❖ Sit to Stand with Moderate Assistance

This is **one way** to bring a patient from sit to stand with moderate assistance. *The following guidelines may need to be modified if your patient has already developed tightness or contractures or if medical conditions interfere.*

Starting Position

The patient is seated in a chair or wheelchair with feet flat on the floor. To determine where to position the feet and the amount of assistance that will be needed in coming forward and into standing, observe the following:

- Is the patient tall or short?
- Is the patient large (will he or she have problems bending forward)?
- On what surface is the patient sitting? Is it higher or lower than normal? (The height of a normal chair is approximately 16” or 40 cm from the floor.)
- Does the patient have any conditions (hip replacement, back injury, hip fracture, Achilles shortening) which may make leaning forward difficult?
- Does the patient appear to have any active trunk control?
- How alert is the patient?
- Does the patient wear any lower extremity orthopedic devices? For example, an AFO fixed at 90˚ of ankle flexion would limit ankle dorsiflexion and not allow proper foot placement.

Handling

1. Stand on the weak side, next to the patient.
2. Position the patient’s feet flat on the floor, parallel and about shoulder width apart.
3. Scoot the patient forward in the chair, if necessary, in order for their feet to reach the floor or to clear the distal 1/3 of the femur.
4. Position the feet behind the knees, remembering that the taller the patient, the further back the feet need to be positioned. Tip: As you bring the patient forward, watch the strong leg. The patient often brings it back to the correct position—then you can bring the weak leg back to the same position.
5. Ask the patient to place their hands either on their thigh or, for patients with neglect, ask them to clasp their hands together. (This helps patients remember their arm, keeps them more symmetrical, and from grabbing onto everything in sight.)

6. Position yourself so that your shoulder is behind their weak shoulder. This will help cue them forward and keep them from pushing back into extension.
7. Place your hand around the patient, reaching to their strong hip. This will cue them to come forward, and you’ll also be able to tell when the patient leaves the chair without needing to look back.
8. Place your other hand firmly on the distal portion of the patient’s femur (just proximal to their knee) and bring it down and forward, helping them to put weight onto the weak foot. *This helps to give knee stability and cues the patient to come forward—it is not to block the knee or push it into extension.*

9. Using three points of control, cue the patient (from the shoulder, the knee, and under the opposite hip) to come forward and stand up. You can add simple verbal cues such as “hands together, come forward, and stand up”. Avoid saying “stand up on the count of three”. If the patient is leaning back in the chair on “three” instead of leaning forward, normal movement is not facilitated.
10. As the patient’s hips clear the chair, **don’t give any more forward information.** Allow the patient to come into standing with knee, hip, and trunk extension.
11. As your patient stands, slide your hand along the femur to the pelvis. Stand on their weak side with your hip behind theirs and your hands on their hips.

Tips

- Instead of pushing off or pulling up with a grab bar, the patient must relearn to come forward in order to stand up. And thus becomes more independent with self-care skills. However, if they need equipment at home (such as a grab bar) in order to be safe, make sure that they have it.
- **If your patient is fearful of coming forward**, first prepare the patient by having them reach forward or down toward their shoes.
- Always avoid pulling the patient up with the weak arm. This can cause trauma to the shoulder and teaches compensatory movement instead of normal movement.

Common Mistakes

- The feet are not in the correct position (not far enough behind the knees). This will make it much more difficult for the patient to stand up.
- The therapist does not give enough forward cues from the shoulder, hip, and knee to help the patient shift their base of support from the hips to the feet. If you see the patient’s toes lift up off of the floor, their weight is too far back.
- The therapist continues to give forward cues after the hips have cleared the chair. The patient will feel as though he is falling forward.
- The cue from the therapist is not symmetrical and the patient is pushed away from their weak side onto their strong side.

⌘19 Pause and Practice with a Partner

Variation: Sit to Stand in the Kitchen or Bathroom

Because we have observed the normal movement components necessary to get from sitting to standing, we know that it is necessary to come forward (the taller the patient, the further forward they will need to lean) in order to stand. When a patient needing moderate assistance wants to come from sit to stand at the kitchen counter, bathroom sink, or any other stable surface, the following modifications will be helpful.

- Position the wheelchair (or chair) one or two steps back from the sink, allowing enough room for the patient to comfortably lean forward. If the space is too cramped, the patient will have difficulty standing. Follow the same instructions as mentioned for moderate assist sit to stand. Once the patient comes to standing, they will need to take a step or two to get up to the sink or counter.
- Another option is to position the wheelchair (or chair) in front of the sink and have the patient come forward, bringing the hands and/or arms into the sink or onto the counter. Follow the same instructions as mentioned for moderate assist sit to stand.

Variation: Sit to Stand Using a Cane

Patients often “push themselves up” with a cane and over to the weak side. **This can be dangerous.** The same technique that has been mentioned above (moderate assist sit to stand) can be modified for a patient using a cane during ambulation.

1. Follow the directions in moderate assist sit to stand.
2. Instead of placing the hands on the thighs or clasping the hands together, place the cane between both clasped hands. Come forward sliding the outstretched cane directly in front of the patient.
3. Once the patient is in a standing posture, the cane can return to the strong hand. This eliminates the need to reach back to find the cane along the side of the wheelchair.