Fidelity Tool: Interventions to Improve Function in CP - Guidance Document

Background

This fidelity checklist has been developed to support clinicians and organisations to reflect on their current practice, and review how that practice aligns with the International Clinical Practice Guidelines for improving physical function for children and young people with cerebral palsy. These guidelines were developed for children aged 2 to 18 years who have a functional, child-centred goal.

This guidance document has been developed to be used in conjunction with the one page fidelity self-reflection tool. Clinicians can use the tool to reflect on their own practice, or supervisors, managers or organisations can use the tool to reflect on current practice or provide feedback to clinicians. Whilst this tool is designed to be used as a guide, we recognise that it is not always possible to achieve all elements of best practice, and even if a clinician follows all best practice guidelines, the outcome will vary depending on the children, families and teams that clinician is working with. This tool is designed to be used as a positive motivator for change, rather than a negative or critical reflection on current practice.

It is hoped this tool will facilitate reflection and discussion about areas of practice that can be improved upon to support clinicians to provide best practice aligning with clinical guideline recommendations. When using the fidelity measure, we encourage the user to reflect on current strengths, as well as those areas which could be improved upon. When there are areas of improvement identified, we encourage the user to identify actions that could be taken to more closely align with guideline recommendations. This may include (but is not limited to) upskilling through training, developing new resources or utilising existing resources or connecting with colleagues who are skilled in the area targeted for improvement.

Structure and Use

The fidelity measure has 21 elements, each of which is rated on a 0 to 3 scale (a higher rating reflects more effective demonstration of that element). A rating of 0 indicates that the clinician does not demonstrate that element; a rating of 1 indicates that the clinician shows low quality demonstration of that element; a rating of 2 indicates that the clinician shows moderate quality demonstration of that element; a rating of 3 indicates that the clinician shows high quality demonstration of that element. **Not all items will be applicable to the therapy session being observed, therefore items that are not relevant to that session can be rated N/A (and will not contribute to the overall rating)**.

We encourage users of this tool to seek out additional education when needed, and a number of educational videos have been developed to accompany this tool.

To align with the Clinical Practice Guidelines for improving function in cerebral palsy, clinicians should aim to display moderate or high quality demonstration of each element of the fidelity tool (a rating of 2 or 3). A rating of 0 or 1 indicates that the clinician's practice is not closely aligned with guidelines, and it is these areas that we encourage clinicians and organisations to reflect on and discuss actions that can be put in place to change or improve practice. It is recognised that in many real life situations there will be barriers to clinicians demonstrating all key elements. When items are not demonstrated, we encourage reflection on whether this is something that is within the clinicians control to change. We acknowledge that some items will not be possible to achieve.

The following pages provide detailed scoring descriptions for each of the 21 elements on the Fidelity Tool: Interventions to Improve Function in CP.

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GOALS	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
1. Goals are client chosen Time should be spent understanding what is important to the child, and setting functional goals that focus on improving the child's ability to participate in activities that are most important to them. Goal setting may be done through an interview or using goal-setting tools if available (e.g. Canadian Occupational Performance Measure). If the child is unable to identify or articulate their own goals, families should be encouraged to set goals considering the child's preferences and interests.	Goals are not set OR The therapist determines the goals for therapy, without consultation with the family	The therapist consults the parent and child about goals and a standardised tool or interview may be used, however the therapist defines and chooses some or all of the goals.	Therapist supports the child and family to set some of the therapy goals. Therapist spends time understanding client goals. This may include an interview about daily routines or a standardised tool such as the COPM is used to facilitate the goal setting process.	The therapist supports child and family to prioritise the most important therapy goals. If the child is unable to determine goals, therapist supports family to determine goals with consideration for the child's preferences. Therapist spends time understanding client goals. This may include an interview about daily routines or a standardised tool such as the COPM is used to facilitate the goal setting process. Therapist checks that goals that have been set reflect what is important to the child.
2. Goals are well defined and measurable Goals should be clearly defined, specific and detailed enough to ensure the child, family and clinicians are clear about the goals. Goals should be written in a way to ensure the goal can be measured, including a timeframe for review.	Goals are not set	Goals are vague or not specific. It is not possible to measure progress as goals are not specified in a way which allows for clear measurement.	Goals are written in a way that allows clear understanding, however may not be well defined and measurable, or include a clear timeframe.	Goals are written in a way that allows clear understanding by all parties. The therapist checks with child and family that they understand the goals and goals. The goals are well defined, measurable, realistic and include a timeframe and plan for goal measurement.
3. Goals are functional Functional goals should reflect real-life tasks and activities that are important to the child, such as the child being able to transfer out of bed, put their socks on, ride their bike to school or play a particular activity with their friends. Functional goals are not focussed on impairments, such as improving strength, endurance, sensory processing or joint range of movement.	Goals are not functional. Goals are related to underlying impairments rather than functional activities	Goals are primarily focussed on underlying impairments, but may include some goals that are related to functional activities important to the child/family	Goals are primarily focussed on functional activities that are important to the child, however may include one goal that is focussed on underlying impairments.	All goals are related to functional activities that are important to the child/family

GOALS	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3

4. Goals are achievable within timeframe Goals should be incremented according to the child's ability, and the resources available to support goal practice. It is important to acknowledge the goals and dreams of the child and family, but also important to ensure that children and families have enough understanding about their child's prognosis and current ability to set attainable short term goals for intervention.	Goals are not set	The goals are too challenging or unattainable – they do not match the child's ability	Some but not all of the goals are attainable within the intervention timeframe/plan	Goals are achievable and attainable within the intervention timeframe/plan
5. Goals agreed upon communicated to the family Goals should be documented and a copy of the goals should be given to families. Clinicians can discuss with the child and family what format the goals should be provided in to suit the family best, and where a copy of the goals will be stored to remind the child and family of the current goals.	Goals are not documented	Goals are documented but a copy of the goals is not provided to the family.	Goals are documented and a copy provided to the family.	Goals are documented and a copy provided to the family. Clinician discusses with the family the goal format that best suits them, as well as a plan for where a copy of the goals will be kept.
6. Goals are measured at the beginning and the end of the intervention The clinician should measure goal performance at the beginning and end of the intervention. A review of goal performance and progress should be carried out at each intervention session to ensure the clinician is aware of any progress or changes in goal priorities. Formal goal measurement tools, such as the COPM or GAS may be used to measure goal performance if available.	Goal performance is not measured at the beginning or the end of intervention.	Goal performance is measured at the beginning of the intervention but is not completed at the end of the intervention.	Goal performance is measured at the beginning and the end of intervention, however formal goal measurement tools may not be used.	Goal performance is measured at the beginning and end of the intervention using a valid and reliable goal measurement tool (e.g. COPM or GAS)

INTERVENTION	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3

7. Clinician observes the child attempting the goal to determine factors limiting achievement The clinician should fully understand the child's current ability to carry out the goal. This may include observation of the child attempting their goal to identify goal limiting factors, or discussion (if the goal is not able to be observed). Clinicians should consider both task and environmental factors that may be impacting goal achievement. This may include a discussion with the child and family regarding social and environmental supports and barriers to the child's participation in their chosen goal. Observation of the child attempting the goal should be done at each review or intervention session to enable the clinician to understand current goal limiting factors as the child's skills progress, and adapt intervention plans accordingly. Individual factors, such as weakness or poor endurance may be limiting goal achievement, and these should be considered within the context of the goal, rather than isolated as the primary focus of intervention.	The therapist begins intervention without observing the child attempting their goal, or gaining a full understanding of the child's current capacity in attempting the goal. Intervention does not target goal limiting factors.	Therapist may discuss performance of goal with child and family but does not observe child attempting the goal or have a full understanding of all the barriers to task performance prior to beginning intervention.	The therapist observes the child attempting their functional goals or gathers enough information to understand current goal performance. This information is used to identify task components or skills to be targeted in intervention. Therapist may consider but not have a full understanding of all the barriers to task performance prior to beginning intervention.	The therapist observes the child attempting their functional goals or gathers enough information to fully understand current goal performance, including consideration of environmental factors. This information is then used to determine aspects of the goal to be targeted within intervention, including addressing environmental and social barriers to goal achievement and participation.
8. Targets the child's chosen goals Intervention and home program should include direct practice of the child's goals. This may include direct practice of the whole goal, as well as discussion about improving goal performance and when and where home practice of the goal will occur. It is recognised that it is not always possible to spend a whole session practicing the child's goals, and that the child's motivation, behaviour and potential distractions within the setting may limit capacity to do so.	The child's goals are not the focus of intervention and home program.	Intervention and home program primarily involves activities or recommendations that do not include direct practice of the child's goals. This may include activities that address underlying impairments or practice of general skills, such as fine and gross motor skills. The client's goals may be practiced, but only for a minimal part of the session.	Intervention and home program primarily focusses on goals but involves some activities or recommendations that do not directly relate to the client's goals (for example, may be focussed on underlying impairments, such as fine and gross motor skills).	The client's goals are the focus of intervention and home program. Intervention is not focussed on underlying impairments or general skills.

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INTERVENTION	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
9. Involve whole task practice Therapy is most likely to lead to goal achievement when the focus of intervention is on whole task practice. When the aim of intervention is to achieve a functional goal, the focus should not be on underlying impairments, although consideration of underlying impairments may be included during goal practice. If practice of the whole goal is not possible, part task practice can be undertaken in order to work towards practice of the whole goal.	Intervention does not include whole task practice. Intervention and home practice focusses on underlying components or skills.	Intervention does not include whole task practice. Intervention may include some part-task practice.	Intervention includes a combination of part-task and whole task practice. If part task practice is undertaken it is done so with a plan to build up to whole task practice.	Intervention and home program focus on practice of the whole task/goal. Part task practice is only carried out if the whole goal is not possible. If part task practice is undertaken, it is done so with a clear plan for whole task practice being undertaken within the current intervention timeframe.
10. Challenging but achievable Intervention should be set at the 'just right challenge'. That is, intervention should be challenging enough that the child makes progress towards goal achievement but allows for small successes to maintain motivation and limit frustration.	Intervention involves activities that are not achievable or challenging	Intervention involves activities that are achievable but not challenging enough for the child to improve or achieve their goal	Intervention involves activities that are achievable and challenging for most of the intervention sessions and home practice	Intervention and home practice involves activities that are achievable and challenging throughout
11. Maximises learning through problem-solving and feedback Child-led problem-solving during goal practice can maximise learning and improve self-efficacy. A key to problem-solving can be the clinician 'asking', rather than 'telling' the client what to do. Therapists can prompt the child to evaluate their own success, and in this way encourage autonomy (rather than the client feeling they need feedback from the therapist). For children who have difficulty evaluating their own performance, providing feedback can be an important part of learning a new task or skill. Feedback can be provided both verbally and non-verbally.	Clinician does not provide opportunities for child-led problem-solving during intervention. Clinician does not provide feedback when appropriate.	Clinician may provide generic feedback and some problem-solving however it is not specific enough to support learning	Clinician includes child-led problem-solving in an effort to maximise learning for some of the intervention. Feedback is provided at times when appropriate.	Clinician includes child-led problem-solving in an effort to maximise learning throughout the intervention. The clinician encourages the child to reflect on their performance and provides feedback when appropriate.

INTERVENTION	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
12. Enjoyable and motivating for the child Opportunities for the child to gain a sense of achievement and have fun are provided throughout the session. If the child is crying or distressed, the clinician stops to comfort the child and changes the intervention to match the child's needs and preferences.	No opportunities for the child to gain a sense of achievement and have fun are provided. If the child is crying or distressed, the clinician does not stop to comfort the child and does not change the intervention to match the child's needs and preferences.	Few opportunities for the child to gain a sense of achievement and have fun are provided. If the child is crying, distressed or not engaged, the clinician may stop to comfort the child but does not sufficiently change the intervention to match the child's needs and preferences.	Opportunities for the child to gain a sense of achievement and have fun are provided for most of the session. If the child is crying or distressed, the clinician stops to comfort the child and makes some attempt to change the intervention to match of the child's needs and preferences.	Opportunities for the child to gain a sense of achievement and have fun are provided throughout the session. If the child is crying or distressed, the clinician stops to comfort the child and adapts the intervention to match the child's needs and preferences.
13. Delivered at a high enough dose to achieve functional outcomes The clinician considers the dose of intervention that is likely to lead to goal achievement when selecting interventions, and ensures this dose is realistic and achievable for the child and family. Whilst there may not be specific guidelines regarding dose available for all interventions, consideration of dose, and education to families regarding impact of dose of outcomes on goal achievement is important.	Dose of intervention is not considered when selecting interventions, or planned for during intervention and home program planning	Plan for dosage of intervention and home practice is less than required to achieve goals	Plan for dosage of intervention is considered when selecting intervention and planning however may be somewhat less than required to achieve relevant goals	Plan for dosage of intervention and home practice guides selection of intervention and appropriate dose is planned for during intervention and home program planning
14. Carried out in the home or community where possible Clinician makes an effort to ensure intervention and goal practice is carried out in real life settings that reflect where and when the child wishes to carry out their goal. When this is not possible, practice should occur within an environment that simulates real life as much as possible. Clinicians can plan with the child and family how and when practice can be undertaken during the family's daily routine.	Intervention is carried out in a setting that is unrelated or not specific to the child's goals. No attempt is made to adapt the environment or task to simulate real life practice of the goal.	Intervention is not carried out in a setting directly related to the real life setting of the goal and minimal attempts are made by the clinician to adapt the environment or task to reflect real life practice of the goal	Part of the intervention is carried out in real life setting directly related to the goal but may not always be possible due to resources. Where not possible, adaptations are made to the environment and task to ensure goal practice occurs in a setting that reflects real life as much as possible.	Intervention is carried out in the specific setting related to the child's goal

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INTERVENTION	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
15. A client-centred home program is developed An individualised, client-centred home program is developed in conjunction with the child and family, including realistic plans for when and where practice can occur. A copy of the program is given to the family.	A home program is not developed.	A generic or prescriptive home program is provided without consultation with the child and family	A client-centred home program is developed in conjunction with the family, however specific plans for when and where practice can occur may not be discussed or included in the home program.	A client-centred home program is developed in conjunction with the child and family, including realistic plans for when and where practice can occur. The home program focuses on practice of the child's goals. A copy of the program is offered to the child and family.
16. Parent/significant others are involved in intervention Clinicians should discuss the benefits of parent/family supported practice of goals and seek to ensure that families have the skills and knowledge to support home practice.	The clinician does not attempt to involve parents in delivery of the intervention.	Parents are informed by the clinician about how they could be involved in delivering the intervention but are not actively engaged or supported. The parent/s does not have sufficient support to deliver the intervention without the therapist present.	Parents are engaged and supported by the therapist in delivering the intervention, where appropriate. The parent/s has sufficient support to deliver the intervention without the therapist present but would have difficulty problem solving.	Parents are actively engaged and supported by the therapist to be involved in the delivery of the intervention, where appropriate. The parent/s has sufficient support to deliver the intervention without the therapist present including problem solving if issues arise.
17. Chosen interventions are supported by evidence Clinicians should use their knowledge of evidence-based interventions to ensure that interventions that are not appropriate for the child's age, ability or goals are not used. Selected intervention should align with the best practice evidence, as identified in clinical practice guideline recommendations 10 to 13, which outline specific interventions that can be used when the goal is related to mobility, hand use, self-care or participation in leisure activities. Clinicians should empower families to understand that interventions that are not appropriate for the child should not be attempted (given the time and effort required that is unlikely to lead to goal achievement).	The chosen intervention does not reflect current evidence relevant to the child's age, ability and chosen goals	The chosen intervention may have some evidence to support it, however there are alternative interventions that evidence suggests would be more appropriate for the child's age, ability and goals	The intervention is supported by evidence, however there may be other interventions that are also supported by evidence that the clinician has not considered or discussed with the family	The clinician has considered all evidence-based interventions appropriate for the child and the chosen goal. Evidence suggests the chosen intervention is the most appropriate for the child's age, ability and chosen goals, and the clinician has discussed the options with the family to ensure the chosen intervention is acceptable.

THROUGHOUT	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
18. Engage the child and family Building a strong relationship with children and families is a key to success of an intervention. Clinicians should take time to get to know individual children and families and build a trusting relationship. This may include understanding what the child and family enjoy doing, and understanding the time, supports and resources available to the family.	Clinician begins intervention without taking the time to get to know the individual child and family, or asking what is realistic for the child and family. Clinician makes intervention plans that are unrealistic for the child and family.	Clinician may take the time to understand the child and family but does not adapt intervention sessions or plan home program to suit individual circumstances.	Therapist takes the time to understand the child and family. Therapist adapts intervention plans according to child and family preferences, but that plan may not be realistic for the family to implement fully.	Throughout the process, the therapist takes time to get to know the child and family. Time is taken during each session to understand current priorities and adapt plans to ensure they suit the child and family at that point in time. Intervention plans are set according to individual family needs and preferences and are realistic for the family to implement.
19. Communicate effectively with the child and family The clinician builds rapport and maintains effective communication with the child and family throughout intervention. The clinician responds to the changing needs of the child and family from one session to the next, including adapting sessions and offering support tailored to individual family needs (for example, phone, email or telehealth support between sessions).	The clinician does not communicate effectively with the child and family or adapt intervention sessions in response to the changing needs of the child and family.	The clinician communicates effectively, however may not respond to the changing needs of the child and family. The clinician does not offer support/communication options suitable for the family between sessions.	The clinician communicates effectively with the child and family throughout intervention sessions but does not offer support/communication options most suitable for the family between intervention sessions.	The clinician communicates effectively with the child and family throughout the session. The clinician responds to the child and adapts session plans. The clinician offers communication and support options that are most suitable for the family both during and between intervention sessions (eg. phone, email or telehealth support)
20. Communicate effectively with the broader therapy team The clinician maintains effective communication with the broader team throughout. This includes ensuring team members work towards goals that the client has prioritised, and intervention plans are shared to decrease the burden on families. At times, this may mean some disciplines are more or less involved in interventions, depending on the current goals of the child. The broader team may include health professionals, extended family members, support workers, education professionals and others who play an important part in the child's life.	Therapist does not communicate goals and intervention plans with the broader therapy team.	Therapist attempts to communicate goals and plans with the broader team but does not adapt the intervention to ensure current overall priorities are the focus.	Therapist communicates goals and plans with the broader therapy team, although intervention plans may only be adapted slightly to accommodate overall priorities.	Therapist effectively communicates goals with all team members and intervention planning is adapted to ensure current goals are the priority and the intervention plan is realistic for the child and family.

THROUGHOUT	No demonstration/0	Low Quality Demonstration/1	Moderate Quality Demonstration/2	High quality demonstration/3
21. Share knowledge and empower family decision making Clinicians should share their own knowledge and expertise, including their knowledge of current evidence regarding interventions. Clinicians should then encourage families to use this information to make their own decisions about intervention options they feel are most appropriate for their child and family at that point in time. Clinicians should work towards empowering families to make decisions without relying on professionals, and therapists should respect child and family decision making in a non-judgemental manner.	Therapist makes decisions about the most appropriate interventions for the child without sharing their knowledge or providing evidence regarding intervention options. Therapist does not encourage the family to make their own decisions. May provide information on intervention options/make recommendations even when not the current goal/priority.	Therapist shares knowledge and evidence but remains the decision making regarding intervention. Therapist may provide recommendations not related to current priorities (this can lead to families feeling guilty about not doing everything possible to support their child)	Therapist shares knowledge and aims to empower families, although child and family still rely upon therapist to make decisions, rather than feeling empowered to make own decisions.	Therapist acknowledges family expertise and empowers families to make their own decision. Therapist shares their knowledge about intervention options and evidence relevant to the individual child and respects the family's right to make their own decision without judgement.

Example of completed Fidelity Reflection Tool

Fidelity Tool: Improving Function in Cerebral Palsy

Name of clinician: Sarah (review of video-taped session with TL)

Date: 26/04/23

Name of person completing checklist: Katherine

	Key element of functional intervention	NO	LOW	MOD	HIGH	N/A	Comments/Variations
GOALS	1. Goals are client chosen	☐	☐	☐	☐	☒	No goal setting observed in the session that was taped and reviewed together
	2. Goals are well defined and measurable	☐	☐	☐	☐	☒	
	3. Goals are functional	☐	☐	☐	☐	☒	
	4. Goals are achievable	☐	☐	☐	☐	☒	
	5. Goals are communicated to the family	☐	☐	☒	☐	☐	
	6. Goals measured at beginning and end of intervention	☐	☐	☐	☐	☒	One videotaped intervention session rated-unable to determine if goals measured
	7. Goal performance observed to determine goal limiting factors	☐	☐	☒	☐	☐	Asks generally about goals, but get more in-depth understanding of where up to through observation and discussion
INTERVENTION	8. Targets the client's chosen goals	☐	☐	☒	☐	☐	
	9. Involves whole task practice	☐	☒	☐	☐	☐	Some component skills targeted at general bimanual use
	10. Challenging but achievable	☐	☐	☐	☒	☐	
	11. Maximises learning via problem-solving/feedback	☐	☒	☐	☐	☐	May be targeted appropriately for age
	12. Enjoyable and motivating for the child	☐	☐	☐	☒	☐	
	13. Considers dose of practice	☐	☐	☐	☐	☒	Does consider practice at home
	14. Carried out in relevant context (eg.home or community)	☐	☒	☐	☐	☐	Not possible - Discusses practice home/school.
	15. A client-centred home program is provided	☐	☐	☒	☐	☐	Discusses School practice
	16. Parents/significant others are involved in intervention	☐	☐	☐	☒	☐	Discusses home ideas with mum
THROUGHOUT	17. Chosen intervention supported by current evidence *Intervention name:* Bimanual therapy	☐	☐	☐	☒	☐	
	18. Engages the child and family	☐	☐	☐	☒	☐	
	19. Communicates effectively with the child and family	☐	☐	☐	☒	☐	
	20. Communicates effectively with the broader team	☐	☐	☐	☐	☒	Not observed during this session
	21. Shares knowledge/empowers family decision making	☐	☐	☐	☒	☐	

Below can be used to discuss skills, identify areas for improvement and make an action plan for change

Strengths: Great rapport with family. Focus on enjoyment. Shares knowledge beautifully and understands capacity of family and where the child is at through discussion and observation.

Areas for improvement: Consider opportunities for child problem solving – try to use less prompts/allow for trial and error/allow time for child to self-reflect. Focus on whole practice of task BEFORE breaking down.

Plans for change: Problem solving -count to 10 in head before jumping in to prompt
Begin sessions with whole task practice of goals if possible, revert to component movements or skills only if needed.
Discuss with family importance of practice of the actual goal, rather than more general active use.

Date/Plan for review: Video next session with this same client in 2 weeks and reflect using fidelity tool

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Using the fidelity tool to audit or measure change

There may be some situations, in clinical practice or research, in which clinicians or organisations may seek to measure change in practice. In this instance, the fidelity self-reflection tool can be used to collect pre and post data regarding change in practice. To do so, demonstration of each element is assigned a numerical value:
0 = No demonstration
1 = Low quality demonstration
2 = Moderate quality demonstration
3 = High quality demonstration
N/A = the item is not possible to reflect on (for example if the fidelity tool is being used to reflect on a videotaped session of only one intervention session, the goal setting process may not have been possible to observe and rate).

An overall percentage score of over 65% indicates that the clinician is demonstrating moderate to high quality in all elements. It is suggested that clinicians and organisations should aim for over 65% fidelity if they aim to align with best practice guidelines to improve function for children and young people with cerebral palsy.

Once the fidelity measure has been completed, in order to get an overall % fidelity score:

1. Count the number of items that have been scored (remove N/A items) and multiply this by 3 to get the TOTAL ITEM SCORE (i.e.. If all 21 items were scored, the total would be 63).
2. Combine the rated scores for each item demonstration, to come up with a TOTAL RATED SCORE
3. Divide TOTAL RATED SCORE by the TOTAL ITEM SCORE, then multiply this by 100 to get an overall percentage score

Using the example completed fidelity tool on the previous page, the % score would be:

1. Total number of items scored = 13. 13 x 3 = 39, TOTAL ITEM SCORE = 39
2. Total rated score = 29. TOTAL RATED SCORE = 29
3. TOTAL RATED SCORE (29) ÷ TOTAL ITEM SCORE (39) = 0.74 x 100 = 74%

It is important to note that inter and intra-rater reliability has not been established for this tool, therefore should be used with caution in research.