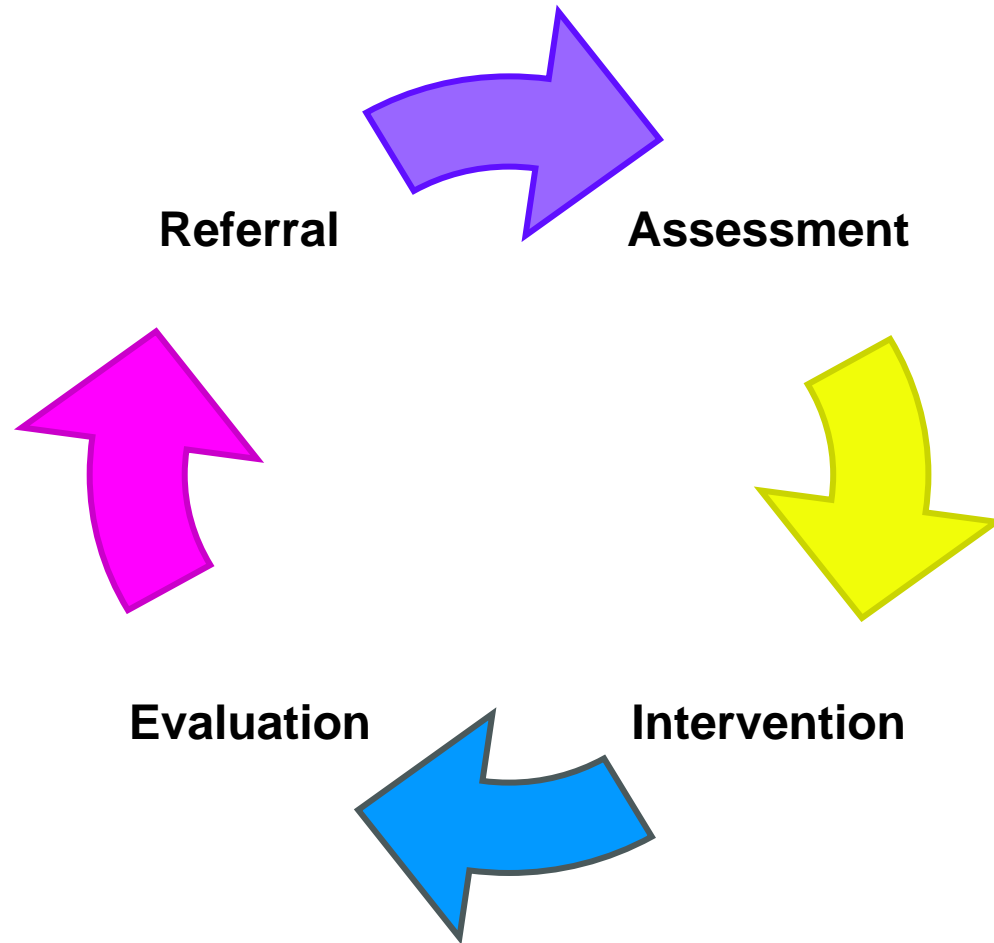
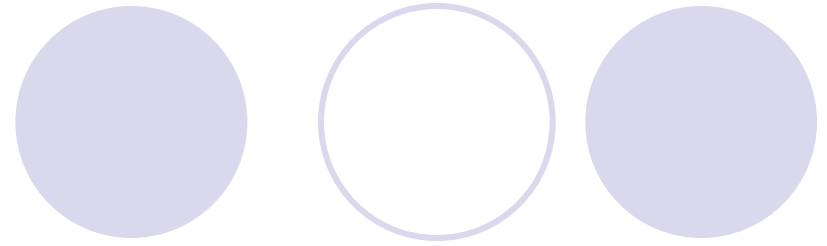


Seating Services Processes



Documentation:



- Forms for Referral, Assessment, Evaluation, and Billing
- Developed by the Alberta Seating Council to support a standardized process for all clinics in Alberta
- Beneficial to use with every client, no matter what their funding is e.g. AADL, WCB, NIHB
- Document thoroughly at each step in the seating process
 - omissions can come back to haunt you!

Clinic processes:

PROCESSES

- Referral

- Assessment

- Intervention

- Evaluation

SUPPORTED BY:

- Referral Form (Form A)

- Assessment Form (Form C)
- Assessment Summary (Form D)
- (There isn't a Form B!)

- Assessment Summary (Form D)
- chart notes, as needed

- chart notes
- and *a bunch of forms* to be discussed! (Forms F, G, H, and I)

Referral Process: Referral Form (Form A)

- Completed by client, caregiver, community therapist, doctor, or another stakeholder.
- Screened by Seating Clinic, usually a 'Coordinator', who:
 - determines appropriateness for Seating Clinic
 - checks for missing information
 - decides type of intervention needed
 - decides if client is a 'priority'

Purpose of the Referral Form:

- Prepares team for the assessment
- Provides baseline data
 - starting point for discussion with client at the Assessment
- 'Live' document during the Assessment
 - add pertinent info to the Referral Form
 - no need to rewrite info that is already stated on the Referral Form

SEATING CLINIC REFERRAL

A

SEATING CLINIC ID 146231

DATE Feb 14	NAME BOB Betty <small>LAST FIRST</small>	M/F F	BIRTHDAY (DD/MM/YY) 07 July 1950	PERSONAL HEALTH NUMBER 68422-4001
ADDRESS 5400 – 54 Avenue		CITY/TOWN Edmonton	POSTAL CODE T4V 0P6	PHONE NUMBER AREA CODE 672-2488 780
Contact Person (to arrange appointment): Name: client Phone: Relationship:			Additional Contacts (e.g., therapists, family) Name(s): Phone: Relationship:	
Evaluation For (check all that apply)		Seating System	Manual Chair	Power Chair
New		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Growth/Modifications		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
INDICATE CLIENT'S PREFERRED CHOICE OF WHEELCHAIR/SEATING VENDOR:				
MEDICAL STATUS		Latex Allergy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Presenting Condition (including date of onset) Multiple Sclerosis		Medications Prozac, Lioresal		
Secondary Diagnosis N/A		Future considerations (planned surgeries, palliative, prognosis) N/A		
FUNDING – All of this section must be completed				
Trustee / Person Financially Responsible: _____			<input type="checkbox"/> Private Funding	
Phone: (____) _____ Address: _____			<input type="checkbox"/> Cost Share with AADL	
<u>IDENTIFY</u> which agency will fund seating/mobility and specify reference number:				
<input checked="" type="checkbox"/> AADL Benefits <input type="checkbox"/> AISH <input type="checkbox"/> SFI <input type="checkbox"/> WCB <input type="checkbox"/> Veteran's Affairs <input type="checkbox"/> MVAC <input type="checkbox"/> Treaty Band and # _____				
Other: _____ Reference # <u>68422-4001</u> Expiry Date: <u>June 30</u>				

SEATING CONCERNS

Please identify specific seating needs that you would like the clinic to address:

1. Leans to the right.

2. Butt uncomfortable.

3. Footrest in poor repair.

These goals are identified by
(check all that apply):

Client

Caregiver

Health Care Professional

** Attach List of Concerns if Needed

POSITIONING

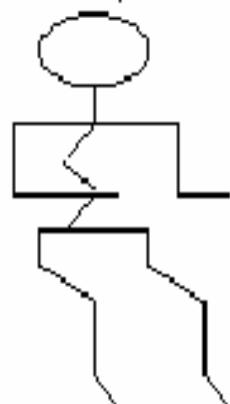
Time spent in wheelchair without a rest 5 hrs Number of times/day 2x

Independent weight shifts Yes No

Number of times repositioning is required continually

Hip width 16 Thigh Length 18

Please describe present seating posture in current seating system/wheelchair:



Hips not level, legs together
and drifts to right, leans right

Attach a photo, if possible, to show seating position

Client Weight 140 lbs / kg

Is positioning affecting the following functions:

YES

Skin Health

Bladder

Bowel Function

Swallowing

Pulmonary

Comfort

YES

Digestion

Hand Function

Head Control

Visual Field

Mobility

Comments:

Wheelchair/Base <input checked="" type="checkbox"/> Manual Brand <u>QLxi</u>	<input type="checkbox"/> Power <input type="checkbox"/> Other	If a new wheel chair/base is required the specs of the wheelchair frame trialled is attached: <input type="checkbox"/>
Width <u>16</u>		
Depth <u>16</u>		
Serial #		
Condition		
Owner <u>AADL</u> Date Received <u>2001</u>		

Person completing this form Susan See, OT

Designation/Agency Home Care Fax: 672-1000

Phone _____

Address _____

Referring Physician J. Jones
(sign and print name)
Address _____

CLINIC USE ONLY

Date Received:

Feb 18

Action:



Assessment Process: Assessment Form (Form C)

- Each Seating Clinic uses the same form for every client
- Following the standardized form leads to a thorough, standardized assessment

Purpose of the Assessment Form:

- Provides an outline of what to assess and what information to seek
- It is the form on which the assessment findings are described & documented
- Documented information provides a basis for developing outcomes
 - the concerns and assessment findings should indicate what the client's desired outcomes of the seating intervention may be

TEAM MEMBERS		Client	Betty BOB
Caregiver:	Jim (husband)	Hospital I.D.	146231
Referring Therapist:	Susan See, OT	Health Number	68422-4001
Occupational Therapist:	Lee		
Physical Therapist:	Chris		
Seating Technician:	Kelly		
Physiatrist:			

SITTING POSTURE

Posture in Chair		If Applicable	Posture on Mat/Table		Comments
			Fixed	Flexible	
Posterior pelvic tilt		X	X	X	- trunk lean to R
Anterior pelvic tilt			Somew	flexible	
Pelvic Obliquity	Right high				
	Left high	X		X	
Pelvic rotation anterior to	Right				
	Left	X		X	
Kyphosis					
Lordosis					
Scoliosis	Convexo: Right				
	Left				
Head/Neck	Flexion				
	Rotation				
	Extension				
Leg	Abduction				
	Adduction	X		Somewhat	- strong tone , knees touching
Windswept	Right	to R			
	Left				
Leg Length Discrepancy	Right				
	Left				
Other					

SITTING BALANCE

Independent 1 hand dependent Dependent

TONAL INFLUENCES

increased in adductors, hams, hip extensors

Circle description and check

SUPINE Deformities	Fixed	Flexible
Pelvic Tilt		
Posterior	<input type="checkbox"/>	<input type="checkbox"/>
Anterior	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Obliquity		
Right Higher	<input type="checkbox"/>	<input type="checkbox"/>
Left Higher	<input type="checkbox"/>	<input type="checkbox"/>
Pelvic Rotation		
Anterior	<input type="checkbox"/>	<input type="checkbox"/>
Right	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>
Kyphosis	<input type="checkbox"/>	<input type="checkbox"/>
Lordosis	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis Convex		
Right	<input type="checkbox"/>	<input type="checkbox"/>
Left	<input type="checkbox"/>	<input type="checkbox"/>

Range of Motion

	Left	Right
Passive		
Hip Flexion (0-125)	<u>90°</u>	<u>90°</u>
Abduction	<u>5°</u>	<u>0°</u> with effort
Adduction	<u> </u>	<u> </u>
Internal Rotation	<u>10°</u>	<u>0°</u>
External Rotation	<u>35°</u>	<u>25°</u>
Knee (hip at 90)		
Flexion	<u> </u>	<u> </u>
Extension	<u>-90°</u>	<u>-80°</u>
Ankle	<u>0°</u>	<u>5°</u>
Active		
Upper Extremity		

<u>SKIN CONDITION</u>		Open	Healed	At Risk	IMPAIRED SENSATION
Ischial Tuberosities	<u>good</u> Bilateral ___ RT ___ LT	___	___	___	___ Yes
Coccyx		___	___	___	Location _____
Spine	Level _____	___	___	___	
Malleoli	<u>no hx of breakdown</u>	___	___	___	___ No
Tracheotomy		___	___	___	
G.I. Tube		___	___	___	___ Unable to Assess
Other		___	___	___	

CURRENT SEATING AND WHEELCHAIR/MOBILITY BASE

(Additional to information on referral)

Condition of Chair and System

- ++ repair hx, footrest holes no longer round, R armrest broken
- STF too high for dining table (hitting knees)

Size

- ½" space either side of hips
- butt forward 3", 8" unsupported thighs
- back lat. Contours very low on trunk; top edge is 3" below shoulder height

Function

- solid base above seat rails by 1"

Other

- when butt forward, IT's are not in gel, hitting top/front edge of Jay dish

OTHER CONSIDERATIONS

Orthoses

Transferability between chairs?

Environmental Considerations

- one person transfer – would be ok if she sat a few inches lower

Method of Transportation

van, tie downs

Other

ADDITIONAL SEATING NEEDS

- footrests wobbly & slanted down/inward. Heels catch on front edge of plates when butt forward.
- not keen on laterals as may limit her propelling, reaching objects, ADL's.
- butt sore & uncomfortable after 2 hours of sitting.

SIGNATURES

CLINIC O.T.:

Lee Jones

CLINIC P.T.:

Chris Davis

OTHER CLINIC STAFF:

Steps in the Assessment Process:

- Interview with client and caregivers
 - Discuss their seating concerns
 - Concerns from the Referral Form and concerns not on the Referral Form
- Examine condition and fit of client's seating components and chairs
- Documentation, of the above, usually is on the 2nd page of the Assessment Form

Next steps in the Assessment Process

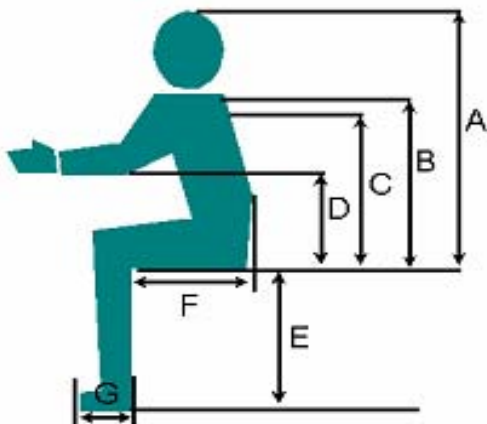
- Examine the client's posture in the wheelchair
- Examine posture on the mat
 - balance, tone, and lower extremity ROM.
- These areas are documented on the 1st page of the Assessment Form.
- Measurements of the client and their chair may be taken

BODY MEASUREMENTS

Client Name Betty BOB

Date Mar 10

Hospital ID 146231



A _____

B 20"

C _____ (Inferior angle of scapula)

D 9"

E 18"

F 20"

G _____

QLxi

STF – 20"

8" castors

composite plates

non-vinyl rims

16 x 16

solids x 4

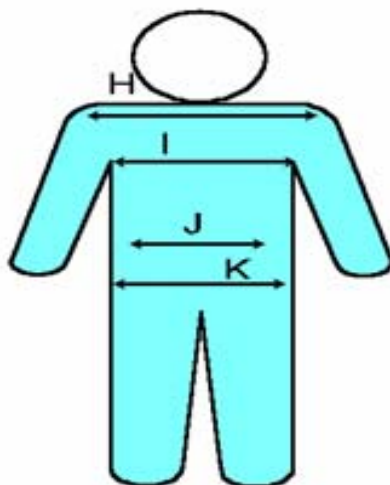
backcanes = 19"

anti-tips

seatbelt

STF to Jay base = 21"

to top of cushion = 23½"



H 15"

I 13"

J _____

K 15"

New w/c

want:

16 x 18

lower STF

Assessment Process : Assessment Summary (Form D)

- Completed at the end of the Assessment
- Copies of the Summary are given to the stakeholders
 - e.g. client, caregiver, technician, funding agency, referring therapist
- The seating team contact person should be clearly indicated

Purpose of the Assessment Summary:

- Contains a brief summary of the pertinent assessment findings
 - two to four sentences.
- Summary provides the funding agency with rationale of why new components are needed
- Documents client's expected outcomes
- Describes the seating intervention plan
 - Intervention = Provide service
 - Provide...equipment, education, recommendations

SEATING ASSESSMENT SUMMARY

Clinic Date	Mar 10
Client Name	Betty BOB
PHN	68422-4001
Authorization #	

Client's Expected Seating Outcomes:

Betty has very tight hamstrings, strong tone and various contractures. As a result, she slides out of her chair and is poorly supported.

1. Betty will be comfortable in the wheelchair for up to 5 hours. Currently, her butt is sore after 2 hours of sitting.

2. Betty will sit up straight in her wheelchair. Currently, her butt slides forward within one hour of sitting.



Intervention Process

Before deciding on equipment the team should:

1. Discuss with the client:
 - assessment findings
 - the rationale for the equipment options
2. Consider showing and demonstrating the components' features, pros/cons
3. Seek input from the client/caregiver about the options discussed

Intervention Process Assessment Summary (Form D)

- Summary indicates what intervention that:
 - Occurred during the assessment session
 - Is planned in the near future
- Contains names of team members at the session, and contact phone number.

Intervention Process: Assessment Summary (Form D)

- **Specifies the Action Plan** (a.k.a Intervention plan)
 - Who is doing what in the plan
 - Equipment the client will try
 - Educational tips
 - e.g. Betty should wear her footstraps when she is being transported to avoid feet getting caught in doorways
 - Recommendations
 - e.g. Strongly advise Betty to see her doctor about spasticity medications

Seating Plan:

1. Betty will try a 16x18 9000 XT manual w/c; standard height, 6" casters. Seating Therapist, Lee Jones, to organize with Home Care OT, Susan. For trial, use her Jay cushion. Try chair at tables, etc. and in all rooms.

2. Home Care OT, Susan, to report feedback on wheelchair trial to Lee Jones. Lee will then order the chair.

3. Once new w/c has arrived, Seating will provide custom contoured back, flat base with dishing and channeling, hip guides, K-belt, and one-piece custom foot plate between casters.

Signatures:

*

Client

**Lee Jones*

Clinic OT

*

Caregiver

**Chris Davis*

Clinic PT

*

Attending Health Professional

**Kelly*

Seating Technician

Intervention Process Assessment Summary (Form D)

- Indicates status of the old equipment
 - i.e. recycle to another client, scrap, reuse with same client.

AADL wants information about:

- why the client no longer needs their components
- whether those components can be recycled to another person

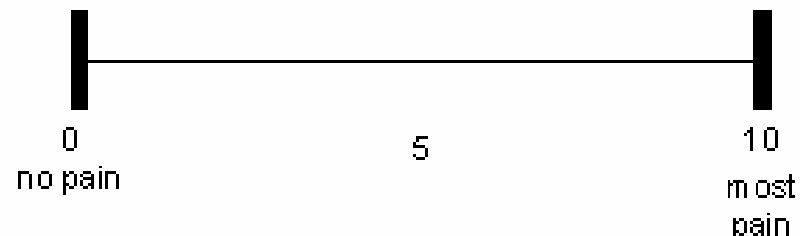
Only complete this page if seating components are being replaced

Rationale for Replacement:

Wheelchair Size Change from <u>16x16</u> to <u>16x18</u> Cross-referenced to Authorization Form # <u>AB4236</u>
<u>Growth</u> - not requiring wheelchair change Increased dimensions of seating system _____ width _____ depth
<u>Change in Condition:</u> (circle applicable): Skin condition, Contractures, Postural changes, <u>Seating components very old and worn out.</u> Stability issues, Mobility issues
<u>Scrapped</u> - Date of provision of component to be scrapped: <u>Back, cushion = 2001</u>
<u>Other:</u>

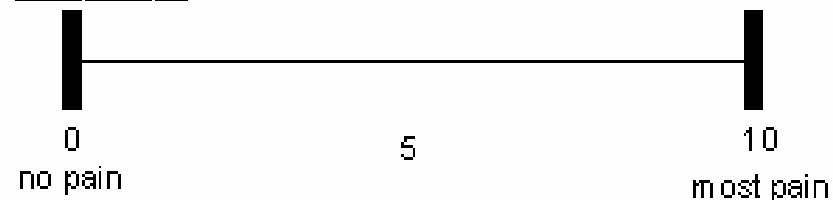
Comfort /Pain

Draw a line on scale below to indicate discomfort/pain after sitting on **current cushion/seating system** for _____ hours:



Draw a line on scale below to indicate discomfort/pain anticipated after sitting on **new cushion/base** for _____ hours

Draw a line on scale below to indicate discomfort/pain anticipated after sitting on a **new custom made base** for _____ hours



Status of Previously Owned Seating Equipment:

Components being replaced:

back	<input type="checkbox"/> Recycle	<input checked="" type="checkbox"/> Scrap
solid base	<input checked="" type="checkbox"/> Recycle	<input type="checkbox"/> Scrap
cushion	<input type="checkbox"/> Recycle	<input checked="" type="checkbox"/> Scrap
	<input type="checkbox"/> Recycle	<input type="checkbox"/> Scrap
	<input type="checkbox"/> Recycle	<input type="checkbox"/> Scrap
	<input type="checkbox"/> Recycle	<input type="checkbox"/> Scrap

Intervention Process



- Intervention should be focused on achieving the client's chosen outcomes
- Beneficial to document information about unsuccessful trials, usually in client's progress notes in seating chart
 - What worked, what didn't, and why.
- Good idea to summarize the entire seating intervention at the end of the process in a report.

Evaluation Process

- When does Evaluation occur?

- upon fitting of the equipment
- after one/two week trial, before equipment is billed

Chart in
Progress Notes

- 3 months after the intervention is complete

Forms F, G, H, I

Evaluation Process



- What is Evaluated?
 - Evaluate how the seating components fit the client
 - Evaluate how the client functions with the equipment,
 - e.g. eating, propelling
 - Evaluate the achievement of the client's expected outcomes

**Seating Outcomes Evaluation Form
(Three Month Follow-up)**

Betty BOB
146231

G

Personal Health Number 68422-4001 Date Seating Completed May 4 Evaluation Date Aug 17

These are the expected outcomes that were set by you and the Seating Team at your assessment. We would like you (the person using the seating system) to let us know how closely these outcomes were achieved.

	Exceeded	Met	Partially Met	Unmet
Outcome 1 <u>Betty will be comfortable in the wheelchair for up to 5 hours. Currently, her butt is sore after 2 hours of sitting.</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outcome 2 <u>Betty will sit up straight in her wheelchair. Currently, her butt slides forward within one hour of sitting.</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outcome 3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outcome 4 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has there been a change in your medical condition in the past three months? If yes, please describe: No

SEATING CLINIC USE ONLY

Followup plan for outcomes which were not met:

Responsible:

Signatures

* note if signature not available or applicable at time of evaluation

CLIENT* _____ CLINIC STAFF: Lee Jones, OT

CA REGIVER* _____

ATTENDING HEALTH PROFESSIONAL* _____

Seating Service How Do You Like Your New Seating System? Client Satisfaction Questionnaire

I

You have had your new seating system for approximately three months. This questionnaire will help the Seating Team to evaluate how well the seating system is working for you.

Please mark with a (✓) "how" or "if" you feel your new seating system has changed any of the following?	No change or Not applicable	Better	Worse	Set as Goal during the Seating Assessment
1. ease of <u>you</u> moving your wheelchair	✓			
2. ease of breathing	✓			
3. swelling	✓			
4. degree of agitation/restlessness		✓		
5. redness/skin breakdown		✓		
6. able to eat by yourself	✓			
7. ease of swallowing	✓			
8. frequency of choking	✓			
9. digestion	✓			
10. communication	✓			
11. range of motion in joints	✓			
12. number of falls	✓			
13. medication changes	✓			
14. able to do personal care, i.e. dressing, hygiene	✓			
15. able to live in the community setting of choice, e.g. nursing home, group	✓			

All of the following questions refer to the person who is in the wheelchair/seating system.

This form was completed by: (check the following that best describes)

- the person who uses the wheelchair/seat
- the person who uses the wheelchair/seat dictating to someone who completed the form
- the person who uses the wheelchair/seat in discussion with a caregiver
- the person who uses the wheelchair/seat with equal input with the caregiver
- the caregiver:
 - Parent Key Worker
 - Spouse Physical or Occupational Therapist
 - Nurse (RN or LPN) Personal Care Attendant
 - Other (Specify) _____

Comments _____

Personal Health Number 63422-4001

Date _____

Thank you for answering these questions.

Evaluation Process

- Seek feedback from the key caregiver on the attainment of the client's expected outcomes
 - Send the following to the to the key caregiver:
 1. **Form H** - Caregiver Satisfaction
 2. Seating Goals Questionnaire
 3. **Form G**
 4. **Form I**

Evaluation Process

- We also want to evaluate service provision
 - Client's satisfaction with the Seating Team's quality and timeliness of service once the intervention is completed.
 - Ask clients to complete and return Form F - How Did We Do On Service Delivery?
- Review the responses and make changes to improve your service



Evaluation Process

- We also want to evaluate the products we use
 - Evaluate during the fitting and evaluation stages.
 - Each client may have different needs for durability, ease of use, ease of cleaning and maintaining
 - Feedback from a client will
 - give the seating team information about the appropriateness of the equipment for that client's needs.
 - adds to our store of knowledge about the pros and cons of the components we use for all clients.

Evaluation Process



In summary, we need to evaluate:

- The fit of the components
- The client's function with the components
- The caregiver's function with the components
- The attainment of the client's expected outcomes
- The quality and timeliness of service provision
- The products/components we use

Request for Seating Clinic Review (Form J)

- Client can be referred to Seating Clinic on Form J, rather than the Referral Form (Form A) if the:
 - Client has been assessed in Seating Clinic within the past 2 years and requires a review
 - Diagnosis, medical status, and functional level have not changed. (If these have changed, a Referral form should be submitted instead.)

REQUEST FOR SEATING CLINIC REVIEW

J

Date	Name	Birthdate(dd/mm/yy)	Personal Health Number
Address		City/Town	Postal Code
			Phone
Contact Person (to arrange appointment): Phone: Relationship:		Additional Contacts (e.g. therapists, family): Phone: Relationship:	
PERSON COMPLETING FORM:			PHONE NO.

FUNDING (if changed from last visit)

Private funding Person Financially Responsible _____
 Cost Share with AADL Address: _____
 Telephone: _____

OR

Coverage, if available. Identify which agency will fund seating/mobility and specify reference number.

AADL Benefits AISH SFI WCB Veteran's Affairs MVAC Treaty Band and # _____

Other _____ **Reference Number:** _____ **Expiry Date:** _____

SEATING COMPONENTS:

DATE

DATE

_____	_____
_____	_____
_____	_____

_____	_____
_____	_____
_____	_____

WHEELCHAIR (brand, size, date received):

SEATING CONCERNS: Please identify specific seating needs that you would like the clinic to address:

Summary:



- Following a standard process for every client, from referral through to evaluation, facilitates:
 - completion of a thorough assessment
 - provision of client centered service
 - achieving client centered outcomes
- Keep thorough notes throughout the entire process!