GRASP

Graded Repetitive Arm Supplementary Program

Instructor's Manual For Hospital GRASP and Home GRASP Version 2.1

HEART & STROKE FOUNDATION
UBC a place of mind THE UNIVERSITY OF BRITISH COLUMBIA
Vancouver CoastalHealth GF Strong Rehabilitation Centre

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Overview of GRASP

GRASP is a self-directed arm and hand exercise program for which is supervised by a therapist, but done independently by the participant (and with their family if possible). GRASP has been shown to improve arm and hand function and strength after stroke. There are two versions of the program: Hospital GRASP and Home GRASP. Both versions prescribe one hour of daily GRASP exercise, plus encourage the patient to use the stroke-affected arm and hand as much as possible.

Brain Repair after Stroke

Following a stroke, brain structures and pathways are damaged. It can take hundreds, if not thousands of challenging repetitions of practice to improve activation of the brain and to relearn movements. In rehabilitation therapy sessions, stroke patients may need to work on many functions such as walking, balance, speech and cognition, and may have little time left to practice reaching and grasping. GRASP is a supplementary program that adds over 300 challenging repetitions per session and has been shown to improve arm and hand function after a stroke.

Goals of GRASP

√ Increase the potential for recovery of the hand and arm through challenging repetitions of practice and encouraging use of the stroke-affected hand in everyday activities

√ Facilitate the eventual transition to self-managed exercise programs post-discharge

√ Prevents the "learned non-use" syndrome often found after stroke

√ Engage the client and family in the therapy process and place an expectation of active participation on the patient

Role of Therapist

The brain has the most ability to repair and improve hand function in the first 3 months after a stroke. While improvements have been reported in more chronic patients, the gains will not be as great. During the first few months after stroke, the brain has enhanced plasticity and is more sensitive to stimuli and experience, such as fine motor exercise. However, patients can be very tired in this period, lack motivation to do exercise or find it frustrating to do a lot of challenging exercises. A therapist plays a key role in the GRASP program; in educating patients and families on the importance of exercise and hand activity early after stroke, teaching the exercises, as well as motivating and monitoring patients.

SECTION 1: Introduction to GRASP

Who is appropriate for GRASP?

The GRASP program is designed for stroke participants who would like to improve their arm and hand function. The GRASP protocol is appropriate for people who are able to actively elevate their scapula (shoulder shrug) against gravity. In addition, they require palpatable wrist extension. Thus, if the participant rests their stroke-affected hand palm down on a table, they are able to start to lift the fingers off the table. A tiny bit of movement on the lift may be visible, otherwise, muscle activation can be felt over the wrist joint tendons. Participants who have a fixed hand and cannot partially open the hand or fingers are not appropriate for this exercise program, and may benefit from other therapies. For participants who have minimal hand movement (Level 1- per Hospital GRASP), we recommend that they attend a clinic or outpatient hospital unit where they can receive other treatments such as electrical stimulation, in conjunction with exercise to optimize their recovery.

Minimum Requirement Checklist

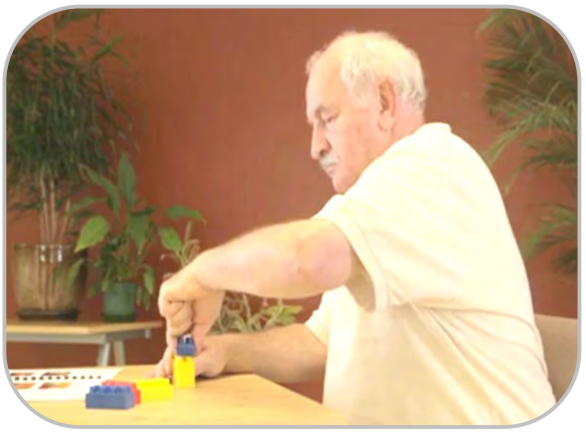
√ Some ability to move stroke affected wrist

√ Some ability to shrug their stroke-affected shoulder

√ Able to follow instructions and mimic exercises for an hour

√ Able to communicate any adverse effects, such as pain.

√ Independently carry out exercises or have caregiver assistance



SECTION 1: Introduction to GRASP

GRASP Research Evidence

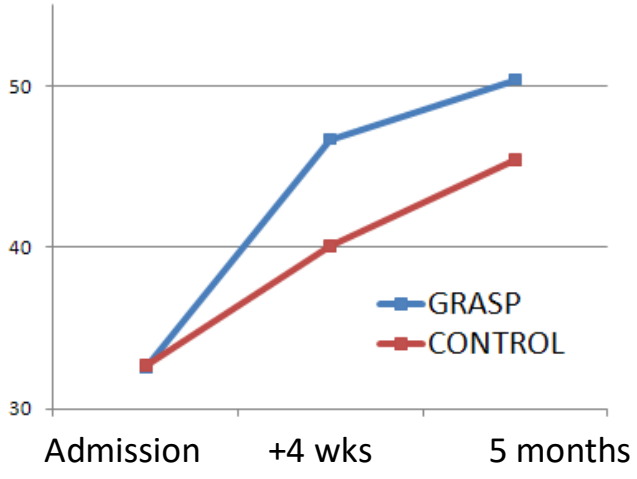
The GRASP Program was originally developed in Vancouver, Canada by Janice Eng, PhD, PT/OT and Jocelyn Harris, PhD, OT with valuable assistance from Andrew Dawson, MD, FRCP and Bill Miller, PhD, OT and with funding from the Heart and Stroke Foundation of BC and Yukon. The following table summarizes the findings. A number of advances in GRASP have been made with assistance from Louise Connell, PhD, PT and Lisa Simpson, MSc, OT.

Summary of Findings

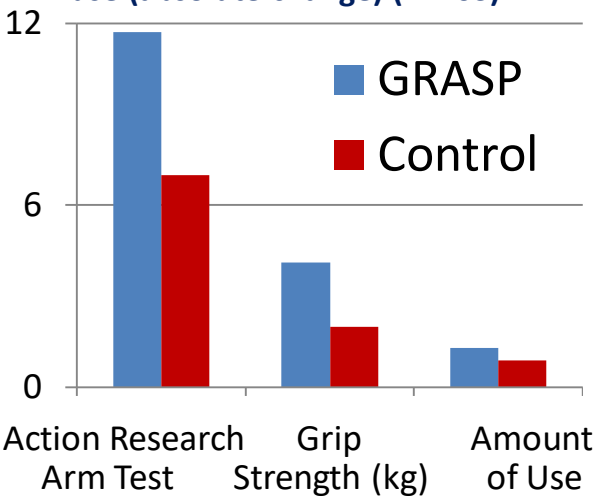
We showed in 103 stroke inpatients within their first 4 weeks of stroke that the GRASP Program (Hospital Version) improved arm and hand function (Chedoke Arm and Hand Activity Inventory, Action Research Arm Test), grip strength and amount of use. GRASP can result in more than 300 hand and arm repetitions per session. In addition, a small study (n=8) showed that community-dwelling individuals with stroke within their first year post-stroke benefited from a weekly phone-monitored and motivated Home Version of GRASP over 2 months.

Graphical presentation of results:

Chedoke Arm & Hand Activity Inventory (n=103)



Improvement of grip strength & hand use (absolute change) (n=103)



SECTION 1: Introduction to GRASP

GRASP Research Evidence

All publications below are freely available through pubmed

Harris JE, Eng JJ, Miller WC, Dawson AS. A self-administered Graded Repetitive Arm Supplementary Program (GRASP) improves arm function during inpatient stroke rehabilitation: a multi-site randomized controlled trial. Stroke. 2009 Jun;40(6):2123-8.

Harris JE, Eng JJ, Miller WC, Dawson AS. The role of caregiver involvement in upper-limb treatment in individuals with subacute stroke. Physical Therapy. 2010 Sept; 90 (9): 1-9.

Connell L, McMahon NE, Harris JE, Watkins C, Eng JJ. A formative evaluation of the implementation of an upper limb stroke rehabilitation intervention in clinical practice: a qualitative interview study. Implementation Science. 2014, 9:90

Connell LA, McMahon NE, Watkins CL, Eng JJ. Therapists' use of the Graded Repetitive Arm Supplementary Program (GRASP) intervention: a practice implementation survey study. Phys Ther. 2014 May;94(5):632-43.

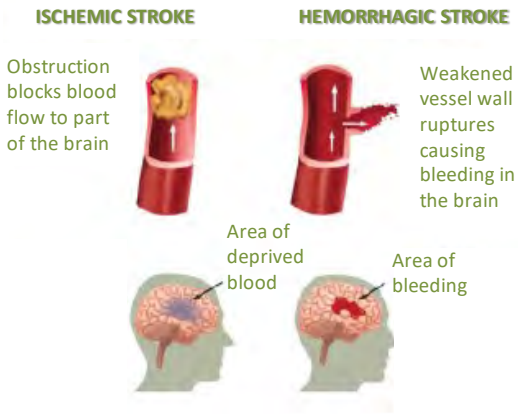
Connell LA, McMahon NE, Simpson LA, Watkins CL, Eng JJ. Investigating measures of intensity during a structured upper limb exercise program in stroke rehabilitation: an exploratory study. Arch Phys Med Rehabil. 2014 Dec;95(12):2410-9.

Simpson LA, Eng JJ, Chan M. H-GRASP: The feasibility of a novel upper limb home exercise program monitored by phone for individuals post stroke. Disabil Rehabil. 2016 Mar 26: 1-9.

SECTION 2: Stroke Information

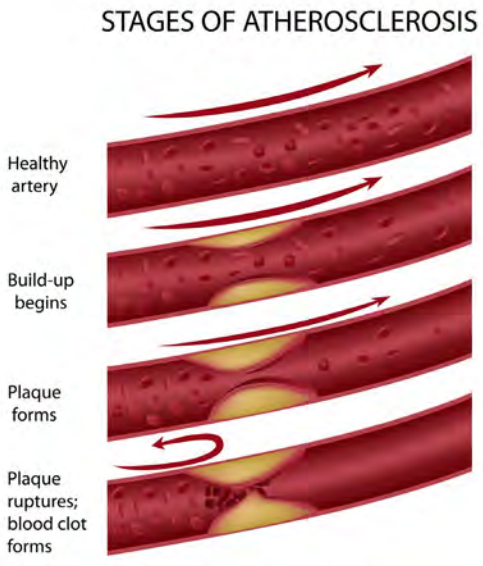
What is Stroke?

Stroke is the sudden loss of brain function that results when the flow of blood to a specific part of the brain is restricted leading to the death of brain cells in the affected area. Stroke is often categorized as either ischemic - an interruption of blood flow to the brain, or hemorrhagic - a rupture of blood vessels in the brain. Temporary or permanent loss of several functions may occur after stroke, including speech and movement.



Causes

Although stroke is considered a condition of the brain, the underlying pathology often leading to stroke is cardiovascular in origin. High blood pressure is the main risk factor for stroke, as it leads to arteriosclerosis and damages blood vessels in the brain.



Stroke Statistics

DEATHS

- Every year, stroke claims 11% (6 million) of the total deaths worldwide
- 2nd leading cause of death in the world

PREVALENCE

- One in 6 people in the world will have a stroke in their lifetime
- Risk of stroke doubles every 10 years after age 55
- Typical age is 70-75 years at the time of stroke, but 25% of strokes occur in people under age 65
- A stroke survivor has a 20% chance of having another stroke within 2 years.
- 60% who have a stroke are women

SECTION 2: Stroke Information

Risk Factors for Stroke

80% of all stroke are preventable

- High blood pressure
- Cigarette smoking
- Obesity
- Diabetes
- Lack of physical activity
- Poor diet
- Alcohol consumption > 30 drinks/month
- Heart Disease

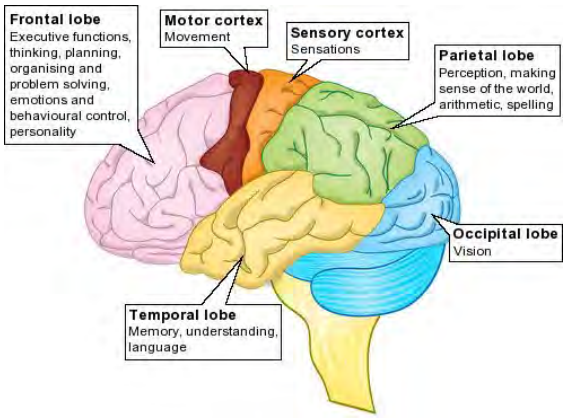
***NOTE*:** Although most prevalent among older adults, stroke can occur at any age. There is an increasing number of younger adults who experience stroke, likely due to a rising number of people with diabetes and obesity. The ability to identify the common signs and symptoms of stroke often determines how quickly an individual receives treatment and will greatly influence the degree of impairment experienced post-stroke. Call for emergency services if you suspect someone is having a stroke.

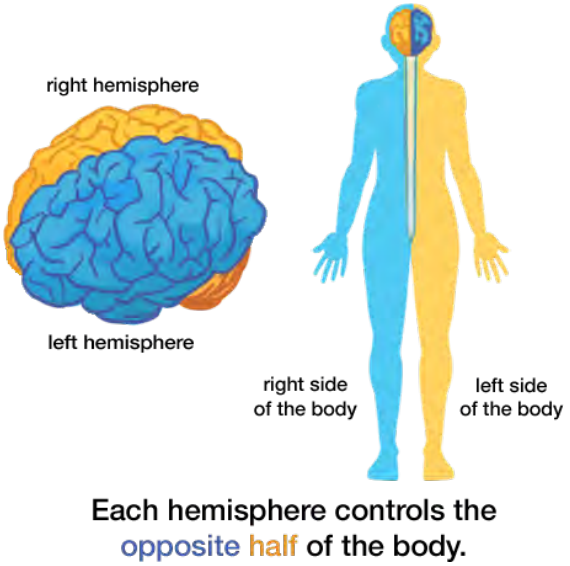
SECTION 2: Stroke Information

Neuroanatomy Background

The brain controls most of the movement and sensation in the body. It is compartmentalized into several segments (lobes), each with a specific function. The type of impairment or dysfunction present after stroke is often indicative of the damage sustained by the brain.

The largest part of the brain is called the cerebrum which is divided into 2 sections; the right hemisphere, and the left hemisphere. Each hemisphere of the brain controls the opposite side of the body. The right hemisphere controls the movement and sensation of the left side of the body and the left hemisphere controls the movement and sensation of the right side of the body.





Each hemisphere controls the opposite half of the body.

Strokes occurring on the right hemisphere of the brain affect motion and sensation on the left side of the body. They may also be associated with deficits in attention to and awareness of one side of space (i.e. hemineglect). While strokes occurring on the left side of hemisphere of the brain often affect movement and sensation on the right side of the body, they may also be associated with problems understanding speech or trouble expressing thoughts (i.e. aphasia).

SECTION 2: Stroke Information

Impact of Stroke

The impact and degree of functional impairment after stroke are highly dependent upon the location and extent of the damage to the brain. The amount of time the stroke is left untreated following the initial stroke can profoundly influences the amount of brain damage incurred. The damage may potentially impact many functions including motor or sensory function, short or long term memory, and the ability to speak and understand language.

Common Effects after Stroke

- Muscle weakness on one side of the body (i.e., hemiparesis)
- Spasticity and abnormal muscle tone
- Fatigue
- Poor balance or lack of coordination
- Changes in cognitive function (e.g., memory, attention, reasoning)
- Difficulty speaking or understanding language
- Reduced bladder or bowel control (i.e., incontinence)
- Numbness or change in sensory function
- Reduced awareness of one side of the body (i.e., neglect)
- Difficulty swallowing (i.e., dysphagia)
- Poor vision and/or changes in vision

SECTION 2: Stroke Information

Understanding Stroke Impact on Upper Extremities

About 85% of participants admitted to hospital for stroke present with problems with their arms and hands. Stroke- related physical impairments such as muscle weakness, pain, and spasticity can lead to a reduction in the ability to use the stroke-affected arm and hand in daily activities. The avoidance of using one's stroke-affected arm is common and is referred to as the "learned non-use syndrome". Unfortunately, not using the stroke-affected arm can prevent the brain from repairing after a stroke and lead to a further loss in strength, range of motion, and fine motor skills. These can then result in contractures, pain and severe bone loss (osteoporosis).

Spasticity

Spasticity consists of exaggerated muscle reflexes, involuntary muscle contractions and stiffness in muscles. Spasticity can be painful and interfere with functional recovery of the upper extremity.

Pain

Pain can occur at various areas of the upper extremity and can result from weakness and spasticity. This occurs most often in the shoulder and pain levels and duration can vary between individuals.

Edema/Swelling

Edema is excess fluid trapped in the body's tissues. This can be due to decreases in muscle contractions, changes in blood vessel function and reductions in activity of the stroke-affected arm. Edema commonly occurs in the hand after stroke and can lead to pain and reduced range of motion.

Potential Fractures

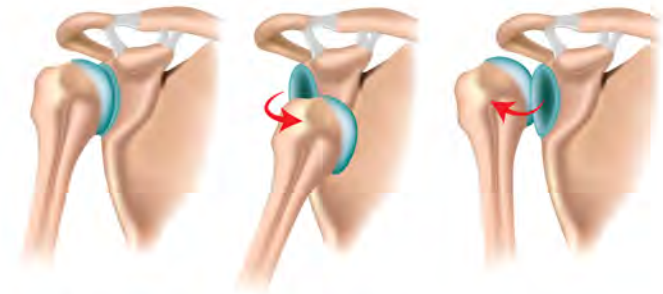
Following a stroke, the bone mineral density (BMD) and muscle mass usually decline. Changes to the stroke-affected side are more profound. In addition, with balance deficits, resulting from stroke, there is increased risk of fractures from falls. The most common fracture of the upper extremity is a wrist fracture due to a fall on the hand.

Exercise and use of the stroke-affected arm and hand can reduce the risk of the above complications.

Understanding Stroke Impact on Upper Extremities

Shoulder Pain

Shoulder pain is caused by muscle weakness and spasticity. This causes the shoulder to subluxate or partially drop out of the socket. The joint structures get stretched and the tissues and tendons get pinched with movement. Participants with a history of shoulder pain need to be treated with care.



Some participants wear a sling to reduce pain or may hold onto their stroke affected arm to raise it. It is important not to pull on the affected arm or to increase the stress with an added weight, as it is a vulnerable joint. Movements within the participant's pain free range of motion is recommended if an upper extremity component is incorporated. Encourage bilateral movements with safe mechanics (e.g., hold on to paretic arm during arm raises). Ensure that participants with a history of shoulder pain, subluxation or instability do not perform resisted over head movements (e.g., pulleys). Keep the upper limb under 90 degrees unless the limb is being stretched.

Some participants may have mild shoulder pain following exercise in the first 1 to 2 weeks, but this should resolve with continued use and with exercises that help to stabilize the shoulder. However, if the exercises continue to aggravate the shoulder, modify or discontinue the exercises. If it persists, participants should see their physician.

SECTION 2: Stroke Information

Stroke Treatment

Treatment duration and hospitalization may vary among stroke survivors.

- Many stroke survivors will spend between 1-2 weeks in acute care
- Up to 1/2 of stroke patients go home directly after hospital admission
- 1/3 of stroke patients go to hospital rehabilitation for a period of 4-6 weeks
- Up to 1/4 of all stroke patients will go to nursing homes or other long-term care facilities

Stroke Rehabilitation

The following services may be used during the recovery and rehabilitation phase following a stroke.

- Medical management, e.g., blood pressure medications, anti-depressants, cholesterol-reducing agents
- Nursing care
- Occupational therapy
- Physical therapy
- Speech therapy
- Recreation therapy

NOTE: Access to rehabilitation care is time limited. After 6 weeks, most stroke survivors do not receive hospital-based care or treatment.

SECTION 3: GRASP Program Protocol

Hospital or Home GRASP – which program should I use?

Motivating, monitoring and progressing the practice by a health professional are key requirements for success. Hospital or Home GRASP should be practiced one hour, 7 days a week. Exercise sessions can be divided up into two 30 minutes sessions if fatigue or attention is a problem.

The Hospital GRASP is four weeks long and fits typical patients admitted to inpatient rehabilitation settings within the first 4 weeks post-stroke where patients are also receiving standard upper extremity physical therapy and occupational therapy. The exercise can be done in the patient's room, although a good alternative is that some centres have initiated group GRASP programs where patients are supervised by a rehabilitation assistant in the department. The 3 levels were meant to accommodate the fast improvements that often occur in the first weeks after stroke. Once participants are discharged, they can continue the exercises in their home.

Home GRASP is initially prescribed face-to-face, and then monitored and progressed by phone. Home GRASP was designed as a 2-month program for patients who have already had some upper limb treatment and have now been discharged home after inpatient rehabilitation (typically 2 months post-stroke). Only one book level (levels 2 and 3 of Hospital GRASP) was designed as there are less changes expected in this time window. Individuals complete the exercises within their own home. It can also be delivered as a group program where a group of patients are supervised by a therapist, rehabilitation assistant, or trained facilitator.

These rehabilitation models may not fit all jurisdictions. As such, the selection of the Hospital or Home GRASP may be dictated by how patients are moved through your system, and the type of monitoring determined by your resources. We recommend that patients in the first month post-stroke do receive more face-to-face monitoring and progression, give the potential for fast improvements that may occur early after stroke. Thus, if you have a patient discharged home in the first week post-stroke especially with minimal hand function, you may decide to use the Hospital GRASP books which have the Level 1 book, and progress the patient to the other Levels in time. In addition, it would be preferred to have more face-to-face therapeutic sessions to monitor the patient and to address other upper limb issues (e.g., pain, activities of daily living, assistive devices), given the newness of the injury.

GRASP can also be used as a supplementary home exercise program to outpatient therapy or be delivered as a community exercise program. In this case, you may select the Home GRASP (if the patient has some grasp and release) but monitor in person (rather than by phone) during the first few minutes of each session.

SECTION 3: GRASP Program Protocol

Hospital or Home GRASP – which program should I use?

As the acute and rehabilitation stay can vary depending on the jurisdiction, we provide a number of cases to illustrate the use of GRASP. The unifying principle behind all cases is that GRASP is monitored and progressed over the sessions by a therapist, rehabilitation assistant, or trained facilitator.

Cases to illustrate Hospital GRASP use

Case A: Mrs. A receives acute stroke care for 7 days, is then transferred to an inpatient stroke rehab facility for 4 weeks, and then receives outpatient rehab for another 5 weeks. During inpatient rehab, she receives OT and PT for arm and hand function, and is taught the Hospital GRASP program starting with Level 1 by the PT. Mrs. A does GRASP in the evenings. The PT monitors Mrs. A's adherence by checking her logged time, progresses her to level 2 and motivates her to use her affected hand daily in a variety of everyday activities. In outpatient rehab, Mrs. A continues to receive OT and PT, and as well, the outpatient PT progresses her to level 3 and reduces the size of the fine motor objects to make the program more challenging which Mrs. A does daily at home. Mrs. A feels that she has returned to doing most activities with her stroke-affected hand that she did before, and upper extremity PT/OT and GRASP are stopped.

Case B: Mr. B receives acute stroke care for 10 days. At day 5, he starts participating in a daily group Hospital GRASP class supervised by a rehab assistant and overseen by an OT. He is then discharged home with Level 2 but attends outpatient rehab for 4 weeks where he continues GRASP at home which is monitored and motivated by the outpatient OT.

SECTION 3: GRASP Program Protocol

Cases to illustrate Home GRASP use

Case A: Mr. A receives acute stroke care for 5 days, and then is discharged home to a rural area which does not have any rehabilitation services. He is taught the Home GRASP exercises before he is discharged. An OT phones him weekly for 8 weeks to progress the exercises, check the logged time and provide motivation to use the arm and hand. After 8 weeks, Mr. B feels that he is still improving and continues GRASP for an additional month on his own.

Case B: Ms. B receives acute stroke care for 3 days, and is then discharged home with follow-up by a community outreach team for 1 month. She receives OT and PT once a week at home and the PT instructs her in the Home GRASP, checks her logged time and progresses the exercises. Ms. C's improvements have not plateaued, but governmental services have ended. The PT suggests that Ms. C might continue with private PT services which she does, and the private PT continues to progress the GRASP exercises done at home, as well as provide additional upper extremity treatment for another 6 weeks.

Case C: Mr. C receives acute stroke care for 5 days, inpatient stroke rehab for 4 weeks. He then is discharged home to community. He starts participating in a weekly community program for 10 weeks which deliver the Home GRASP at a *local community centre*. The program is run by a rehab assistant and overseen by an OT. There are five participants in the program including Mr.C. He and other participants are taught the GRASP exercises at the first class and practice the GRASP exercises at home. At the weekly GRASP class, a rehab assistant progresses the exercises, checks the logged time, provides motivation to use the arm and hand, and brainstorms activities that the participants can do at their home. At the end of the program, Mr. C discusses with the rehab assistant about continuing the GRASP at home on his own as he feels he is still improving. The rehab assistant suggests him to continue and progress to more challenging exercises until no further improvements are experienced.

SECTION 3: GRASP Program Protocol

GRASP Program Levels

Hospital GRASP has 3 exercise levels (***levels 1 to 3***) to accommodate different levels of upper extremity function and ideally should begin within 4 weeks post-stroke. Each level has its own participant manual.
Home GRASP has 2 exercise levels and is designed as a 2-month program for patients who have already had some upper limb treatment and now have been discharged home after inpatient rehabilitation. Only one book level (***levels 2 and 3***) was designed.

Level 1

Practice of gross motor skills & introduction of fine motor skills

Typical patient function at start of level

- Minimal hand function
- Minimal fine motor skills
- Active shoulder shrug & gravity assisted shoulder flexion

Level 2

Practice of gross motor skills & fine motor skills

- More graded control of hand grasp
- Some release and fine motor skills
- Some gravity assisted shoulder flexion, extension & retraction
- Some elbow extension & flexion
- Some finger flexion & extension
- Grade 2 to 3 wrist extension, therefore, can move almost against gravity

Level 3

Practice of gross motor skills & substantial fine motor skills.

- Substantial fine motor tasks
- Half of active range of motion for finger flexion and extension
- Grade 3-4 shoulder and grade 3 elbow and wrist, therefore, can move against gravity

Appropriate Fugl-Meyer scores or Chedoke Stage for each level:
Level 1 = Fugl-Meyer scores 10-25 or Chedoke stages 2-3
Level 2= Fugl-Meyer scores 26-45 or Chedoke stages 3-4
Level 3= Fugl-Meyer scores 46-58 or Chedoke stages 5-6

See appendices for details on determining the participant's Chedoke Stage.

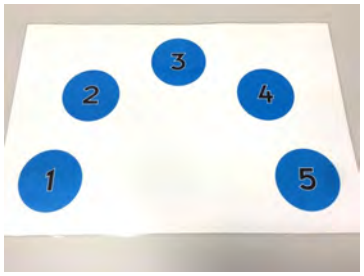
ECLIPSE – The 7 "must-do" parts of GRASP

- **E**quip the patient with the GRASP book and equipment ☐
- **C**oach the patient and family on how to do the GRASP exercises ☐
- **L**og – ensure the patient logs the GRASP practice time ☐
- **I**nvolve family and caregivers with GRASP if available ☐
- **P**rogress the patient weekly so exercises are always challenging ☐
- **S**upport the patient – check weekly logs – work through barriers to doing daily GRASP exercises - motivate ☐
- **E**ncourage and set targets for stroke-affected hand use in everyday home activities ☐

GRASP is not "GRASP" without these 7 parts. GRASP will not be successful if the GRASP manual is simply given to the participant without regular monitoring and progression.

Equipment List

Buttoned shirt



Target Board
Template in appendices

Tennis ball

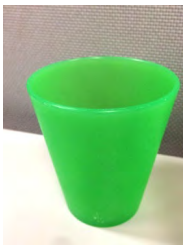
Bean bag

Wrist weight

Hand Gripper- 5lb resistance

Knife & Fork

Towel



Cup

Popsicle sticks & toothpicks

Various sizes of Lego

Various sizes of blocks

Poker chips, pennies, dimes

Various sizes of clothes pins

Various sizes of paper clips

Theraputty

Various jars

SECTION 3: GRASP Program Protocol

Sanitization of Equipment

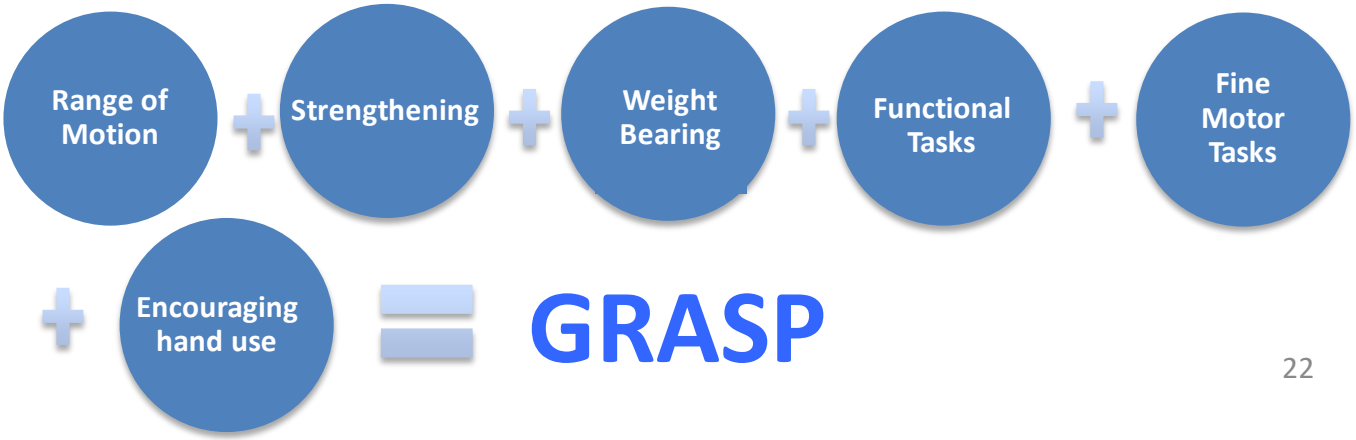
Ensure equipment used in the GRASP program is frequently cleaned by sanitization solution or disinfection wipes, especially if equipment is shared.

Roles

Instructor	Caregiver or Family
Understand issues specific to stroke and its impact on upper extremities.	Help organize exercise equipment for quick changes between exercises. Help put equipment away after each exercise.
Teach GRASP exercises, monitor amount of GRASP done and progress to challenge the participant.	Help keep track of exercises on the daily log sheet.
Brainstorm activities that the participant can do in their own environment to increase their stroke-affected hand use.	Assist with exercises that require a partner.
Encourage and motivate!	Encourage and motivate!

NOTE: It is important to engage the family if possible, as family involvement with GRASP leads to better outcomes.

Format of Upper Extremity Exercises



SECTION 3: GRASP Program Protocol

GRASP Program Components

The GRASP Program consists of exercises grouped into 5 sections within the book: 1. Stretching, 2. Arm Strengthening, 3. Hand Strengthening, 4. Coordination, and 5. Hand Skills. These sections comprise six main exercise components: 1. Range of motion, 2. Strengthening, 3. Repetitions of the stroke-affected arm and hand, 4. Weight-bearing, 5. Trunk control and 6. Repetitions using both arms.

#1-Range of Motion



Loss of joint range commonly develop after stroke and interferes with upper extremity function. Therefore, it is important to maintain extensibility of the muscles to promote subsequent strengthening through full range of motion.

#2-Strengthening



Muscle strengthening after stroke has not been found to increase spasticity, rather strengthening has been found to be effective in improving upper extremity function after stroke. Upper extremity muscle strengthening can improve bone density and the ability to perform activities of daily living involving the upper extremities.

GRASP Program Components

#3: Repetitions of the stroke-affected arm and hand



Hundreds if not thousands of challenging upper extremity repetitions can help the brain recover and result in improvements with the arm and hand after stroke. Varying accuracy and speed requirements are integrated within the fine motor and gross motor repetitive tasks.

#4: Weight Bearing



With a reduction in arm use, there is reduced loading to muscle, bone and sensory receptors. Controlled weight-bearing through the hand is one method to increase muscle activation without weights. In addition, weight-bearing will help to reduce the known bone loss which occurs early after stroke

GRASP Program Components

#5: Trunk Control



Better trunk control is known to facilitate arm reaching. Thus, exercises to challenge trunk movements are important for upper extremity function.

#6: Repetitions Using Both Arms



The majority of daily tasks use both arms and hands. Repetitive bilateral arm training has been shown to improve arm and fine motor function. Bilateral tasks are realistic of the many activities of daily living, which require bilateral arm and hand coordination.

Note: Repetition

It is known that many repetitions are required for improving motor learning. Thus, exercises are generally done in "sets" of 5 or 10 and then repeated as tolerated.

SECTION 4: GRASP Implementation

General Implementation Overview

1. Describe program to participant and family. Do behavioural contract and confidence assessment with participant/family. Discuss barriers and feasibility if confidence is low.

2. Provide participant HOME GRASP manual or with appropriate level of the HOSPITAL GRASP Manual (Level 1, 2, or 3). Review exercises with the participant and family.

3. Provide participant with equipment. Alternatively, show sample kit with equipment items and give suggested equipment list for client to purchase. Help source more difficult items (weight, therapy, gripper)

4. Instruct participant and family on how to perform exercises with the equipment and modify if needed. Exercises are done outside of formal one-on-one therapy and can be done in the hospital room, in a group GRASP program or at home.

5. Encourage the participant to rest as necessary but a goal should be to work towards 60 continuous minutes of exercise.

6. Do not limit movement if the person is unable to do the movement properly. It is important that they are encouraged to move their stroke-affected arm as best they can. **Improper movement should not be the cause of omitting an exercise.**

7. Review the Daily Exercise Log Sheet with the participant and family and emphasize the importance of tracking their exercises.

1. Encourage the participant to use their stroke-affected arm as much as possible for daily activities. Set weekly targets (eg, use their stroke-affected hand 20% of time when they have tasks that require their arm/hands). Brainstorm tasks to increase amount of use of the stroke-affected hand. Examples include: Opening the door, brushing teeth, eating lunch.

1. Progress exercises with participant on a weekly basis (in person or by phone), as well monitor for adverse events (eg. Pain). Challenge the participant with an appropriate level of graded exercise. Exercises must be challenging to the participant to result in improvements**.** If the participants is able to complete exercise sets without making any mistakes (eg, dropping or mishandling item) or without fatigue, the exercises should be advanced.

Hospital GRASP Detailed Implementation Timeline (face-to-face visits)

FIRST VISIT

1. Explain purpose and benefits of program and what is expected of them
a) GRASP exercise daily either for one 60 minute period or two 30 minute periods
b) Importance of continuing regular therapy if they are receiving it (eg. OT/PT)
c) Importance of using the stroke-affected arm and hand as much as possible during waking hours
2. Complete behavioural contract and confidence form – brainstorm barriers/facilitators and decide if the program is realistic
3. Show the participant and family how to do each exercise and have participant do selection of exercises. Assign the appropriate grade of sets.
4. Show participant and family how to fill out the log sheet. Let them know when you will see them again

approx 60 min

SECOND VISIT

1. Have participant and family demonstrate some of the GRASP exercises to you (i.e. you observe their exercise session)
2. Ask the participant and family if there are any issues with the exercises (query if too easy, too hard; query pain)
3. Check to see if log sheets are done. Discuss barriers and potential solutions if exercise compliance is low (< 45 min daily).
4. Progress exercises to ensure they are challenging eg. should drop or mishandle fine motor items at least once per set or muscles are tired during strengthening
5. Set targets for waking hour stroke-affected hand use in participant's environment and brainstorm activities to increase use. Let them know when you will see them again

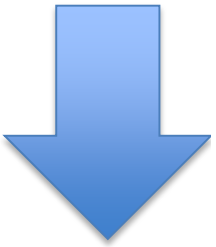
approx 30 min- ideally the next day

GRASP Detailed Implementation Timeline Continued

THIRD VISIT

1. Observe 6 exercises (choose two from strengthening, two from coordination, and two from hand skills categories)
2. Ask the participant and family if there are any issues with the exercises (too easy, too hard; query pain)
3. Progress exercises to ensure they are challenging, eg. should drop or mishandle fine motor objects at least once per set or muscles are tired during strengthening
4. Check log sheets and and discuss barriers and potential solutions if exercise compliance is low (< 45 min daily).
5. Check on targets (and set new ones) for stroke-affected hand use in own environment and brain storm activities to increase use. Let them know when you will see them again

NOTE: The first 3 visits would ideally occur within the first 10 days of enrollment in the program.



approx 10 min, 1 week after 2nd visit

WEEKLY VISIT

Same as Third Visit

approx 10 min

LAST VISIT BEFORE DISCHARGE

1. If the stroke took place recently (e.g., last month), at least 4 weeks of GRASP should be trialled. Participants with more chronic stroke may need more weeks; we found positive results with an 8-week GRASP program for people 4-12 months post-stroke. However, if the participant is no longer making any gains, GRASP should be stopped.
2. If further improvements are expected (e.g., participant has not plateaued), but no further services can be provided, then explain to the participant and family the importance of continuing the exercises at home until no further improvements are being experienced.

SECTION 4: Implementation

Home GRASP Implementation (phone monitoring)

1. Implementation when phone monitoring is similar to face-to-face. GRASP exercises need to be taught face-to-face with the participant (participant visits clinic or therapist provides home visit). Telehealth applications (video-conferencing) might be possible as well. Participants need to log their exercise minutes. The more detailed Exercise Progress Check Form can be used to facilitate the review of exercises with the therapist over the phone.

2. Check in with the participant on a weekly basis and progress the exercises. Monitor for adherence to exercise. Brainstorm with the participant on daily activities they can use their stroke-affected hand. Discuss barriers and solutions if GRASP minutes are less than 45 min daily. See the sample telephone follow-up script.

5. Modify exercises as appropriate. Ensure activities are challenging (eg. should drop or mishandle fine motor objects at least once per set or muscles are tired during strengthening) and suggest ways to advance the challenge. See section on Grading for more information.

SECTION 4: Implementation

Home GRASP- Phone Follow Up Sample

Hello! My name is ____. I am an occupational/physical therapist with___. May I speak with: Mr./Mrs. ____Hi, Mr. (Mrs.) "___", This is ___ from _hospital and I am calling you to see how you are doing with the GRASP program for your hand. Your ___(wife/husband/friend) was going to join us on this call. Can you put them on the speaker phone?

Do you have your GRASP book and log sheet with you? Could you please go get your GRASP book and logsheet? (note some patients will not be able to hold phone and turn pages of GRASP at same time). Are you ready?

In the past week, how many minutes did you do the GRASP exercise each day?
Mon: _____ Tues: _____ Wed: _____Thurs: _____ Fri: _____Sat: _____Sun: _____

If less than 45 min daily, probe barriers and brainstorm potential solutions.

Have you had any increase in arm or shoulder pain over the week? If yes, need to probe on what exercises, where is the pain, and how severe. Can then adjust exercises – i.e. emphasize to shoulder height only, reduce weight or no weight, reduce repetitions.

Are you able to get thru all the exercises in the book each day? We had prescribed 3 sets of 5 (or 8, 10) for most of your exercises. Are you able to do this many repetitions? Why not? Did you have any problems with any of the specific exercises over the past week? *Common issues are fatigue, pain, time commitment, motivation, lack of caregiver support.* (ideally, arrange for the caregiver to be available for the phone call)

Are the exercises challenging to you or difficult to do? Probe if they drop or mishandle objects on the fine motor tasks at least once per set or if their muscles feel tired in the strengthening tasks. If not, advance fine motor (eg, reduce size of fine motor objects) and strengthening tasks. See Grading section.

Now probe target use of the arm. When I last spoke to you, you set a target to use your weaker hand about X% of the time to do anything that requires your arms and hands. Do you think you reached that target over the last week? If not, probe barriers/solutions.

You mentioned that you were going to try to use your weaker hand during ____, ____, and _____, Were you able to use your weaker hand for these tasks? Discuss barriers and solutions.

Can you think of tasks that you could try this week to increase the amount you use your weaker hand? You can try to brainstorm tasks that are safe for that patient (e.g., turning book, turning door knob, brushing teeth, combing hair, using towel with 2 hands, doing up buttons/zippers). Especially promote the weaker hand to be the active "doer" and not just stabilizer.

What percent of the time do you think you can use your weaker hand during tasks that require your arms and hand over the next week? Let's set that as your target for next week.
Wrap up emphasizing how hundreds of hand repetitions and lots of everyday use of the arm/hand can promote activation of brain pathways, and help recover after a stroke.

Implementation Options- Group GRASP

GROUP GRASP PROGRAM

- Can be done in clinical settings or community centres
- Use of rehab assistants to undertake a group GRASP class
- Requires large table and books/equipment available
- Ensure compliance with exercise and progression to next levels
- Socialization is helpful, but ensure that intensity does not decline with chatting (not all patients can talk and exercise at same time!)
- Rehab assistants assist with documentation of minutes and challenge of task, as well as monitor compliance and motivate participants
- Given multiple participants, the detailed GRASP Exercise Program Check form should be completed
- Participants can take turns sharing how they used their stroke-affected hand in the previous day, and what activities they plan to use their stroke-affected hand with over the next day to increase its use

SECTION 4: Implementation

GRASP- Exercise Progress Check

Do you have problem doing……
How many sets and repetitions do you do for this exercise? Is it easy or hard for you? Any problem?

	Items	#Sets	#Reps	Easy? Hard?	Note/Tips
1	Total Arm Stretch				
2	Shoulder Shrug				
3	The Twist				
4	Hand and Wrist Stretch				
5	Push-ups				
6	One Arm Push-ups				
7	Chair-ups				
8	Shoulder exercise: Arm to Front				
9	Shoulder exercise: Arm to Side				
10	Elbow Exercise				
11	Wrist Exercise – Part 1				
12	Wrist Exercise – Part 2				
13	Grip Power				
14	Finger Power				
15	The Twist				
16	Finger Strength				
17	Cutting				
18	Waiter				
19	Advanced Waiter				
20	Pouring				
21	Start the ball rolling				
22	Start the ball rolling – Advanced				
23	Drop and Catch				
24	Total Arm Stretch (again)				
25	Laundry				
26	Button				
27	Hanging Up the Clothes				
28	Lego				
29	Block Towers				
30	Pickup Sticks				
31	Paper Clips – Part 1				
32	Paper Clips – Part 2				
33	Flip Over				
34	Jar				
35	Drying Off				

SECTION 4: Implementation

GRASP Behavioral Change Techniques

Behavioral strategies should be built into the protocol to ensure exercise adherence and promote integration of the stroke-affected upper limb into daily activities. See below for some suggestions that a therapist can do which will benefit the participant in between sessions:

ACCOUNTABILITY

Weekly phone calls to participants to inquire about adherence to program, ascertain level of challenge and progress the program as needed.

COLLABORATIVE GOAL SETTING

Work collaboratively to identify weekly task goals for increasing upper limb use during daily activities.

Review participant's experience in completing weekly task goals.

SOCIAL SUPPORT:

Encourage participants to invite caregivers to training sessions and be involved with exercise program and upper limb task goals.

INTENTION FORMATION:

Ask participants to identify their level of confidence to adhere to exercise targets. If confidence is less than 80%, discuss facilitators and barriers to adherence and problem solve strategies for overcoming barriers.

FEEDBACK ON PERFORMANCE

Ask participants to report the % of time they were using their affected upper limb over the day in tasks that required the arms or hands.

BARRIER IDENTIFICATION

Ask participants to identify barriers to completing GRASP exercise and using the arm/hand. Assist participants to problem solve solutions.

BEHAVIORAL CONTRACT

Emphasize the need for commitment through a behavioral contract where participants (and caregivers) agree to adhere to exercise targets.

SECTION 4: Implementation

GRASP Behavioral Contract- Sample

Explain the GRASP Behavioral contract and confidence form to the participant. Ask the participant to fill out this confidence form so that you can discuss ways that might help the participant meet the exercise targets. Record the level of confidence for your records. If confidence is low (less than 8), then discussion is required to brainstorm barriers/facilitators and to decide if the program is realistic.

Stroke participant:

I will do the GRASP exercises ONE hour each day, seven times a week starting _____(date) and ending _____(date).

How confident am I that I will do this? _____
Use a scale of 0 to 10, with 0 being not at all confident and 10 being completely confident.

Signed _____ (patient)

Family/Caregiver:

I will assist _____(patient name) with the GRASP exercises _____times per week starting (date) and ending _____date()
How confident am I that I will do this? _____
Use a scale of 0 to 10, with 0 being not at all confident and 10 being completely confident.

Signed _____ (family/caregiver)

Tips for Modifying Exercises

Condition	Possible Modification
Participants with shoulder pain	• Decrease repetitions • Restrict shoulder movements to below the horizontal • Reduce or eliminate the weights • Encourage more rest breaks
Participants using major compensatory movements (i.e. shoulder hiking, shoulder abduction etc. for reaching)	• Do exercises in front of a mirror to encourage proper movement but compensatory motions should not be a reason to avoid an exercise • Participants can use the stronger hand to correct themselves. For example, if the right shoulder hikes when reaching, they can place the left hand on the right shoulder as a reminder. • Correcting a compensation can be used to make the exercise more difficult. For example, when pouring one cup of water into another, a participant may accomplish this with trunk tilting and shoulder abduction due to poor pronation/supination and wrist control. A mirror may be helpful to reduce compensations.
Participants with whom tone substantially increases with the exercises	• Modify gripping exercise by using ball instead of gripper • Use gripper with less resistance • Encourage stretching and weight-bearing thru arm
Participants unable to maintain upright position	• Place support behind the participant's back and appropriate safety belts. Do exercises in supportive wheelchair

Grading of the Exercises

Hospital GRASP
Each manual level has graded exercises within them. Work with your participant to determine which level to start with for each exercise. For example strengthening exercises start at 1 set of 5 and then increase to 3 sets of 5. Once the participant progresses to GRASP Manual Level 3, the exercises can be made more challenging by using different equipment or by increasing the number of repetitions. For instance, smaller pieces (ie. small Lego, Pick Up sticks) can be used. Check in frequently with your participant to ensure that they are doing the exercises at the appropriate level of difficulty. If the participant completes the exercise without making any mistakes, such as mishandling or dropping the object once per set, you need to make it more difficult.

Home GRASP
Each exercise in the manual is graded. Work with your participant to determine which level to start with for each exercise. It is important that the exercises are challenging. If the participant completes the exercise without making any mistakes, such as mishandling or dropping the object, you need to make it more difficult.

Grading of the Exercises Continued

These exercises need to be challenging to the participant to improve brain function. For instance, if the participant completes the hand exercise without making any mistakes, such as mishandling or dropping the object, the exercises need to be made more difficult. See below for some ideas of how to make the exercises more challenging:

Use smaller objects for the fine motor exercises

Use toothpicks instead of popsicle sticks

Use smaller pegs

Use smaller coins, lego or bloccks

Use various sized objects for the exercises. For instance, a variety of jars with different mouth sizes (eg. Narrow, wide)

SECTION 4: Implementation

Grading of the Exercises Continued

Increase the resistance for strengthening tasks

Increase the weight of the wrist weights, select a higher theraputty grade, or increase the resistance of the gripper.

For the pouring exercise, more water can be added to increase the weight of the cups.

Increase the number of repetitions for each exercise

- ☐ **3 sets of 5 repetitions**
- ☐ **3 sets of 8 repetitions**
- ☐ **3 sets of 10 repetitions**

Try to do the exercises faster but still accurately

Maximizing Adherence & Having Fun

Emphasize reasons for doing exercise

Emphasize that the greatest recovery of the brain occurs in the first months after a stroke and the need to maximize one's abilities during this time period

Emphasize that thousands of challenging repetitions of the stroke-affected arm and hand are needed to maximize outcomes

Emphasize that it is normal to feel frustrated when doing difficult repetitions or challenging daily tasks with the stroke-affected hand

Seek solutions for poor adherence

Therapists should explore reasons behind non-adherence with the participant to determine whether there are solutions to the problems

Consider clarification of exercises, equipment adaptation, as well as caregiver or family support

Encourage socialization

Some stroke units are now using GRASP as a group inpatient or outpatient program led by a therapist or rehabilitation assistant.

Families, friends and caregivers can be involved to motivate and encourage the participant, help with the exercises, record the daily log or simply do the exercises together

Maximize feedback of performance

The exercises are designed to maximize sensory or visual feedback. Thus, moving a cup of water on a target board allows the participant to be aware of their abilities (they may spill water or not reach the target). In addition, grading the exercises will make the participant aware of their improvement.

Create a positive environment

The book and equipment should be accessible to the participant and stored in view as a reminder to do the exercises (and not in a closed cupboard). Participants say that the books are easier to use if printed in colour. A selection of music of an hour length may help to cue the participant that they have done sufficient exercises.

SECTION 5: Program Evaluation

Measuring Progress

It is recommended to conduct a pre- and post assessment to evaluate the effects of the GRASP program. The first scheduled class can be used to introduce the program and conduct the assessments. If desired, review the results with participants regarding their progress. Recommended assessments are the Fugl-Meyer Upper Extremity Scale (FM-UE), Action Research Arm Test (ARAT), Nine Hole Peg Test (NHPT), and Stroke Upper Limb Capacity Scale (SULCS).

Fugl-Meyer Upper Extremity Scale (FM-UE) can be found by following the link below:
https://www.strokengine.ca/en/assess/fma/

Action Research Arm Test (ARAT) can be found by following the link below:
https://www.strokengine.ca/en/assess/arat/

Nine Hole Peg Test (NHPT) can be found by following the link below:
https://www.strokengine.ca/en/assess/nhpt/

Stroke Upper Limb Capacity Scale (SULCS) can be found by following the link below:
https://rde.maartenskliniek.nl/innovations/sulcs/

Stroke Upper Limb Capacity Scale (SULCS)

Objective

The SULCS is a reliable and valid upper limb measure for individuals with stroke which consists of 10 meaningful functional tasks related to daily activities. While FM-UE, ARAT, and NHPT require special equipment or a lot of practice, the SULCS is a fairly short assessment that does not require special equipment and training.

Instructions For Administration And Scoring

- The 10 tasks on the list are in order of difficulty and complexity.
- The tasks are performed either standing or sitting. It is permissible to deviate from the prescribed order of the tasks for practical reasons.
- All tasks must be performed unaided.
- It is important to score whether the task can be performed in line with the instructions, (able/unable), not the quality of how it is performed.
- If necessary, it is permissible to repeat the instructions or to demonstrate the task.
- Starting with either task 1 or task 10 can be decided by making a before-hand judgment of the level of upper limb capacity. Start with task 1 for low capacity and task 10 for high capacity.

Test materials

- A height-adjustable table
- A chair
- A pen
- A towel
- An empty jar, ± 400 grams, with a plastic screw top lid (± 20 mm high, diameter lid ± 77 mm). The closed lid and the jar are marked with a marker pen so that each time the jar is re-closed, as it would be after normal use, the marks line up (goal: to ensure that the degree of difficulty is the same each time the test is carried out).
- A tall drinks glass (diameter ± 55 mm, ± 150 mm)
- A tennis ball
- A comb
- A buttoned shirt
- A stopwatch
- Three different sized coins: a quarter, nickel, and dime
- A scoring sheet

SECTION 5: Program Evaluation

Stroke Upper Limb Capacity Scale (SULCS) Instructions

Scoring
Score 0 = patient is unable to perform the task in the manner described
Score 1 = patient is able to perform the task in the manner described

Note
Option 1: if a patient has low arm and hand capacity, start the test with task 1 and work forwards from there. When 3 consecutive tasks *cannot* be performed, the test may be stopped. Each remaining item is scored with 0.
Option 2: if a patient has high arm and hand capacity, start the test with task 10 and work backwards from there. When 3 consecutive tasks *can* be performed, the test may be stopped. Each remaining item is scored with 1.

Item	Description	
1	What	Using the affected forearm for support while seated
	How	Reaching forward across the body, leaning on the affected forearm
	Preparation	The patient is seated at a table. The affected forearm is on the table, parallel to the edge where the patient is sitting. A pen is placed on the table, in front of the affected elbow and far enough away so that complete extension of the non-affected arm and movement of the upper torso is needed to reach the pen.
	Task	The patient reaches to pick up the pen with the non-affected hand. The affected forearm is used as a support.
	Note	The affected arm must not shift as the patient reaches forward to pick up the pen.
2	What	Clamping an object between torso and upper arm
	How	Pressing the affected arm firmly against the side of the body
	Preparation	The patient is standing (sitting, if necessary) at a table. A magazine folded lengthways in half is on the table. The affected upper arm is hanging freely next to the body.
	Task	The patient picks up the magazine with the non-affected hand and clamps it between the torso and the affected upper arm.
	Note	The magazine must be held firmly for 10 seconds. The therapist checks this, if necessary, by lightly pulling on the magazine.
3	What	Sliding an object across a table while seated
	How	Using controlled sliding movement of the affected hand
	Preparation	The patient is seated at a table. The affected hand is on the table on a tea towel that has been folded in four, with the palm facing downwards and the fingers pointing forwards.
	Task	The patient pushes the tea towel forwards over the table.
	Note	The elbow must be extended by at least 160°, and may be lifted off the table. Fully extended fingers are not necessary.

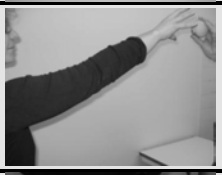
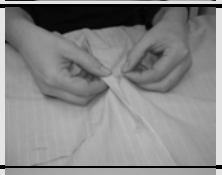
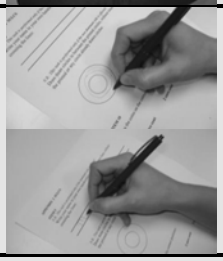
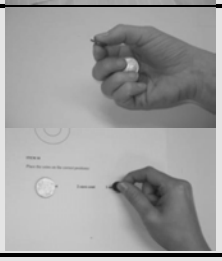
Stroke Upper Limb Capacity Scale (SULCS) Instructions

Item	Description	
4	What	(Partly) unscrewing a screw-top lid
	Preparation	The patient is sitting at a table with both arms on the table. A closed peanut butter jar with a plastic screw-top lid is 15 cm in front of the patient on the table.
	Task	The patient holds the jar firmly on the table with the non-affected hand and, using the affected hand, turns the lid at least a quarter of a turn.
	Note	The jar must remain in the same place on the table and may not turn.
5	What	Picking up a glass of water and drinking from it
	Preparation	The patient is sitting at a table with both arms on the table. A glass, ½ filled with water, is 15 cm/6 inches in front of the patient on the table.
	Task	The patient picks up the glass from the table with the affected hand, takes a drink and places the glass back on the table without spilling.
	Note	The non-affected hand is not used.
6	What	Grasping a ball presented from a high angle
	Preparation	The patient is standing (sitting, if necessary) with no other support within reach. The therapist holds a tennis ball in front of and above the affected shoulder in such a way that the patient has to fully extend the affected arm and must raise the arm ±120° to grasp the tennis ball.
	Task	The patient reaches for the ball and takes it with the affected hand.
7	What	Combing one's hair
	Preparation	The patient is standing (sitting, if necessary) at a table. A comb is within reach on the table.
	Task	The patient combs his/her hair with at least two strokes on the top and each side of the head.
	Note	The head should be held straight. The patient may reach the sides from above or from the side. Where the personal situation is less suited to this test, an 'as-if' movement should be made.

Stroke Upper Limb Capacity Scale (SULCS) Instructions

Item	Description	
8	What	Fastening buttons
	How	Working with two hands
	Preparation	The patient is sitting at a table. A buttoned shirt is on the table directly in front of the patient. The collar is at the top, facing upwards. The top button is fastened, all the others are unfastened.
	Task	The patient fastens four buttons within 60 seconds using both hands.
	Note	The affected fingers must be used actively, either to hold the material or the button, or to keep open the button hole.
9	What	Writing
	How	See SULCS form A
	Preparation	The patient is sitting at a table. The sheet of paper, included as SULCS form A, is 15 cm/6 inches in front of the patient on the table. A pen is on the sheet of paper.
	Task	(Version 1: the affected side is the non-dominant side) The patient picks up the pen and draws three circles between the two circles on the sheet, without touching the edges of the printed circles or any circle already drawn.
	Note	Explain the instructions in full before-hand and suggest that the patient starts near to the inner circle. The patient may move the sheet of paper.
	Task	(Version 2: the affected side is the dominant side)
	Note	The patient picks up the pen and writes his/her first and last name legibly in his/her own handwriting between the lines. The patient may move the sheet of paper.
10	What	Manipulating coins
	How	See SULCS form B
	Preparation	The patient is sitting at a table. The sheet of paper, included as SULCS form B, is on the table, directly in front of the patient. There are a 50 eurocent coin, a 2 eurocent coin and a 1 eurocent coin (or their equivalents in size and weight) on the table. The affected forearm is on the table with the hand facing palm-up. Using the non-affected hand, the patient puts all 3 coins in the affected hand.
	Task	The patient manipulates the coins within the affected hand, holds between the tips of the thumb and index finger one at a time, and places on their designated positions on the sheet.
	Note	It does not matter in which order the coins are placed in their designated spots. During the manipulation, the forearm must rest on the table.

Stroke Upper Limb Capacity Scale (SULCS) Scoring Sheet

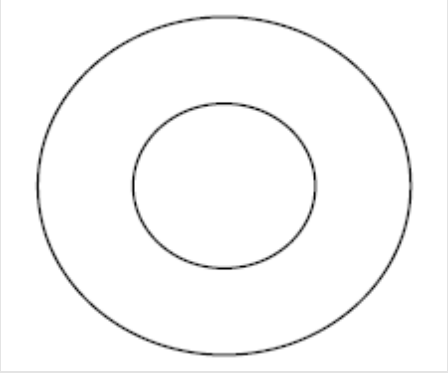
Score	Item		Score	Item	
	1. Using the affected forearm for support while seated			2. Clamping an object between torso and upper arm	
	3. Sliding an object across a table while seated			4. (Partly) unscrewing a screw-top lid	
	5. Picking up a glass of water and drinking from it			6. Grasping a ball presented from a high angle	
	7. Combing one's hair			8. Fastening buttons	
	9. Writing (See SULCS form A)			10. Manipulating coins (See SULCS form B)	

TOTAL SULCS SCORE ☐ / 10

Stroke Upper Limb Capacity Scale (SULCS) Scoring Sheet

SULCS FORM A FOR TASK 9

Note: This task is performed only if the non-dominant side is affected
Draw three circles in between the printed circles, without touching the edges of the printed or any circle already drawn circles:



Note: This task is performed only if the dominant side is affected.
Write your name in your own handwriting between the two lines, without crossing the lines:

_____

_____

SULCS FORM B FOR TASK 10
Place the coins on the correct positions:

Quarter Nickel Dime

SECTION 6: Fidelity Evaluation

GRASP Program Fidelity Checklist

Objective

The GRASP Program Fidelity Checklist is a tool to assess fidelity of delivering the GRASP Program. The checklist describes core principles and key components of the GRASP program that contribute to expected benefits and provide guidance for adaptability of the program into various settings. It is recommended to use this checklist to assess fidelity at the second session and midway through the program to monitor progress.

Scoring

Score 0 = Did not demonstrate = this item was not demonstrated at all

Score 1 = Partially demonstrated = this happened to some extent, but not or all group members, all of the time (e.g., instructors facilitate discussion, but only among certain members of the group)

Score 2 = Demonstrated consistently through entire class = the item was demonstrated consistently and appropriately throughout the entire session

NA: not applicable

Item		Score
I. Program preparation		
Training workshop	GRASP classes are provided by trained instructor(s).	
	Instructor attended the training workshop.	
Naming	The program is marketed as the “GRASP program.”	
Screening	Participants are appropriately screened.	
II. Program parameters		
Frequency	Classes are run one time per week.	
Length	Classes last 60 minutes.	
	Length of the program is at least 4 weeks (Hospital GRASP) or 8 weeks (Home GRASP).	

SECTION 6: Fidelity Evaluation

GRASP Program Fidelity Checklist Continued

Item		Score
III. Class structure		
Set goals and monitor progress	Instructor emphasizes the expectation to practice challenging arm and hand movements daily as much as possible in order to improve activation of the brain to relearn movements.	
	Instructors prompt participants to set targets for affected hand use in everyday activities (e.g., use the affected arm 30% of time when they have tasks that require their arm).	
	Instructor reviews prior week's GRASP log sheet with participants.	
	Instructor elicits discussion about facilitators and barriers to doing daily GRASP exercises and initiates problem-solving approach to address barriers.	
	Instructor facilitates participants to identify new activities that they will do with their affected hands to increase the use of their affected hands.	
Assess and tailor	(1st session) Instructor assesses participants' confidence level by asking participants to fill out the GRASP behavioral contract and confidence form.	
	Instructor equips each participant with a GRASP book that matches the participant's level.	
	Instructor selects appropriate exercises for participants (e.g., stacking Lego blocks).	
	Instructor selects appropriate level of exercises for participants (e.g., big Lego blocks or small Lego blocks).	
	Instructor selects appropriate number of repetitions of exercises for participants (e.g., 3 sets of 10 repetitions).	
	Instructor encourages and facilitates good exercise form by verbal cues, tactile cues, or demonstration.	
	Instructor progresses each participant weekly so exercises are always challenging.	
	Instructor updates participants' progress tracker.	

SECTION 7: Fidelity Evaluation

GRASP Program Fidelity Checklist Continued

Item		Score
IV. Class process		
Manage the class	Instructor ensures that the space is adequate for exercises.	
	Instructor ensures that the space is adequate for discussion.	
	Instructor ensures that the space is adequate to involve caregivers and family members.	
	Instructor involves family and caregivers if available.	
	Instructor allocates time appropriately.	
	Instructor facilitates discussion and interaction using open-ended questions, affirmations, reflections, summaries.	
Stay on track	Instructor addresses process (tangential) issues but did not allow them to disrupt content agenda.	
	Instructor moderates distractions (e.g., side bar conversations, interrupted by family members)	
Create a supportive and empathetic climate	Instructor avoids judgmental feedback on participants' contribution.	
	Instructor responds empathetically and accurately to individual or group member behavior (verbal, nonverbal)	

SECTION 7: Appendices

GRASP Daily Log Sheet

Customize the calendar by writing in month and dates on the lines. Write the number of minutes you did GRASP exercises each day. Note unusual events such as flu or surgery that may have prevented GRASP practice. Also note if pain or excessive fatigue.

Month: _____

Day	Mon	Tues	Wed	Thur	Fri	Sat	Sun
GRASP minutes	_____	_____	_____	_____	_____	_____	_____
GRASP minutes	_____	_____	_____	_____	_____	_____	_____
GRASP minutes	_____	_____	_____	_____	_____	_____	_____
GRASP minutes	_____	_____	_____	_____	_____	_____	_____
GRASP minutes	_____	_____	_____	_____	_____	_____	_____

SECTION 7: Appendices

Chedoke Assessment Stages

To determine which Chedoke Stage, have the participant perform the following tasks. Begin with Stage 3 and move a stage up or down from there.

The participant should be in the standard sitting position with feet supported: sitting with the forearm in the lap, or supported on a pillow, in neutral position, wrist at 0 degrees and fingers slightly flexed. The participant can sit either supported or unsupported. Encourage good sitting posture for testing.

Stage 1

Does not have at least TWO of Stage 2 tasks.

Stage 2

NOTE: Support the limb as necessary while facilitating the movements.

Task #1: Positive Hoffman.
"Let me move your fingers"
• *With one hand support the participant's middle phalanx of middle finger. With the other hand, snap the distal phalanx of middle finger into flexion. A positive response is flexion of fingers and/or thumb.*

Task #2: Resistance to passive wrist or finger extension.
"Let me move your hand". *Flex and extend wrist or fingers 5 times quickly. A positive response is resistance to passive movement and possible contraction of wrist/finger flexors.*

Task #3: Facilitated finger flexion
"Bend your fingers". A positive response is some active finger flexion.

Stage 3

Task #1: "Bend wrist backwards"
•*Active wrist Extension greater than ½ of range. Can support forearm and movement may be in synergy.*

Task #2: "Make a fist"
•*Finger or wrist flexion greater than ½ of range*

Task #3: "Touch your index finger with your thumb". Can support hand in supination and movement may be in synergy.

Chedoke Assessment Stages Continued

Stage 4

Task #1: "Stretch your fingers out straight, then make a tight fist"
•*Greater than half range of extension followed by full flexion of PIP and DIP.*

Task #2: Hold piece of paper between thumb and index finger. "Straighten your thumb, then bring it down to hold onto the paper."
•*Thumb extension greater than ½ range, some pressure to hold paper.*

Task #3: "Make a tight fist and bring your thumb down to your index finger. Don't let me move your thumb." Therapist tries to move thumb away from the index finger
•*Finger flexion to close hands and active thumb flexion.*

Stage 5

Task #1: "Make a tight fist then straighten fingers"
•*Smooth reversal from full flexion to full extension of fingers.*

Task #2: "Spread fingers apart as far as you can"
•*Full range finger abduction without wrist of finger flexion*

Task #3: "Touch the tip of your little finger with the tip of your thumb"
•*Opposition of thumb to little finger without wrist flexion*

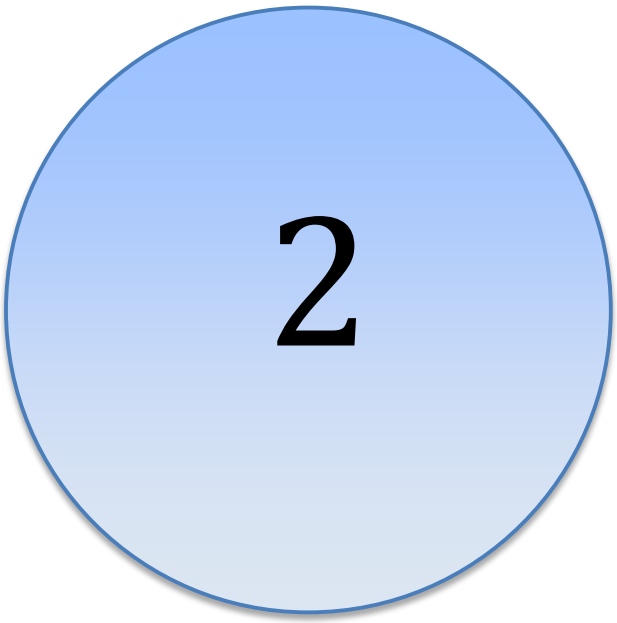
Stage 6

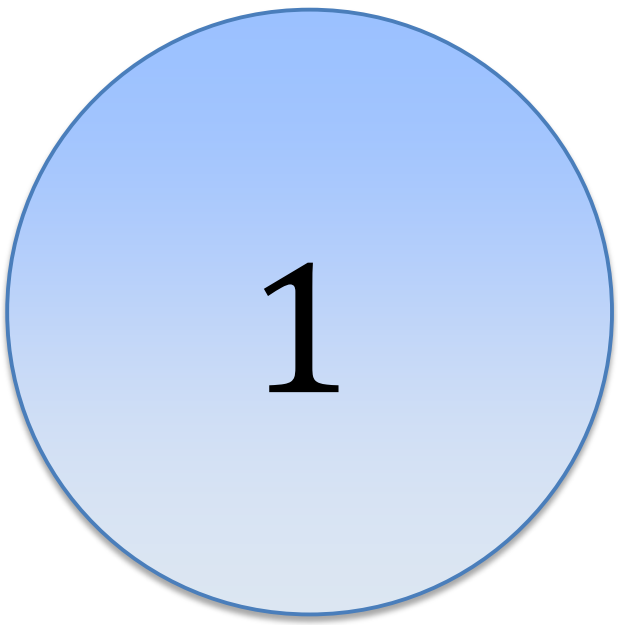
Task #1: "Keeping your fingers straight, tap your index finger as quickly as you can"
Taps index finger 10 times in 5 seconds without wrist or IP motion.

Task #2: Start in pistol grip. "Bend and straighten your index finger without moving anything else."
•*Full range of PIP and DIP without index MCP or thumb motion.*

Task #3: "Lift your wrist as far up as you can and then stretch your fingers apart"
•*Full range of wrist and finger extension with finger abduction*

Target Board Print-Out





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