fact-987.pdf>
 - Darling Downs Hospital and Health Service, State of Queensland (2015). Fact Sheet 2164.v1 - Energy conservation and work simplification. Available at: <http://qheps.health.qld.gov.au/darlingdowns/pdf/fact/fact-2164.pdf>
 - Metro South Health: Princess Alexandra Hospital. Occupational Therapy: Dressing Aids (2015). Available at: <http://paweb.sth.health.qld.gov.au/sqrm/qiu/brochures-posters/documents/ot-dressing-aids.pdf>
 - Queensland Government (2017) QEII Jubilee Hospital. Occupational Therapy: Dressing Aids (2017). Available at: <http://qheps.health.qld.gov.au/qeii/docs/patient-info/QEH1414.pdf>
 - Torres and Cape Hospital and Health Service: Client Information: Dressing Aids (n.d.) Available at: <http://qheps.health.qld.gov.au/torres-cape/docs/procedure-0388-dressing-aids.pdf>
- Example recording forms
 - Queensland Government (2014). Showering observation record occupational therapy v1-04/14. Available at: <http://qheps.health.qld.gov.au/tville/cdsu/clinical-forms/docs/cf-showering-observation-record.pdf>
 - Queensland Government. West Moreton Hospital and Health Service. Occupational task performance: showering. Available on request from Occupational Therapy department West Moreton.

Assessment: Performance Criteria Checklist

CTI S-AD03: Assess dressing and provide basic/bridging intervention

Name:

Position:

Work Unit:

Performance Criteria	Knowledge acquired	Supervised task practice	Competency assessment
	Date and initials of Lead HP	Date and initials of Lead HP	Date and initials of Lead HP
Demonstrates knowledge of fundamental concepts required to undertake the task through observed performance and the clinical reasoning record.			
Identifies indications and safety considerations for the task and makes appropriate decisions to implement the task, including any risk mitigation strategies, in accordance with the clinical reasoning record.			
Completes preparation for the task including ensuring dressing equipment and clothes are available and in good working order.			
Describes the task and seeks informed consent.			
Prepares the environment and positions self and client appropriately to ensure safety and effectiveness of the task, including reflecting on risks and improvements in the clinical reasoning record where relevant.			
<p>Delivers the task effectively and safely as per the CTI procedure, in accordance with the Learning Resource.</p> <ul style="list-style-type: none"> a) Clearly explains and demonstrates the task, checking the client's understanding. b) Gains a dressing history from the medical record and subjectively from the client/carer. c) Confirms the client's capacity to participate in a dressing assessment including dynamic sitting balance. d) Determines the client's capacity to participate in both upper and lower limb dressing including assessing the client's ability to sit to stand. e) Assesses the client's dressing/undressing. f) Describes dressing performance including compensatory strategies and limitations. g) Determines if the client would benefit from a basic/bridging intervention/s. h) Selects appropriate intervention/s. i) Develops a plan with the client for the planned intervention/s. j) Implements the agreed intervention/s, including observation of the client using the technique/equipment. k) Makes any adjustments to the plan. 			

l) Determines if the client will require review and/or rehabilitation.			
m) During the task, maintains a safe clinical environment and manages risks appropriately.			
Monitors for performance errors and provides appropriate correction, feedback and/or adapts the task to improve effectiveness, in accordance with the clinical reasoning record.			
Documents in the clinical notes including a reference to the task being delivered by the skill share-trained health professional and CTI used.			
If relevant, incorporates outcomes from the task into an intervention plan e.g. plan for task progression, interprets findings in relation to care planning, in accordance with the clinical reasoning record.			
Demonstrates appropriate clinical reasoning throughout the task in accordance with the Learning Resource.			

Comments:

Record of assessment of competence

Assessor name:	Assessor position:	Competence achieved: / /
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Scheduled review

Review date / /

S-AD03: Assess dressing and provide basic/bridging intervention

Clinical Reasoning Record

The clinical reasoning record can be used:

- as a training resource, to be completed after each application of the skill shared task (or potential use of the task) in the training period and discussed in the supervision meeting
- after training is completed for the purposes of periodic audit of competence
- after training is completed in the event of an adverse or sub-optimal outcome from the delivery of the clinical task, to aid reflection and performance review by the lead practitioner.

The clinical reasoning record should be retained with the clinician's records of training and not be included in the client's clinical documentation.

Date skill shared task delivered: _____

1. Setting and context

- insert concise point/s outlining the setting and situation in which the task was performed, and their impact on the task

2. Client

Presenting condition and history relevant to task

- insert concise point/s on the client's presentation in relation to the task e.g. presenting condition, relevant past history, relevant assessment findings

General care plan

- insert concise point/s on the client's general and profession-specific / allied health care plan e.g. acute inpatient, discharge planned in 2/7

Functional considerations

- insert concise point/s of relevance to the task e.g. current functional status (including cognition/perception), functional needs in home environment or functional goals. If not relevant to task - omit.

Environmental considerations

- insert concise point/s of relevance to the task e.g. environment set-up/preparation for task, equipment available at home and home environment. If not relevant to task - omit.

Social considerations

- insert concise point/s of relevance to the task e.g. carer considerations, other supports, client's role within family, transport or financial issues impacting care plan. If not relevant to task - omit.

Other considerations

- insert concise point/s of relevance to the task not previously covered. If none, omit.

3. Task indications and precautions considered

- insert concise point/s on the indications present for the task, and any risks or precautions, and the decision taken to implement / not implement the task including risk management strategies.

4. Outcomes of task

- insert concise point/s on the outcomes of the task including difficulties encountered, unanticipated responses

5. Plan

- insert concise point/s on the plan for further use of the task with this client including progression plan (if relevant)

6. Overall reflection

- insert concise point/s on learnings from the use of the task including indications for further learning or discussion with the lead practitioner

Skill share-trained health professional

Lead health professional (trainer)

Name:

Name:

Position:

Position:

Date this case was discussed in supervision: / /

Outcome of supervision discussion e.g. further training, progress to final competency assessment

Assess dressing and provide basic/bridging intervention: Learning Resource

Dressing/undressing is an activity of daily living and is the act of putting on and taking off clothing, referred to as donning and doffing respectively. Clients who are able to dress and undress themselves are more independent and require less care and support when going to the toilet, performing hygiene (showering/bathing) and for maintaining general health (warmth).

The frequency, style and amount of clothing is dependent upon a variety of factors including personal preference, safety, cultural and societal expectations, environment, functionality and purpose/event. Socially, clothing is expected and preferred by most people for modesty. Generally clothing consists of a minimum of two layers, undergarments and outer wear. The aim of a dressing assessment is to determine the client's functional ability to dress and undress.

Included with the dressing assessment is the observation of donning and doffing footwear. Ill-fitting or poorly maintained footwear is hazardous to walking due to increasing the risk of falls. The dressing assessment includes determining the client's functional ability to don and doff footwear and select appropriate footwear for safety.

Required reading

General

- Cohen-Mansfield J, Jensen B (2007). Dressing and grooming: preferences of community-dwelling older adults. *Journal of Gerontological Nursing* 33(2):31-9. Available through CKN:
- Hall C (2013). Dressing. *Occupational Therapy Toolkit*. Available at: <http://www.ottoolkit.com/pdfs/dressing.pdf>
- The OT Process (2016). Practical guides #8: How to do a washing and dressing assessment and introduction to dressing aids. Available at: <https://theotprocess.wordpress.com/2016/12/21/practical-guides-8-how-to-do-a-washing-and-dressing-assessment-and-introduction-to-dressing-aids/>

Dressing and grooming equipment

- DLF Shaw Trust (2018). Choosing clothing and dressing equipment. Available at: <http://www.dlf.org.uk/factsheets/clothing>
- Government of South Australia (2013). Disability information: Personal care: looking after yourself. Available at: http://www.sa.gov.au/_data/assets/pdf_file/0019/15184/personal-care-looking-after-yourself.pdf

Foot wear

- Queensland Government (2011). The Queensland stay on your feet® checklist: Footwear. Available at: https://www.health.qld.gov.au/_data/assets/pdf_file/0027/428139/33381_f.pdf

One-handed dressing techniques

- Edmans J (Ed). (2010). Appendix: One-handed techniques. In Occupational therapy and stroke (2nd Ed). Blackwell Publishing Ltd. ISBN:978-1-405-19266-8. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/9781444323801.app1/pdf>
- Library for health information (n.d.) Putting on pants with one hand. Available at: <https://patienteducation.osumc.edu/Documents/Pants1Hand.pdf>
- Library for health information (n.d.) Putting on a pullover shirt with one hand. Available at: <https://patienteducation.osumc.edu/Documents/PulloverShirt1Hand.pdf>
- UPMC Life Changing Medicine (2017). Dressing: Button-front shirt over-the-head method. Available at: <http://www.upmc.com/patients-visitors/education/rehab/Pages/dressing-button-front-shirt-over-the-head-method.aspx>

Pacing

- Independent Living Centre WA: Conserve energy and simplify tasks. Available at: <https://ilc.com.au/wp-content/uploads/2015/03/Work-Simplification-and-Energy-Conservation.pdf>

Required viewing – demonstrations

Button hook

- Adaptive Equipment Corner (2015). A button hook and how to use it. Available at: <https://www.youtube.com/watch?v=YOXCvMKrZN4>

Dressing stick

- Disable Living Foundation - DLF (2015). Dressing stick. Available at: <https://www.youtube.com/watch?v=AjNklal80yw>
- DMEgirl (2016). Dressing stick. Available at: <https://www.youtube.com/watch?v=mneg5y7pZng>

Long handled reacher

- CurePSPHowto (2010). Putting on pants with a reacher aid. Available at: <https://www.youtube.com/watch?v=ZrZ6bx5GUMw>
- Hospital for special surgery (2012). Activities of daily living: dressing. Available at: <https://www.youtube.com/watch?v=qDr1zQeZZ1A>

One-handed techniques

- Miller A (2010). Stroke survivor exercise' getting dressed r. Available at: https://www.youtube.com/watch?v=zZkwr_mfU5Y

Sock Donner

- Adaptive equipment corner (2015). What is a sock aid and how to use it? Available at: <https://www.youtube.com/watch?v=YCPE491anQM>
- Hospital for special surgery (2012). Activities of daily living: putting on and taking off socks. Available at: <https://www.youtube.com/watch?v=9hG-RSWyFJs>

Various equipment

- VCU Occupational Therapy (2015) Dressing with a hip kit. Available at: <https://www.youtube.com/watch?v=c4ssccByUHBw>

Optional reading

- Richards-Yarnell C (2003). Task analysis of functional dressing skill. Vermont. Available at: http://wps.prenhall.com/wps/media/objects/2357/2414567/Volume_medialib/Featured_Teacher/Chap01/dressing_skill.pdf
- Vanderburgh PL (2012). Pair of pants and method for donning and removing a pair of pants. US20120317700A1. Available at: <http://www.google.com/patents/US20120317700>

Guide to conducting a dressing history

- These questions assist in determining the type of clothing items required for the assessment:
 - What type of clothes does the client normally wear at home during the day? Does this differ between going out and staying at home? What do they wear at night to sleep? Do they require any activity specific clothing e.g. bowls, church clothes, gardening or for an exercise group?
 - What clothes do they wear underneath their clothes e.g. bra, underwear, singlet, petticoat or nil? If nil underclothes, determine the reason e.g. personal preference, rash, wound, comfort, difficulty donning.
- Determine the suitability of the client's clothing choices for the environment, climate and purpose e.g. are they wearing a raincoat indoors, overcoats in summer or pyjamas for shopping? Discuss with the client the rationale and reasoning for the clothing choice. Determine the risk to the client's health and safety e.g. risk of overheating, modesty concerns. If a health and safety risk exists, liaise with the health professional with expertise in the task to develop a management strategy.
- What does the client wear on their feet, inside and outside? Do they require any additional purpose orientated footwear e.g. gum boots, bowling shoes, slippers or medical-grade footwear?
- Does the client require any other equipment/aids e.g. orthotics, AFOs, prosthetic limb, splints, compression garments, glasses, hearing aids, wigs, incontinence pads or pull ups, stoma and IDC bags, personal alarms, glasses, dentures, hearing aids, wigs or toupees?
- If the client uses dressing equipment/aids, determine their confidence with donning and doffing it. Determine if clothing and/or its adjustment impacts on the equipment/aid wear. If clothing is placed under or over the aid/equipment, the client may be at risk of pressure injury e.g. pants crossing over a stoma, hats over hearing aids or jumpers over splints. Liaise with the health professional with expertise with the equipment/aid to determine risk and a suitable management strategy if required.
- For each 'dressing type' clarify personal, cultural and/or spiritual preferences including attire choice, suitability for the activity, dressing order and assessment requirements.
- Deodorant may be considered to be part of dressing or grooming process. Determine if the client has/will be assessed applying deodorant as part of the dressing assessment. If yes, does the client normally wear deodorant? If no, determine the reason e.g. doesn't like it, cannot afford it or prefers not to. If yes, when does the client apply deodorant i.e. prior to dressing or after donning undergarments/over garments? Do they experience any difficulty? Roll-on deodorant is usually milder on the skin and requires less co-ordination to apply.
- Does the client dress independently? If no, clarify the level and the type of assistance and/or aid required e.g. verbal cueing, manual guidance and/or dressing aid.

- Does the client have any difficulties with dressing/undressing? If so, describe what aspects of the task?
- Does the client use any dressing aids and/or modified techniques for dressing/undressing?
- Where does the client perform dressing e.g. bedroom or bathroom? Do they use hand support e.g. hand rail for steadying while pulling on pants?

Dressing assessment - observations

Prior to the dressing/undressing assessment

The observation of dressing/undressing occurs at the commencement of the task. Information gathering includes observing the client's current state of dress. For example, does information on the history coincide with the client's attire? Is clothing arranged correctly? Is dressing complete and appropriate for the environment e.g. buttons may be misaligned or underwear missing?

Commencing the assessment

As part of dressing assessment, the client should be requested to identify, locate and collect the required dressing items. The health professional should note if assistance is required, including the type. For example the health professional may need to locate or collect shoes, the client gathers clothing but is unable to carry it to the dressing area for the assessment, or the client demonstrates uncertainty in which items to collect.

Determine the client's management plan to collect these items e.g. the client uses carer support, a basket or trolley to transport items or the items are stored in the dressing area.

Dressing/undressing

The formal assessment commences with the removal (doffing) of/or initiation of donning of clothing. The dressing/undressing clothing order will be influenced by the client's personal preference, modesty and functionality of the upper limbs, torso and lower limbs. For example, the client may have poor lower limb function and be assessed after showering. The assessment may commence with donning underpants first for modesty. Dressing of the upper limbs and torso then occurs due to the intact upper limb function, followed by dressing the lower limbs and feet prior to leaving the dressing area.

If the client will be wearing equipment/aids, seek advice regarding their correct application. This may include reading manufacturer's guidelines, liaising with the prescriber or a health professional with expertise in training in the equipment/aid use.

Completion

The task is completed once the client is dressed or undressed for the planned activity e.g. undressed for the shower, dressed for breakfast, bed or gardening. The skill share-trained health professional, as part of making dressing recommendations, must assess the client's ability to perform both dressing and undressing as per *Table 1: Clinical reasoning guide to common observations and adapted strategies for dressing* in the Learning Resource.

If the client is seen immediately after showering and observed performing dressing, the skill share-trained health professional should determine when and how the undressing observation will occur. This may include having the client demonstrate the components of undressing through simulation of the activity, rather than actually undressing and then redressing, or scheduling an undressing assessment session e.g. prior to showering on another day. The health professional should consider client fatigue, pain and tolerance as part of the decision-making process.

Table 1 Clinical reasoning guide to common observations and adaptive strategies for dressing

Assessment component	Observation performance criteria	Common problems	Adaptive strategy/remedy
Limb function	<p>Upper limb</p> <p>The client is able to use both hands and arms in a co-ordinated fashion during the task including the ability to manipulate equipment safely and effectively. The upper limbs demonstrate adequate strength and control to move to the required positions and manipulate equipment appropriately for the task.</p> <p>Lower limb</p> <p>The client is able to use both legs in a co-ordinated fashion during the task to fit clothing and shoes including lifting their bottom to put on underwear/pants. The lower limbs demonstrate adequate strength and control to move the lower limbs and trunk to the required positions.</p>	<p>The client demonstrates:</p> <ul style="list-style-type: none"> • difficulty adjusting clothing and/or manipulating zippers, buttons, ties and buckles, shoe laces, back of clothing e.g. bra • difficulty manipulating equipment/aids for appropriate fit • poor positioning/neglect of limb/s during clothing adjustment due to problems with proprioception, muscle control, neglect • difficulty shifting weight to adjust clothing 	<p>Provide dressing retraining including:</p> <ul style="list-style-type: none"> • education on adapted clothing options including elastic shoe laces, Velcro® fasteners, clothing that easily stretches e.g. elastic/lycra® fabric • training in one handed techniques see the required reading and viewing in the Learning Resource • carer support for safety including verbal prompting, manual guidance and physical assistance
Dynamic balance	The client is able to reach and adjust their clothing in sitting and/or standing as required.	The client moves their bottom too far forward when sitting on a chair, reducing their base of support and increasing the risk of falling.	Provide education on sitting positioning and posture to reduce dynamic balance requirements.
		The client reaches and/or grabs for hand support during dressing due to loss or near loss of balance.	Provide education on suitable hand supports during dressing i.e. grab rail, window sill or bench.
Initiation and completion	The client recognises when to commence the task and when the task is completed. This includes the client's perseverance within the task.	The client does not initiate or complete dressing/undressing due to poor cognition, neuromuscular control such as freezing and/or poor vision.	<p>Use verbal cueing to prompt the client e.g. "what part comes/happens next?", "have you completed the task?"</p> <p>Carer support for verbal prompting, manual guidance and physical assistance e.g. provide clothing item, guide movement.</p> <p>For visual problems relocate items to be within the visual field.</p>

Assessment component	Observation performance criteria	Common problems	Adaptive strategy/remedy
Concentration and attention	The client is able to maintain attention during the task. This includes avoiding distractions.	The client lacks attention and concentration during the task due to poor cognition e.g. problems with memory, problem solving, sequencing, planning.	Reduce distractions in the environment e.g. turn TV off, close door, avoid conversation. Carer support for verbal prompting, manual guidance and physical assistance e.g. provide clothing item, guide movement.
Memory and recognition	The client is able to recall the purpose of the task and the equipment required.		
Problem solving	The client is able to identify and solve a problem if presented during the task e.g. left shoe on right foot, clothing inside out or back to front.		
Foresight and planning	The client is able to plan out the task and any required equipment e.g. undergarments on before outer wear.		
Orientation	The client is able to locate the correct clothing/equipment/aids and orientate to/on the body.	The client puts clothing on incompletely, backwards, inside out. The client uses the equipment inappropriately.	Carer support for verbal prompting manual guidance and physical assistance e.g. provide clothing item, guide movement. Dressing retraining program.
Sequencing	The client is able to perform the task in an appropriate order in keeping with safety, personal/cultural preference.	The client puts clothing on in an inappropriate order e.g. underpants on the outside/on head, legs in arm holes. This may be due to poor cognition and/or poor vision.	Ensure all the required equipment is in the client's visual field. If due to poor cognition reduce the object selection choice. Carer support for verbal and visual cueing to correct the sequencing problem.
Timeliness	The task was completed in a timely manner that is suitable for the client's condition and improves the client's quality of life.	The client is unable to complete the task in a timely manner due to poor cognition and/ or physical capacity e.g. breathlessness, pain.	Reduce distractions e.g. turn TV off, close door, avoid conversation. Carer support for verbal prompting, manual guidance and physical assistance to complete the task. If due to poor physical capacity provide pacing education (see the required reading in the Learning Resource).

Assessment component	Observation performance criteria	Common problems	Adaptive strategy/remedy
Judgement Safety	The client is aware of the potential dangers and is able to modify performance accordingly. The client causes no harm to self, others or the environment. Near miss incidents do not occur.	The client is at risk of harming themselves or others through lack of insight/awareness. This is generally due to poor cognition e.g. poking eyes, not using clothing/equipment features correctly, creating trip hazards or pressure area.	Cease the task to prevent harm. Carer support for verbal prompting, manual guidance and physical assistance to complete the task.
Effectiveness	Despite the deficits was the task completed?	Yes/No criteria	Determine the required interventions to improve performance.

Dressing equipment

For all equipment hygiene see the manufacturer's instructions e.g. wipe surfaces using available product

Equipment	Instructions	Indications/Precautions	Possible performance errors
<p>Sock donner Assists with putting socks on.</p> <p>For examples see: Care4Senior's (2009). Aid helps put on socks and stockings. Available at: https://care4seniors.wordpress.com/tag/sock-donner/ Independent Living Centres Australia (2011). Sock donner. Available at: http://ilcaustralia.org.au/products/search?utf8=%E2%9C%93&q=sock+donner</p>	<p>The client is in a seated position. The sock is placed over a flexible plastic gutter, and long handles are used to lower the donner to the ground. The foot is placed in the gutter and then the user pulls the handles upward and pushes the foot forward. As the sock becomes positioned the plastic gutter pulls out behind the calf.</p>	<p>Indications:</p> <ul style="list-style-type: none"> • Unable to reach feet to don socks adequately • Sufficient upper limb co-ordination to place sock over gutter <p>Precautions:</p> <ul style="list-style-type: none"> • Clients with fragile skin or reduced sensation will require education i.e. skin inspection and protection. • Consider movement restrictions e.g. post THR. 	<ul style="list-style-type: none"> • Sock not appropriately positioned at the end of the task. Address through practice, or check position of the sock prior to attempt. • Failure to adhere to movement restrictions. Address through education and demonstration of technique
<p>Dressing stick Assists with reaching/dragging items of clothing</p> <p>For example see: Independent Living Centres Australia (2011). Dressing stick. Available at:</p>	<p>The client may be in seated or standing position. The hook is used for reaching items, and/or looping around fabric, and/or pulling/pushing clothing items such as underwear, pants up/down lower part of leg to a point where client can then adequately grasp item to finish dressing.</p>	<p>Indications:</p> <ul style="list-style-type: none"> • Unable to reach to the ground and/or to feet to don lower body clothing items adequately • Sufficient upper limb co-ordination to grasp and manipulate dressing stick 	<ul style="list-style-type: none"> • Clothing item not able to be hooked/manoeuvred. Address by considering the clothing type and compatibility with stick, practice, demonstration of technique, prompting. • Failure to adhere to movement restrictions. Address through education and demonstration of the technique.

Equipment	Instructions	Indications/Precautions	Possible performance errors
<p>http://ilcaustralia.org.au/products/search?utf8=%E2%9C%93&q=dressing+stick</p>		<p>Precautions:</p> <ul style="list-style-type: none"> • Clients with fragile skin or reduced sensation will require education i.e. skin inspection and protection • Adherence to movement restrictions e.g. post THR 	
<p>Long handled shoe horn Assists with putting on shoes</p> <p>For example see: Independent Living Centres Australia (2011). Long handled shoe horn. Available at: http://ilcaustralia.org.au/products/search?utf8=%E2%9C%93&q=long+handled+shoe+horn</p>	<p>The client is in a seated position. The client commences donning of footwear by placing forefoot in the shoe. The moulded plastic or metal end assists with levering the heel in to complete the task.</p>	<p>Indications:</p> <ul style="list-style-type: none"> • Unable to reach to ground and/or to feet to don lower body clothing items adequately • Sufficient upper limb co-ordination to grasp and manipulate dressing stick <p>Precautions:</p> <ul style="list-style-type: none"> • Clients with fragile skin or reduced sensation will require education i.e. skin inspection and protection • Adherence to movement restrictions e.g. post THR 	<ul style="list-style-type: none"> • Shoe not able to be donned successfully. Address by considering the shoe type, adjusting laces/Velcro®, further practice, demonstration of technique, prompting. • Failure to adhere to movement restrictions. Address via education and demonstration of technique
<p>Button hook/Zipper pull</p> <p>For example see: Independent Living Centres Australia (2011). Button hook and zipper aid. Available at: http://ilcaustralia.org.au/products/search?utf8=%E2%9C%93&q=button+hook</p>	<p>The client needs to be positioned to be able to access buttons using the button hook. It has different ends to achieve 2 functions i.e. button hook and zipper pull. The looped end is used to do up buttons. Push the loop end through the button hole, catch the button in the loop and pull back through in the opposite direction to fasten. The process can be reversed to undo buttons.</p> <p>The hooked end is used to do/undo zippers. Place the hook into the hole in the zipper pull and move up or down according to need.</p>	<p>Indications:</p> <ul style="list-style-type: none"> • Hand and upper limb co-ordination insufficient to manage fastenings such as zippers and buttons <p>Precautions:</p> <ul style="list-style-type: none"> • Nil 	<ul style="list-style-type: none"> • Buttons or zippers may be unable to be fastened. Address by considering the clothing type (i.e. button hole too snug for button and aid, zipper stiff) and adjust if able, further practise, demonstration of technique, prompting. • Consider alternative clothing options e.g. Velcro® fasteners, ties, stretchy Lycra® or loose clothing.

Equipment	Instructions	Indications/Precautions	Possible performance errors
<p>Long handled reacher Obtain items out of reach</p> <p>For example see: Independent Living Centres Australia (2011). Reachers. Available at: http://ilcaustralia.org.au/products/search?utf8=%E2%9C%93&q=reacher</p>	<p>The client positioned for dressing. Features vary but will inevitably have a grasp function for obtaining items from the floor or other e.g. on a shelf/cupboard. Depending on the manufacture other features may include a hook and/or magnet to aid in obtaining items. The client may use the reacher in preference to a dressing stick.</p>	<p>Indications:</p> <ul style="list-style-type: none"> • Unable to reach to ground and/or overhead to obtain items • Sufficient upper limb co-ordination to grasp and manipulate reacher <p>Precautions:</p> <p>If using for dressing consider:</p> <ul style="list-style-type: none"> • Clients with fragile skin or reduced sensation will require education i.e. skin inspection and protection • Adherence to movement restrictions e.g. post THR. 	<ul style="list-style-type: none"> • The object may not be able to be grasped. Address by considering the object and compatibility with reacher (is it too heavy, too large), practice, demonstration of technique, prompting. • Failure to adhere to movement restrictions. Address by education and demonstration of technique.

Selecting a basic/bridging intervention

When selecting a basic/bridging intervention the following should be considered:

- the level of independence required for the dressing activity (short term and long term),
- client/carer goals,
- the impact of the activity on fatigue, pain or other symptoms in the context of other daily activities and demands on the client.

The general hierarchy of interventions for dressing is:

- altering the environmental set-up
- providing education on dressing techniques, including adapted clothing
- providing equipment
- providing assistance e.g. verbal cueing or manual guidance/physical assistance.

The first three interventions can promote or maintain a client's independent performance of the activity and should be trialled before assistance of a carer is recommended. This general concept should be balanced with the client's safety, goals and ability to perform the task in a timely manner.

Each intervention has some specific considerations.

- environmental set-up: acceptability by other user or carers
- education on dressing techniques: the client/carer's ability to train in use of the technique
- equipment: required skills, cost, ease of use
- assistance: carer availability, willingness and capacity to support the client.

Outcomes of a dressing assessment

At the completion of the dressing assessment a recommendation should be made regarding the client's ability to dress. The recommendation will be one of the following:

- Safe to dress/undress independently i.e. the task was completed successfully and there is no required intervention.

This should include a list of the clothing and any personal equipment/aids the client used to dress/undress during the assessment e.g. underwear, pants, shirt, dress, jacket, shoes, personal alarm, prosthetic leg and the environment where the task occurred e.g. bathroom, bedroom, ward/home. A note can also be included that the client should be re-referred should issues/concerns arise.

- Client requires assistance to dress/undress. This may be due to incomplete, inefficient or unsafe performance during the assessment.

Documentation will include a list of the problems observed and the recommended intervention/s.

Intervention/s will be developed in consultation with the client and aim to improve task performance and maintain modesty and safety for dressing/undressing. This may include a brief/bridging intervention to improve dressing performance.

If support is required, assessment of dressing will need to include the carer providing the support to ensure safety and understanding of the role.

A rehabilitation plan may also be required if the basic/bridging intervention does not achieve client goals. This may require further assessment and/or intervention by a health professional with expertise in the task or implementation other skill shared task.

Note: a client may be safe in undressing but require support for dressing. Where this occurs dressing/undressing requirements should be listed separately.

Guide to Clinical Reasoning

1. Setting and context

- Inpatient/Community Outpatient
 - home visit completed
 - if unable to complete home visit, ability to replicate home environment during assessment.

2. Client

- Presenting condition and history relevant to task
 - presenting condition
 - relevant past history.
- relevant assessment findings
 - weight
 - skin condition.
- General care plan
 - discharge planning
 - community services involved.
- Functional considerations
 - sitting balance i.e. independent/assist/unsafe
 - sit-stand chair i.e. independent/uses chair arms/physical assistance
 - mobility i.e. independent/aid (list)/physical assistance
 - upper limb function i.e. ensure the client has sufficient upper limb strength to manipulate clothing
 - cognition i.e. intact/unable to follow directions/unable to retain instructions.
Note: may need to liaise with an occupational therapist
- Environmental considerations
 - where does the client get dressed e.g. bedroom, bathroom? Additional information/prompts may be provided e.g. if in the bedroom on the edge of the bed, also need to consider the type of bed, height, access.
 - current equipment
 - access difficulties e.g. limited space in bedroom/bathroom.
- Social considerations
 - carer considerations
 - type of carer e.g. informal, community service/formal, none
 - level of assistance provided pre-morbidly
 - safety of client and carer
 - level of assistance required
 - others living in home environment.

3. Task indications and precautions considered

- client's medical stability and physical capacity
- noted/reported difficulty with dressing
- restrictions to movement, hip precautions (if applicable)
- level of pain and pain relief
- level of alertness.

4. Outcomes of task

- premorbid function
- current performance
- home environment
- client identified goals
- cognitive capacity demonstrated
- physical capacity demonstrated
- nil perceptual deficits
- compensatory movements.

5. Plan

- Is the client able to safely and independently dress/undress or are they at the required level for home?
- Is a trial of equipment and/or modified techniques indicated?
- Is further intervention indicated?

6. Overall reflection

- Is further discussion and liaison with the lead health professional required for this client?