The purpose of this paper is to present and describe a motor assessment scale (MAS) for stroke patients and to report on the investigation of two aspects of its reliability. The MAS is a brief and easily administered assessment of eight areas of motor function and one item related to muscle tone. Each item is scored on a scale from 0 to 6. To check interrater reliability, we videotaped five stroke patients while they were being assessed with the MAS. These scores were then correlated with the criterion ratings. Twenty raters then assessed these patients, and their results were correlated with the criterion ratings. We determined test-retest reliability by assessing on two occasions, separated by a four-week interval, 14 stroke patients whose recovery was considered to be stable and by correlating these scores. The MAS was found to be highly reliable with an average interrater correlation of .95 and an average test-retest correlation of .98.

Key Words: Cerebrovascular disorders, Evaluation studies, Motor skills.
MOTOR ASSESSMENT SCALE

NAME __________________________

MOVEMENT SCORING SHEET

DATE ................

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COMMENTS (IF APPLICABLE)

Figure. Scoring sheet for MAS.

item. The criteria for each point consists of a description of the activity to be performed followed by an italicized clarification of details to help the examiner (Appendix 1).

The points within each item in the MAS are based on observations made over many years of the progress of a large number of patients. Some points reflect quality of performance directly (Balanced Sitting, Point 6); others require performance within a specified time. The higher points of certain items reflect quality of performance in an indirect manner (Sitting to Standing, Point 6) because it is impossible to perform incorrectly in such a brief period of time. The General Rules list details of equipment, define terms, and give guidelines for instruction and feedback and for the general milieu in which the scoring is performed (Appendix 2). Total scoring time is approximately 15 minutes.

Because we believed the MAS could be a useful evaluation tool, we tested its reliability by investigating the scale’s intrarater reliability and test-retest reliability.

METHOD

Intrarater Reliability

We selected a group of five stroke patients, four women and one man at various stages of recovery. The only criterion for selection was the patient’s willingness to consent to participate in the study. An attempt was made, however, to select five patients who were different from each other in terms of time since stroke and obvious degree of disability, so that the full range of possible scores on the MAS would be represented. The group had three patients with left hemiplegia and two patients with right hemiplegia. None of the patients were dysphasic. The average age was 65 years old (range, 55–78 years). The time from onset of stroke to the time of scoring averaged 14 weeks (range, 6–40 weeks). Hemiplegia was due to cerebrovascular lesion in all five patients.

The last author assessed the five patients, and her scores became the criterion ratings. We videotaped the assessment sessions, but the tapes do not indicate what score was assigned to each item. The timed items have a digital display of elapsed time in one corner of the screen.

A group of 20 volunteers (physical therapists and physical therapy undergraduate students) were involved in the study. The physical therapists were all working in stroke rehabilitation, and several were clinical tutors in the School of Physiotherapy, Cumberland College of Health Sciences. The undergraduates were in their final year of a physical therapy educational program. Each volunteer was instructed in the use of the MAS and provided with a copy of the Criteria for Scoring and General Rules. This instruction was followed by a period of about three weeks to practice using the MAS. A questionnaire completed by each rater revealed that the average number of patients scored during this period was four (range, 1–5). After the practice period, we showed the physical therapists and students the videotapes of the five patients and asked them to use the MAS to score each patient’s performance. General Tonus, item 9, was not included because this was considered to be too difficult to score from observation alone.

Videotape was used to avoid the following: 1) the variability of patient performance that may occur if several raters scored the one patient on different occasions and 2) the stressful situation that would occur for patients if each were to be scored by 20 raters.

Test-Retest Reliability

A group of 15 stroke patients, 5 women and 10 men, were selected. The
only criteria for selection were the patients' willingness to consent to participate and the stable nature of their disability. Six patients had left hemiplegia and nine patients had right hemiplegia. The degree of disability varied. The rehabilitation team of the Lottie Stewart Rehabilitation Unit considered each patient's recovery to have reached a plateau. The average age of the patients was 70 years (range, 42–85 years). The time from onset of stroke to the time of the first evaluation for the purposes of this study averaged 55 months (range, 5 months–34 years). Hemiplegia was the result of cerebrovascular lesion in all 15 patients.

The last author scored the patients on two occasions separated by a four-week interval. One male patient with left hemiplegia was unable to participate in the retest procedure because of admission to a hospital. The results have therefore been correlated for 14 patients.

Data Analysis

We tabulated the assessments made of the five patients by the 20 raters. Each rater's scores were compared with the criterion ratings. Two different measures of interrater reliability were computed: 1) percentage agreement and 2) Pearson product-moment correlation coefficients.

The last author's assessments of 14 patients on two occasions were correlated using Pearson product-moment correlation to measure test-retest reliability. One correlation was computed on the eight scores made on each patient on the two occasions.

RESULTS

Interrater Reliability

Table 1 summarizes the percentage agreement obtained between each physical therapist's scores and the criterion ratings for each of the five patients. Table 1 also presents average percentage agreement for each rater across the five patients (row means) and average percentage agreement among the 20 raters for each patient (column means). The overall average of these means was 87 percent agreement. This figure represents the average agreement with the criterion ratings.

Table 1 also lists Pearson correlation coefficients. Each rater's scores for the five patients (40 scores in all) were correlated with the criterion ratings. The results are presented in the last column of Table 1. The correlations show greater relationship between the rater’s scores and the criterion ratings than does the measure of percentage agreement. Percentage agreement is a more stringent measure of consistency because only scores that match exactly on the seven-point scales are considered as agreement. Thus, if rater 1 has scored Walking with a 5 when the criterion is 4, this is a disagreement. The correlation coefficient, however, determines the extent of linear relationship in two sets of scores. Thus, a substantial relationship can be found if the two sets of scores have general agreement in high and low sections of the scale without complete agreement. Both percentage agreement and correlation coefficients, however, indicate that the MAS can be used reliably by physical therapists after instruction and a short practice period. The average percentage agreement for each patient (column means) shows some variability, but all of the five patients could be assessed reliably. This finding strengthens the claim that the MAS is a reliable instrument.

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Test-Retest Reliability

The test-retest correlations ranged between .87 and 1.00, with an average correlation of .98. Thus, reliability was very satisfactory. The test-retest reliability was somewhat higher than interrater reliability, a common finding in reliability studies. A high test-retest reliability is necessary for the scale to be confidently used to assess a patient’s progress. With a reliable scale, a physical therapist has reason to believe that changes in the scores of a particular patient indeed reflect a change in the patient’s motor abilities and not just measurement error.

DISCUSSION

Although we found no significant relationship between the number of practice patients and the raters’ reliability in the original study, this may not be true for practicing physical therapists in general. They may need to apply the MAS to a larger number of patients to become proficient and accurate in its use. In the past 12 months, the first two authors have led training sessions for both physical therapists and physical therapy undergraduate students (a total of 103) and have compared their reliability with the criterion ratings used in this study. Feedback from this group and their reliability scores suggest that the MAS should be used with at least six patients for an individual to be sufficiently familiar with the criteria to score patients on the videotape with consistent reliability.

We also found it interesting to investigate the various items of the MAS to determine whether any one was more reliable or less reliable than the others. Table 2 has been compiled for this purpose. Table 2 presents the percentage of raters who agree with the criterion ratings for each of the eight items and five patients. Note that item 3 (Balanced Siting) of the MAS had the highest degree of consistency and that item 4 (Sitting to Standing) had the lowest. This low score was attributable to poor results with one patient. Some raters com-

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Appendix 1 Criteria for Scoring—continued

6. Walks up and down four steps with or without an aid but without holding on to the rail three times in 35 seconds.

6. Upper-Arm Function
1. Lying, protract shoulder girdle with arm in elevation. (Therapist places arm in position and supports it with elbow in extension.)
2. Lying, hold extended arm in elevation for 2 seconds. (Physical therapist should place arm in position and patient must maintain position with some external rotation. Elbow must be held within 20° of full extension.)
3. Flexion and extension of elbow to take palm to forehead with arm as in 2. (Therapist may assist supination of forearm.)
4. Sitting, hold extended arm in forward flexion at 90 degrees to body for 2 seconds. (Therapist should place arm in position and patient must maintain position with some external rotation and elbow extension. Do not allow excess shoulder elevation.)
5. Sitting, patient lifts arm to above position, holds it there for 10 seconds, and then lowers it. (Patient must maintain position with some external rotation. Do not allow pronation.)
6. Standing, hand against wall. Maintain arm position while turning body toward wall. (Have arm abducted to 90° with palm flat against the wall.)

7. Hand Movements
1. Sitting, extension of wrist. (Therapist should have patient sitting at a table with forearm resting on the table. Therapist places cylindrical object in palm of patient’s hand. Patient is asked to lift object off the table by extending the wrist. Do not allow elbow flexion.)
2. Sitting, radial deviation of wrist. (Therapist should place forearm in midpronation-supination, ie, resting on ulnar side, thumb in line with forearm and wrist in extension, fingers around a cylindrical object. Patient is asked to lift hand off table. Do not allow elbow flexion or pronation.)
3. Sitting, elbow into side, pronation and supination. (Elbow unsupported and at a right angle. Forearm should be kept in contact with the ball.)
4. Reach forward, pick up large ball of 14-cm (5-in) diameter with both hands and put it down. (Ball should be on table so far in front of patient that he has to extend arms fully to reach it. Shoulders must be protracted, elbows extended, wrist neutral or extended. Palms should be kept in contact with the ball.)
5. Pick up a polystyrene cup from table and put it on table across other side of body. (Do not allow alteration in shape of cup.)
6. Continuous opposition of thumb and each finger more than 14 times in 10 seconds. (Each finger in turn taps the thumb, starting with index finger. Do not allow thumb to slide from one finger to the other, or to go backwards.)

8. Advanced Hand Activities
1. Picking up the top of a pen and putting it down again. (Patient stretches arm forward, picks up pen top, releases it on table close to body.)
2. Picking up one jellybean from a cup and placing it in another cup. (Teacup contains eight jellybeans. Both cups must be at arms’ length. Left hand takes jellybean from cup on right and releases it in cup on left.)
3. Drawing horizontal lines to stop at a vertical line 10 times in 20 seconds. (At least five lines must touch and stop at the vertical line.)
4. Holding a pencil, making rapid consecutive dots on a sheet of paper. (Patient must do at least 2 dots a second for 5 seconds. Patient picks pencil up and positions it without assistance. Patient must hold pen as for writing. Patient must make a dot not a stroke.)
5. Taking a dessert spoon of liquid to the mouth. (Do not allow head to lower towards spoon. Do not allow liquid to spill.)
6. Holding a comb and combing hair at back of head.

9. General Tonus
1. Flaccid, limp, no resistance when body parts are handled.
2. Some response felt as body parts are moved.
4. Consistently normal response.
5. Hypertonic 50 percent of the time.
6. Hypertonic at all times.

Experience with the MAS, both during this study and subsequently, indicates that certain minor changes may make it a more useful measurement tool. For example, Point 5 in Balanced Sitting requires clarification of height of the stool in relation to knee-joint angle.

We have found the MAS to be useful for providing feedback to the patient on his progress, and it can be used to motivate him toward recovery. Two questionnaires are being designed to investigate whether progress measured by the MAS relates to the physical therapist’s and patient’s subjective impressions of progress.

CONCLUSION

We have developed this MAS for stroke patients and investigated it for reliability. This scale has been found to be highly reliable and its validity and usefulness in measuring the progress of patients in physical therapy should be investigated. Because the reliability of each individual rater is considered an essential factor in the use of this scale, we recommend that physical therapists intending to use the MAS should become familiar with the criteria for scoring by testing at least six patients before formally using it in clinical practice.

REFERENCES

APPENDIX 2
General Rules for Administering the MAS

1. The test should preferably be carried out in a quiet private room or curtained-off area.

2. The test should be carried out when patient is maximally alert. For example, not when he is under the influence of hypnotic or sedative drugs. Record should be made if patient is under the influence of one of these drugs.

3. Patient should be dressed in suitable street clothes with sleeves rolled up and without shoes and socks. Items 1 to 3 inclusive may be scored if necessary with patient in his night clothes.

4. Each item is recorded on a scale of 0 to 6.

5. All items are to be performed independently by the patient unless otherwise stated. "Standby help" means that the physical therapist stands by and may steady the patient but must not actively assist.

6. Items 1 to 8 are recorded according to the patient's responses to specific instructions. General Tonus, Item 9, is scored from continuous observations and handling throughout the assessment.

7. Patient should be scored on his best performance. Repeat three times unless other specific instructions are stated.

8. Because the scale is designed to score patient's best performance, the physical therapist should give general encouragement but should not give specific feedback on whether response is correct or incorrect. Sensitivity to the patient is necessary to enable him to produce his best performance.

9. Instructions should be repeated and demonstrations given to patient if necessary.

10. The order of administration of Items 1 to 9 can be varied according to convenience.

11. If patient becomes emotionally labile at any stage during scoring, the physical therapist should wait 15 seconds before attempting the following procedures:

   (1) ask the patient to close his mouth and take a deep breath;
   (2) hold patient’s jaw closed and ask the patient to stop crying.

   If patient is unable to control behavior, the examiner should cease testing him, and rescore this item and any other items unscored at a more suitable time.

12. If performance is scored differently on left and right side, the physical therapist may indicate this with a L in one box and R in another box.

13. The patient should be informed when he is being timed.

14. You will need the following equipment: a low wide plinth, a stopwatch, a polystyrene cup, eight jellybeans, two teacups, a rubber ball approximately 14-cm (5-in) diameter, a stool, a comb, a top of a pen, a table, a dessert spoon and water, a pen, a prepared sheet for drawing lines, and a cylindrical object such as a jar.