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Functional independence measure scoring manual

Functional independence measure pdf. Functional independence measure score interpretation. What is the functional independence measure. Functional independence measure instrument. Functional independence measure scoring.

A uniform system for assessing disability is provided by the International Classification of Impairment, Disabilities, and Handicaps. This system measures a patient's level of disability, indicating how much assistance they require to perform daily activities. The FIM Instrument contains 18 tasks: * **Motor Tasks (13)**: Eating, grooming, bathing, upper body dressing, lower body dressing, toileting, bladder management, bowel management, bed-to-chair transfer, toilet transfer, shower transfer, locomotion, and stairs. * **Cognitive Tasks (5)**: Cognitive comprehension, expression, social interaction, problem solving, and memory. These tasks are rated on a 7-point scale from total assistance to complete independence. Scores range from 18 (lowest) to 126 (highest), indicating the level of function. The FIM Instrument scores are generally taken at admission and discharge. The dimensions assessed by the FIM Instrument include eating, grooming, bathing, upper body dressing, lower body dressing, toileting, bladder management, bowel management, bed-to-chair transfer, toilet transfer, shower transfer, locomotion, stairs, cognitive comprehension, expression, social interaction, problem solving, and memory. The Functional Independence Measure (FIM) is a tool used to assess patients' abilities in various areas. Research by Nichol et al. in 2011 suggested the FIM's versatility across different levels of disability. For accurate assessment with the FIM, it is crucial that the instrument is administered and scored correctly. Ideally, this involves a trained evaluator scoring in consensus with a multi-disciplinary team. This method ensures accuracy and considers various aspects of patient recovery. Interestingly, studies have shown that the FIM and Barthel Index (BI) possess similar psychometric properties, despite the FIM being developed to address the limitations of BI. A Rasch analysis was conducted on the FIM Motor Scale involving 340 patients post-stroke. The results demonstrated that the scale met the requirements for uni-dimensionality without requiring any item deletions, reinforcing its clinical significance. Another study combined the FIM and Nottingham Extended Activities of Daily Living (NEADL) assessment. This secondary analysis involved 188 participants post-stroke and resulted in a final model containing 36-items after removing an item that showed high correlation with another. The Barthel Index is frequently used by healthcare staff to measure recovery following patient discharge for neurologic disorders or stroke. The index can be directly measured or estimated from the Northwick Park Dependency Scale (NPDS) or the FIM, showing excellent agreement between total scores and intra-class correlations. A study involving 717 patients post-TBI and stroke showed strong item-by-item agreements between the FIM and NPDS, with average absolute item % agreement ranging from 71.1% to 90.6%. Members of the StrokEdge Task Force emphasize the importance of trained evaluators and multi-disciplinary consensus for accurate scoring with the FIM instrument. They also highlight that the FIM might not capture key aspects of patient recovery such as return to work, social relationships, or recreational activities. The FIM Instrument: A Review of its Diversity Sensitivity and Translation Nichol et al. (2011) demonstrated that the FIM instrument is suitable for patients at all levels of EDSS, despite limited responsiveness data, training requirements, and copyright issues. A study by Berges et al. (2012) examined the diversity sensitivity of the FIM in white, black, and Hispanic patients post-stroke admitted to inpatient rehabilitation. The results showed that black and Hispanic patients had lower FIM totals compared to whites at three months post-discharge. However, total FIM ratings increased for all groups from admission to discharge, but then showed little change after. Racial/ethnic group, age, length of stay, and medical comorbidities were significant predictors of total FIM ratings over the four time points. The Japanese version of the FIM+FAM-J was found to have excellent internal consistency and reliability in 42 patients with a mean of 30.2 days post CVA. Excellent intra-rater reliability was observed within the FIM+FAM-J full scale, motor subscale, and cognitive subscale. The FIM+FAM-J showed excellent criterion validity with other scales such as the Barthel Index, National Institutes of Health Stroke Scale, modified Rankin Scale, and Brunnstrom Recovery State. Adequate correlations were found between the FIM+FAM-J cognitive scale and other scales, but a floor effect was observed with the Catherine Bergego Scale. Another study on the Persian FIM found excellent intra-rater reliability and internal consistency, as well as significant Pearson correlation between the PFIM and the Persian Barthel Index. A systematic review of outcome measures used in robot-assisted exercise trials (RAET) found that the FIM Motor Scale was used to measure activity level in 9 out of 28 RAET trials. The results showed high/excellent reliability, validity, and responsiveness for the FIM Motor Scale, but moderate responsiveness in chronic stroke survivors with severe impairments persisting beyond six months. As a global measure of physical activities, the FIM Motor Scale may be influenced by various factors beyond specific arm function. The CAHAI or ARAT may be more suitable arm outcome measures for stroke survivors with severe impairments (Sivan et al., 2011). Studies have explored the validity and reliability of the FIM Motor Subscale in various stroke populations. In one study, patients with higher admission FIM scores (>73) were significantly younger than those with lower scores (37-72 or