Allied Health Professions' Office of Queensland

Occupational Therapy Learner Guide

Support the fitting of assistive devices

April 2017

Queensland Government

Occupational Therapy Learner Guide – Support the fitting of assistive devices

Published by the State of Queensland (Queensland Health), April 2017

For more information contact:
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An electronic version of this document is available at
https://www.health.qld.gov.au/ahwac/html/ahassist-modules/

Acknowledgement

The Allied Health Professions' Office of Queensland wishes to acknowledge the Queensland Health Allied Health Clinicians who have contributed to the development of these learning support materials. In alphabetical order:

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INTRODUCTION

Welcome to Occupational Therapy Learner Guide for *Support the fitting of assistive devices.*

Learner Guide Structure

This Learner Guide has been developed specifically for Allied Health Assistants to provide the skills and knowledge required to receive and respond to rehabilitation programs developed by Allied Health Professionals

This Learner Guide contains information and activities relating to key topics to enhance learning opportunities. The guide is broken up into three topic areas with sub-topics for each. These are as follows:

Organisation Requirements:

- Policies and procedures relevant to fitting assistive devices
- Record keeping practices including confidentially requirements
- Infection control principles and applications

Assistive Devices:

- Movement, mobility and posture management
- Fitting and using assistive devices
- Evaluating the client environment

Service Provision:

- Assistive device services
- Model of care
- Scope of practice

Each topic includes sub-topics which cover the essential knowledge from the unit of competency. You will be asked to complete the activities in each topic to support your learning. These activities address the essential skills from the unit of competency and will be part of your assessment.

Throughout the guide, you will be given the opportunity to work through a number of activities, which will reinforce your learning and help you improve your communication and organisation skills, manual handling skills and ability to apply therapeutic exercise practices. Take time to reflect during the module on how you may be able to apply your new knowledge and skills in your role as an allied health assistant.

Learning requirements

It is important that you have an allied health workplace supervisor who has agreed to support in your study. Regular clinical supervision during the course of your study should also assist you to stay “on track”, provide opportunities for your supervisor to monitor your progress, provide encouragement, and to check that you understand the information in the learning materials. This will be particularly important if you are having any specific learning difficulties.

Self Completion Checklist

The Self Completion Checklist outlines the underpinning knowledge and skills contained in each of the topics for the unit of competency you will be assessed against. You will be asked to review the list and place a tick in the box if you feel you have covered this information in each section and if you feel ready to undertake further assessment. If you have any questions about this checklist, ask your supervisor.

Recognition for Prior Learning

If you subsequently enrol in the Certificate IV in Allied Health Assistance you may be able to undertake recognition assessment for the study that you have done. To enable you to gain recognition for the learning you have undertaken in this Learner Guide, it will be necessary for you to complete the Assessment Guide associated with this unit of competency. The assessment activities in this Assessment Guide must be signed off by an **occupational therapist.** Copies (Word version) of the Assessment Guide can be obtained by contacting the Allied Health Professions’ Office of Queensland via e-mail AH_CETU@health.qld.gov.au

Please Note

Due to the varied environments in which allied health assistance is carried out, the terms ‘patient’ and ‘client’ are used interchangeably throughout this resource. Please use your organisation’s preferred term when performing your duties.

Symbols

The following symbols are used throughout this Learner Guide.

Important Points – this will include information that is most relevant to you; statistics, specific information or examples applicable to the workplace.

Activities – these will require you to reflect on information and workplace requirements, talk with other learners, and participate in a role play or other simulated workplace task. You may use the space provided in the Learner Guide to write down a draft response. Record your final answer in the Assessment Guide.

Further Information – this will include information that may help you refer to other topics, complete activities, locate websites and resources or direct you to additional information located in the appendices.

Case Studies – these will include situations or problems for you to work through either on your own or as a group. They may be used as a framework for exploration of a particular topic.

Research – this refers to information that will assist you complete activities or assessment tasks, or additional research you may choose to undertake in your own time.

LEARNING OUTCOMES

As an Allied Health Assistant assisting with the rehabilitation of clients you will be required to perform the following tasks.

1. Prepare for filling of assistive device (which may include: hand rails, bath seats, walking frames, wheelchairs, crutches or tap adjusters etc) :
   - Confirming assistive device details and fitting requirements against the prescribed information (which may include client care plan, case notes or Allied Health Professional instructions etc.) provided by the responsible Allied Health Professional
   - Confirming with the responsible Allied Health Professional specific client needs and abilities (which may include co-morbidity, cultural needs, joint or muscle weakness, mental health status)
   - Conferring with the responsible Allied Health Professional if fitting requirements are outside scope of role and responsibilities as defined by the organisation
   - Determining the clients' availability, according to the organisation's protocols
   - Gathering assistive device and any equipment required for fitting
   - Preparing the setting for the fitting and instruction for use
   - Obtaining informed consent from the client before commencing the fitting

2. Fit assistive device by:
   - Providing client with the assistive device
   - Confirming the suitability of fit, size, and operation meets expected performance parameters, prescription and conforms to the manufacturer's guidelines
   - Confirming the assistive device is in safe working order within the user environment (which may include hospital, home, school, or workplace etc.)
   - Obtaining relevant measurements and data where adjustments are required
   - Restricting device functions for initial or trial periods to enable familiarity and ensure safety, where necessary
   - Documenting and reporting the process and outcomes of fitting ensuring that arrangements for further action are implemented
   - Documenting maintenance periods and requirements for the assistive device, where necessary
   - Identifying any faults and complete necessary documentation
   - Confirming that client (and carer) have relevant documentation and understand any further action that needs to be taken

3. Support the client to use assistive device by:
   - Explaining and reinforcing information about the use of the assistive device, in a manner, and at the level and pace, appropriate for the client

- Confirming client understanding and answer any questions
- Confirming that the assistive device is clean and in good working order for the client's requirements before use
- Labelling, removing from use and reporting defective assistive devices to the appropriate person, and ensuring an alternative is supplied as promptly as possible
- Removing and minimising potential hazards in the immediate environment
- Educating (may include demonstration, facilitation, observation or explanation etc.) client (and carers) in the safe use, transportation and maintenance of the assistive device within the context of the user environment
- Offering appropriate constructive feedback, encouragement and reinforcement
- Providing a safe physical support to enable the client to use the assistive device
- Identifying incorrect use and giving verbal feedback and physical guidance where necessary
- Monitoring the effectiveness of the assistive device and reporting any problems to the appropriate person with minimum delay
- Reporting any adverse effect, and major progress to the appropriate member of the care team
- Agreeing relevant trial period and review periods to co-ordinate with client treatment

4. Complete basic equipment construction and modification by:
   - Obtaining equipment construction or modification specifications from the responsible Allied Health Professional
   - Confirming requirements with the responsible Allied Health Professional
   - Procuring materials required for basic equipment construction and modifications
   - Completing construction and modifications according to specifications
   - Seeking support from the responsible Allied Health Professional if difficulty arises meeting the specifications
   - Checking completed construction and modifications with the responsible Allied Health Professional
   - Completing and filing any required documentation, according to organisation protocols

5. Clean and store assistive devices after use by:
   - Cleaning assistive devices according to manufacturer's recommendations, infection control requirements and organisation protocols
   - Storing assistive devices according to manufacturer's recommendations and the organisation's protocols
   - Reporting faults to the appropriate person(s) and complete necessary documentation

6. Report and document information by:
   - Reporting suggested adjustments to assistive device, together with rationale, to the responsible Allied Health Professional
   - Providing client progress feedback to the treating Allied Health Professional
   - Reporting client difficulties and concerns to the treating Allied Health Professional
   - Implementing variations to the assistive device according to the advice of the treating Allied Health Professional
   - Documenting information about the client use of the assistive device according to the organisation's protocols

LEARNING TOPICS

The table below outlines the relationship between the topics presented in this Learner Guide and the Essential Knowledge required for completion of the unit of competency.

Topics	Essential Knowledge
1. Organisation Requirements	• Organisation procedures in relation to assistive devices, including repairs, ordering specific assistive devices and modifications • Relevant National and State/Territory legislation, guidelines and reporting requirements • A working knowledge of record keeping practices and procedures in relation to diagnostic and therapeutic programs/treatments • OHS policies and procedures that relate to the Allied Health Assistant's role in implementing physiotherapy mobility and movement programs • Infection control policies and procedures that relate to the Allied Health Assistant's role in implementing physiotherapy mobility and movement programs • Supervisory and reporting protocols of the organisation
2. Assistive Devices	• Knowledge of how to evaluate the user environment and the importance and methods of making the environment safe for use of the assistive device • Principles associated with fitting and using specific devices, or where to access information relating to the range of assistive devices, associated systems and purpose • Knowledge of how to fit, test and adjust assistive devices to meet individual needs, including the range of measurements required to prepare a specification for modification or adjustment to the original prescription • Knowledge of the principles of movement, mobility, posture management and special seating, including an understanding of balance and gait • Knowledge of the range, associated systems and purpose of assistive devices • A working understanding of the psychological effects of disability due to injury or disease and strategies used to cope with this • A working understanding of the signs of adverse reaction to different programs and treatment
3. Service Provision	• Roles, responsibilities and limitations of own role and other allied health team members and nursing, medical and other personnel • A working knowledge of factors that facilitate an effective and collaborative working relationship • Basic knowledge and understanding of equipment used to support clients with disability, illness and injury

CONTENT

1. Organisation Requirements

This topic covers information about:

- Policies and Procedures
- Record Keeping Practice
- Infection Control

Activities in this topic address the following essential skills:

- Identify and manage environment to maximise safe use of an assistive device
- Identify and report adverse effects
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work under direct and indirect supervision

1.1 Policies and Procedures

Within all health settings, there are many documents that outline set standards of behaviour and formalised ways of doing things. These should guide actions of staff within that setting. These may be in the form of written policies, procedures, codes of conduct or codes of ethics.

These documents exist to make sure high standards of behaviour, safety and consistent ways of doing things are maintained. They help protect both patients and staff from questionable conduct, and support provision of efficient, effective, consistent health care. Basic knowledge of relevant policies and procedures is essential, as these documents underpin work behaviours in a health setting.

Queensland Health policies and procedures are managed in the following way:

Policy	A statement of intent to achieve a particular outcome
Policy Implementation Standard	Defines the parameters, including responsibilities and accountabilities, of implementing the policy.
Procedure	Agreed set of practices, generally sequential, to support the consistency and quality of an activity or service in more than one work unit.
Workplace Instruction	Procedures, protocols and guidelines which apply only to staff within a particular work unit.

(Queensland Health, 2009)

The most current state-wide policies and procedures are located on the Queensland Health Intranet site. Current district and work unit policies, procedures and work instructions will be managed on the District intranet site or local shared drive. It is important you ensure you have access to these.

You will need to be familiar with policies and procedures that address the following:

1. Supervisory and reporting protocols
2. Occupational health and safety
3. Infection control
4. Legal and organisational requirements
5. Quality assurance, best practice and accreditation standards
6. Codes of practice for work in occupational therapy

Queensland Health Policies

Queensland Health policies should always be aligned with Queensland Health's 'strategic direction'. They should be in line with the state and federal legislation on the same matter and be easily accessible for those required to implement the policies (Queensland Health, 2015). On an employee level, we must apply Queensland Health policies and guidelines to our work to ensure we are providing client care that is of a high standard, safe, and accessible to all.

You do not need to be aware of all of Queensland Health's policies. However, you should have an awareness of and understanding of specific Queensland Health policies that apply to your role.

To find out more about the Department of Health's policy framework: https://www.health.qld.gov.au/system-governance/policies-standards/types/default.asp

The following policies include some that you should consider when conducting your work as an Allied Health Assistant. Please note this is not an exhaustive list. There will be additional policies relevant to your particular workplace.

- Work Health and Safety Policy (July 2014)
- Anti-discrimination and vilification Policy (November 2016)
- Orientation, Induction and Mandatory Training Policy (November 2016)
- Workplace Equity and Harassment Officers Policy (May 2010)
- Performance and Development Policy (June 2014)

You should discuss with your supervisor or line manager which additional Queensland Health Policies (not listed above) are relevant to your particular workplace.

Activity 1 - How Policies and Principles Impact on Work

Please answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Refer to Queensland Health's intranet site for the full Queensland Health Policy Management Policy
https://www.health.qld.gov.au/__data/assets/pdf_file/0037/395974/qh-pol-042.pdf

and list three ways in which this document impacts on your work.

1.

2.

3.

Supervisory and Reporting Protocols

Supervision refers to instructing, advising, and monitoring another person in order to ensure safe and effective performance in carrying out the duties of their position. You will be responsible for reporting to the Allied Health Professional and providing supervision to less experienced Allied Health Assistants. To successfully achieve this, you will need to identify your organisations policies that outline how to complete this in relation to your role and boundaries.

Supervision can be direct with face to face contact or indirect, such as via electronic communications e.g. telephone and videoconferencing. The method and frequency of your supervision will be determined by other factors including:

- your experience
- task maturity
- your non-clinical skill development
- your organisation's reporting protocols on patient treatment programs and progress

With your supervisor, you need to identify at what level you require direct or indirect supervision for what activities. A Performance Appraisal and Development plan (PAD) may be used by your supervisor to formally document your performance expectations, ensuring feedback and guidance and a way of jointly identifying your learning and developmental needs and activities.

Performance Appraisal and Development (PAD)

This is a process to be completed by all Queensland Health staff, which involves setting goals for improving work performance and progressing career paths. This is intended to benefit both staff and the organisation. Your PAD is usually completed once a year with a six monthly review of the goals that you set.

There is a clear process and structure for employees participating in a PAD including the use of standardised forms. Participating in PAD ensures:

- clear performance expectations for employees
- feedback and guidance on performance – both positive and negative
- joint identification of learning and developmental needs and activities

In addition, your PAD can be used to identify areas of work you would like to improve or develop. You and your manger can develop a plan about how to achieve your goal. For example, you may wish to improve your knowledge of wheelchair maintenance. In your PAD, you can record this as a goal and work out with your manager how you can learn more e.g. work-shadow another staff member or attend a workshop on the topic.

This plan is designed to be used for longer term career planning as well as short term needs. For example, perhaps you wish to work in an acute ward setting. Your manager may then plan with you how you can work towards that goal while still working in your current position.

Goals need to be relevant to your employer and their business of health care. Your manager may use your PAD to identify and discuss areas they require you to work on, including if parts of any of your work performance that may be a concern (Queensland Health, 2014).

Quality Assurance

Queensland Health has a set of policies, processes, and accountabilities that are aimed at improving client safety and the quality, effectiveness and dependability of its services. It does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are an essential part of healthcare (Queensland Health, 2007).

Quality is a continuous process and you will find yourself participating in and leading quality activities within your department and unit. The guiding principles of quality are:

- respect for people
- client satisfaction
- improvement through change (plan, do, check, act quality cycle)
- management by fact
- teamwork

(Queensland Health State wide Occupational Therapy Clinical Education Program, 2009)

For more information on continuous quality improvement, see http://qheps.health.qld.gov.au/cqld/quality-safety/quality-improvement.htm

Accreditation

At an organisational level, all Queensland Health services must participate in a periodic accreditation process. The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The 10 NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health service organisations.

In September 2011, Health Ministers endorsed the NSQHS Standards and a national accreditation scheme. This has created a national safety and quality accreditation scheme for health service organisations. https://www.safetyandquality.gov.au/our-work/accreditation-and-the-nsqhs-standards/

The primary aim of the National Safety and Quality Health Service (NSQHS) Standards are to protect the public from harm and to improve the quality of health service provision.

 The National Safety and Quality Health Service Standards are clearly outlined on the following website.
http://qheps.health.qld.gov.au/psu/safetyandquality/standards/default.htm

Review the table and highlight those standards that you believe will apply to you in your workplace setting.

Best Practice

Best practice is a term used 'in referring to procedures which are believed to result in the most efficient provision of a product or service' (Canadian Association of Occupational Therapists, 2009). Other terms such as evidenced-based practice may also be used in this area. In the healthcare setting, you will be required to ensure your clinical practices are based on current best practice. Ways of achieving this include:

- reviewing the literature
- participating in ongoing professional development

 On an employee level, you must apply Queensland Health policies and procedures to ensure that you provide client care that is of a high standard, safe, and accessible to all.

Queensland Health is committed to providing a safe working environment for all staff, clients, visitors, students and volunteers. The following Queensland Health documents outline how this is achieved:

1. Work health and safety policy statement (Queensland Health 2015, http://qheps.health.qld.gov.au/safety/safety_topics/p_statement/unsigned.pdf, viewed 13 February 2017,)
2. Work health and safety policy (Queensland Health, 2014, https://www.health.qld.gov.au/__data/assets/pdf_file/0034/395764/qh-pol-401.pdf

   viewed 13 February 2017)

Under the Code of Conduct for the Queensland Public Service (2010) and the Queensland Workplace Health and Safety Act 2011, you have a duty of care to ensure the health and safety of yourself, colleagues, clients and members of the public. Many of the activities you carry out at work have the potential to cause harm. It is important to follow correct occupational health and safety (OHS) policies and procedures to prevent or minimise workplace injuries and harm.

Whilst delivering a client's program, it is your responsibility to put in practice these OHS policies and procedures such as:

- ensuring that the equipment, materials and environment used during programs is cleaned, correctly set up, maintained and stored appropriately
- ensuring correct client handling techniques are used when moving, positioning and transferring clients
- reporting all injuries, incidents and unsafe conditions or work practices appropriately
- reporting equipment faults to appropriate person

The Queensland Health OHS online learning packages will provide you with a summary of the Queensland Health's OHS strategic plan, policies and integrated safety management systems. These packages form part of your orientation to Queensland Health.

http://qheps.health.qld.gov.au/safety/elearning.htm

Activity 2 - The Quality Cycle

You have been ordering stock for the work area now for a few months, and you have some ideas about how you may be able to do this more efficiently. You think it will save time and make re-ordering easier to track. You may find it helpful to refer to the following quality cycle.

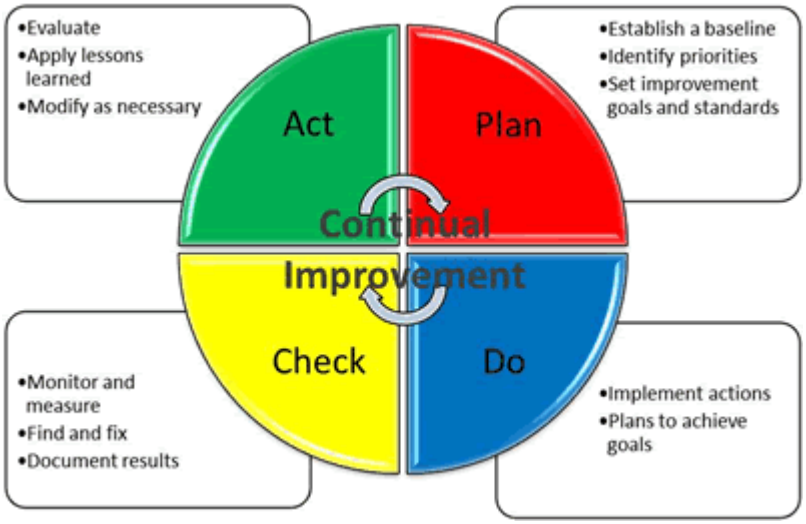


Figure 1 **Quality Cycle (Queensland Health, 2017)** http://qheps.health.qld.gov.au/darlingdowns/html/quality-safety/quality.htm

Answer the following question. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

How do you go about doing this?

Activity continues on the next page

Activity 2 - The Quality Cycle (continued)

FAMMIS

Queensland Health uses the Finance and Materials Management Information System (FAMMIS) to service a range of business processing and reporting functions including the ordering of all equipment and consumables.

Each department will have a particular process for ordering equipment or consumables, however all departments need to access the online FAMMIS site to submit orders. In some workplaces the Allied Health Assistant will have FAMMIS access and complete these orders. In other workplaces it may be an Allied Health Professional who completes these orders.

To access the FAMMIS homepage visit:
http://qheps.health.qld.gov.au/fammis/home.htm

The Allied Health Assistant may also assist with:

- contacting equipment suppliers to gain particular details about products and quotes
- completing departmental paperwork to place orders
- completing FAMMIS orders
- processing equipment once obtained e.g. adding to inventory, labelling, notifying Allied Health Professional of receipt

Ordering Assistive Devices or Equipment

The process for ordering assistive devices or equipment will vary between facilities and also according to the funding source. Some assistive devices will be funded by Queensland Health e.g. if equipment is being purchased as a trial item whereas others will need to be funded by the client. In addition, there are number of different organisations which can provide financial assistance to clients for equipment such as the Department of Veteran Affairs (DVA) and the Medical Aids Subsidy Scheme (MASS). Therefore, the ordering process will differ, depending on the type of funding.

Incident Management

In Queensland Health it is mandatory to report all incidents. All incidents are investigated and corrective actions taken. Queensland Health (QH) has developed a web-based tool - PRIME Clinical Incidents (CI) to assist QH staff to report and manage clinical incidents. This application is available from every QH networked computer. Any event during which harm occurred or could have occurred as part of the clinical care of a client should be reported on PRIME CI.

The following have a separate reporting procedure and are not reported on PRIME CI:

- workplace health and safety Issues
- concerns about the performance of an individual clinician
- complaints or compliments from a member of the public
- alleged official misconduct/intentionally unsafe/or criminal acts by staff
- alleged bullying/harassment or staff grievances

Incident Reporting Process

1. Identify the hazard/incident and take immediate action to minimise further risk(s)
7. If it's client-related, complete a PRIME Incident Report and print a copy of the reference number and send:
    - original to your supervisor & advise them of the risk/incident and/or:
    - follow instructions from your supervisor
8. If it's a non-client related incident, complete the relevant District Incident form, available from the local Queensland Health Electronic Publishing Service (QHEPS) site. Allied Health Assistants should discuss any incidents as soon as possible with their supervisor.


Visit Queensland Health's Reporting Concerns Portal (Concerns, Incidents & Complaints Reporting)
http://www.health.qld.gov.au/nonconsumer_complaint/default.asp

Activity 3 – Question and Answer

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

On your way to meet a client you trip up the stairs, which causes you to bump into a chair. You don't actually fall and there is no tripping hazard. It would appear that you were a victim of clumsiness.

1. Do you need to report this incident? Why or why not?

2. Speak with your nominated health and safety officer in your area and ask them to outline how they became the nominated officer and what are their key responsibilities. Record their responses below.

Occupational Health and Safety Policies and Procedures

Queensland Health's overarching commitment is to provide 'Safety for ALL'. The following information is based on this commitment.

Ergonomics and Manual Handling

For Allied Health Assistants there are many potential ergonomic issues that they may face in the workplace. For example:

- client/materials handling
- using heavy tools to modify assistive devices
- transporting equipment for trials i.e. in and out of cars etc.

Healthcare ergonomics (HCE) is more than just back care education and ergonomic office furniture. The healthcare environment presents some unique ergonomic issues and risks and has been widely reported as one of the most prevalent industries for work related Musculoskeletal Disorders (MSD).

 Research how to manage ergonomic risks in your workplace: http://qheps.health.qld.gov.au/safety/ergo/managing_ergo.htm

People Handling

The People Handling Code of Practice states ways to prevent or minimise exposure to risk due to the handling of people. Incorrect manual handling practices may cause or aggravate work related musculoskeletal disorders. This code of practice applies to any workplace activity requiring the use of force by a person to hold, support, transfer (lift, lower, carry, push, pull, slide), or restrain another person at a workplace.

This code outlines practical ways in which a person to whom this code applies can meet the requirements of the Work Health and Safety Act 2011.

 Review the Manual Tasks Involving the Handling of People Code of Practice 2001. In particular, look at Chapter 1 which identifies what the risk factors are and then at Chapter 7 which identifies control measures. https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0007/58174/manual-tasks-people-handling-cop-2001.pdf

Sprains and Strains prevention

Risk of sprains and strains is a potential risk for the AHA. Manual tasks can result in serious injury such as sprains and strains. High risk tasks in your role resulting in sprains and strains include:

- raising patients from the floor
- handling patients
- pushing trolleys or wheeled equipment

The simplest way to manage sprain and strain injuries at your workplace is to develop a risk management plan that identifies, assesses, controls, and evaluates safety hazards and risks.

For further information about strains and sprains locate the Sprains and Strains Prevention booklet.
https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0007/82852/sprains_strains_booklet2005.pdf

Repair of Equipment

When equipment is identified as being faulty e.g. broken brake on a mobile commode chair, the following process is a general guide of the steps to follow. Note that some details may vary between locations:

1. Clearly label equipment as faulty and if possible remove from the vicinity of the usual equipment pool to an area that does not obstruct access.
3. Ensure equipment is clean i.e. if it has just been used/returned by a client; it needs to be cleaned before maintenance work is carried out.
4. Complete a maintenance request or a BMS request through the Finance and Materials Management Information System (FAMMIS) system (discussed above). The exact process will be different, depending on what district you work in.
5. For some equipment, assist in delivery to the workshop/maintenance area.
6. Once the repair has been completed, return the equipment to its usual storage area and notify relevant staff that it is available for use.
7. In some cases, contact the owner of the equipment for repair if DVA or MASS equipment; or the supplier if it is loaned or trial equipment.

Repair of equipment on loan to the patient

If the equipment is the patient's and is a DVA or MASS piece of equipment or a loan piece of equipment from an external supplier and needing repairs the process is slightly different.

For DVA Equipment: You need to assist the patient to contact the known supplier or DVA to organise repairs or replacement of the equipment as required.

For MASS Equipment: MASS will subsidise repairs and maintenance to its MASS-plaqued permanent loan aids, associated with reasonable wear and tear and use within the home environment and reasonable community access. For equipment that has been purchased by the patient and is privately owned, MASS will not perform or fund repairs.

If repairs and maintenance are required to a MASS-plaqued permanent loan aid, the MASS patient is required to contact:

MASS Brisbane Service Centre: (07) 3136 3636

When contact is made, the MASS plaque number of the aid requiring repairs and maintenance must be quoted as well as a brief description of the repairs and maintenance required. The local MASS service centre will then issue a commercial order to have the repairs and maintenance performed.

For Supplier Loaned Trial Equipment: Contact the supplier to notify them of the required maintenance/repair and follow their instructions for repairs to be completed. They may be happy for the facility to complete the repairs or they may prefer to complete the repairs themselves.

Procedures for the management of equipment repairs may vary between work locations. It is recommended to review the appropriate local procedure in conjunction with this information.

Activity 4 – People Handling

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Identify two risk factors in your workplace related to patient handling and outline three strategies to reduce the risk for one of your selected risk factors.

Risk factors:

1.

2.

Control measures:

Fire Safety

Each district/facility will have its own emergency procedures, including information such as the number(s) to dial and the procedures to be followed in the event of an emergency. Ensure you know where these are located for your reference. All work areas are required to have Warden(s) who are trained to implement and coordinate emergency procedures and staff, taking responsibility for a Floor/Area in emergency situations.

The colour codes below are used for specific emergency situations which apply to all Queensland Health workplaces that all staff need to be aware of.

Code BLUE	**MEDICAL EMERGENCY**
Code YELLOW	**INTERNAL EMERGENCY** (Failure or threat to essential services or hazardous substance incident; illegal occupancy etc.)
Code BLACK	**PERSONAL THREAT** (Armed or unarmed person/s threatening injury to other or to themselves)
Code RED	**FIRE/SMOKE EMERGENCY**
Code PURPLE	**BOMB / ARSON THREAT**
Code ORANGE	**EVACUATION**
Code BROWN	**EXTERNAL EMERGENCY -** (Natural & Technological Disasters)

Hazardous Substances

Allied Health Assistants may come into contact with hazardous substances while working with assistive devices.

This may be in the form of:

- cleaning products used to sanitise the devices (alcohol wipes)
- adhesive removers
- glues or bonding agents used to modify assistive equipment (zoff)
- general low risk hazards such as permanent marker pens

There is a Managing risks of hazardous chemicals in the workplace Code of Practice 2013 that outlines how to manage specific risks associated with these substances. This code can be accessed online at:

https://www.worksafe.qld.gov.au/__data/assets/pdf_file/0005/58172/managing-risks-hazardous-chemicals-cop-2013.pdf

ChemAlert

On the desktop of any Queensland Health networked computer, access the ChemAlert intranet icon. ChemAlert is QLD Health's enterprise system for the management of information about hazardous substances and dangerous goods, collectively known as hazardous materials (HAZMAT). Information on over 100,000 products is available via ChemAlert.

This intranet site is divided accordingly to work units and/or areas and outlines possible hazards in your work unit or area.

In the login section, select the district you work in. This will take you to a new screen where your work area should be displayed via a tree in the left column of the screen. Select either your hospital or workplace and if available, your department e.g. Sunshine Coast – Wide Bay.

Activity 5 – Hazardous Substances

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Locate your work area in ChemAlert and identify two hazardous substances that you work with. If you are unable to locate your work area for the purposes of this activity use the following example: Health Service District → Nambour General Hospital → Allied Health.

1.

2.

For one of these hazardous substances, view the product details (right click over the item) and outline the emergency first-aid care for someone who comes into contact with this substance.

Occupational Violence

Dealing with difficult behaviour is something we may face in many different circumstances for example:

- being at home with children
- socialising with friends
- attending a sporting event
- work with clients and/or consumers , or fellow employees

In the workplace, one of the most difficult situations for employees is dealing with persons who are angry. At times the anger escalates to aggressive, abusive behaviour or even behaviour that results in assault.

A high number of employees are assaulted during the course of their duties as a result of difficult situations with clients or patients. This trend is even more common in industries such as health and disability services, social and employment services, banking, and retail.

 For more information on Occupational Violence Prevention and Management, review Queensland Health's QHEPS page on this topic: http://qheps.health.qld.gov.au/safety/occup_violence/home.htm

Activity 6 – Occupational Violence

Review Queensland Health's QHEPS page on Occupational Violence Prevention and answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

You are an allied health assistant fitting a hand splint for a client with traumatic brain injury. The client is resistive to your handling for you to be able to fit the splint appropriately and is trying to hit you.

1. What are the reasons that the client may be behaving in this way?

2. How will you deal with the situation?

1.2 Infection Control

Allied Health Assistants are expected to adhere to infection control procedures and take responsibility for ensuring your safety as well as the safety of others.

Infection arises from invasion and multiplication of microorganisms in a host, with an associated host response (e.g. fever, purulent drainage).

Colonisation is the multiplication of a micro-organism at a body site without evidence of infection. Colonisation is a form of carriage and can be a potential method of transmission and is a precursor to infection.

Infection control principles are derived from the study of infectious disease transmission, involving the interaction between host, agent and environment. Infection control practices aim to prevent infection transmission by limiting the exposure of susceptible people (hosts) to microorganisms (agents) that may cause infection (Queensland Health, 2008)

Infection control measures protect people in health care settings from infection by:

- maximising host defences
- removing or controlling sources and reservoirs of micro-organisms (the 'agent')
- reducing the risk of transmission by promoting an environment where the risk of interaction (i.e. Contact, droplet or airborne) between potentially infectious agents and susceptible people is minimised

Standard Precautions

Standard precautions form the basis for the prevention and control of infection in healthcare settings and include:

- hand hygiene
- immunisation
- asepsis
- personal protective equipment
- maintenance of a clean, safe environment
- cough etiquette
- sharps management

Hand Hygiene

Hand hygiene is the single most important strategy to reduce the risk of infection. Hands must be cleansed by both soap and water, anti-septic solution, or alcohol-based hand rub immediately before and after any direct client care or after handling blood or body substances.

 Review the basics on Hand Hygiene: https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/infection-prevention/standard-precautions/hand-hygeine/about

Skin Care

Skin Care is important as our skin is the biggest barrier against infection. The following should be observed:

- a moisturiser is imperative for hand care however;
    - skin moisturisers may negate the effect of the hand wash
    - do not use immediately before or immediately after hand wash
- skin breaks should be kept covered with an occlusive dressing
- nails should be kept short
- fingernail polish and artificial fingernails should be discouraged

Immunisation

Immunisation protects healthcare workers and those in their care from vaccine preventable diseases.

Refer to the Queensland Health Guideline on the vaccination of healthcare workers in relation to https://www.health.qld.gov.au/__data/assets/pdf_file/0029/444872/vaccination-of-healthcare-workers.pdf

Measles, mumps, rubella

Hepatitis B (mandatory for Queensland health's healthcare workers)

Hepatitis A

Varicella zoster virus (chickenpox)

Influenza

Pertussis

Asepsis

Aseptic techniques are measures to lower the risk of infection risk by minimising the number of pathogenic microorganisms people are exposed to:

- 'clean' technique involves the use of standard precautions to limit the number of microorganisms present, such as hand hygiene, reprocessing of equipment between clients, environmental cleaning, and other measures to reduce microbial load
- 'sterile' technique involves practices that aim to eliminate the introduction of microorganisms into surgical incisions, tissue or wounds (e.g. use of sterile instruments, dressing materials and gloves, skin antisepsis, and creation of a 'sterile field' within which to operate). Refer to 'antisepsis' in the glossary.

Personal Protective Equipment (PPE)

Personal protective equipment is required in the following situations:

- when there is risk of exposure to blood and other body fluids, secretions and excretions regardless of whether they contain visible blood (excluding sweat)
- contact with non-intact skin, including skin rashes
- contact with mucous membranes

Healthcare facilities are responsible for providing readily available PPE for staff that complies with relevant Australian Standards. Personal protective equipment for standard precautions comprises:

- use of gloves (appropriate to the task)
- facial protection: use of protective eyewear and a fluid repellent surgical face mask, or use of a face shield
- use of impermeable aprons or gowns

Maintenance of a clean, safe environment

Routine environmental cleaning of healthcare facilities is required to minimise the number of microorganisms in the environment. Microorganisms are unable to multiply on clean, dry surfaces. Environmental cleaning is particularly important when trialling assistive devices with clients. Ensure routine cleaning after every use.

Cough Etiquette

Covering a cough is a simple measure to help decrease the likelihood of spreading seasonal influenza (the Flu) and even a cold.

1. You should always cough and sneeze into a disposable tissue
1. Discard the tissue after use
2. Remember to wash your hands afterwards
   https://www.health.qld.gov.au/__data/assets/pdf_file/0016/151018/infectioncontrol.pdf

Sharps Management

Contaminated sharps pose the greatest risk to healthcare workers of exposure to blood-borne viruses. They should be handled with due care (Queensland Health Elements of the Infection Control Program, 2008).

Activity 7 – Infectious Disease and Precautions

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Review the following link and write down the risk factors and/or prevention methods for each of the following infectious diseases/multi-resistant organisms (MRO):
http://disease-control.health.qld.gov.au/

Infectious Disease/MRO	Risk Factors	Prevention Methods
Methicillin resistant Staphylococcus Aureus (MRSA)		
Extended Spectrum beta-lactamase (ESBL)		
Vancomycin resistant enterococcus (VRE)		
Hepatitis B & C		
Human Immunodeficiency Virus (HIV)		
Rotavirus		
Airborne Virus or Microorganism e.g. influenza(H1N1) or TB		

1.3 Record Keeping

The Public Records Act 2002 defines a ‘record’ as recorded information created or received by an entity in the transaction of business or the conduct of affairs that provides evidence of the business or affairs and includes:

a) anything on which there is writing or

b) anything on which there are marks, figures, symbols or holes having meanings for persons, including persons qualified to interpret them or

c) anything from which sounds, images or writings can be reproduced with or without the aid of anything else or

d) a map, plan, drawing or photograph

(The State of Queensland, 2002)

Therefore, everything you record in the course of seeing a client is considered a public record.

As an Allied Health Assistant, you have an important role in ensuring client records comply with legal and organisational requirements. Medical records should be complete, concise and accurate notes, which act as a permanent, continuous record of client care (Queensland Health, 2007).

Record keeping includes, but is not limited to, documenting progress notes. When you conduct group sessions, additional record keeping considerations may also include:

- secure storage of client files
- correct filing of notes, correspondence and reports within medical files
- electronic client information (emails, reports etc)
- maintaining your individual clinical statistics

Depending upon your workplace, most health service districts will have their own policy on documentation in client files. Some districts may even offer information sessions on clinical documentation. Your district health information manager can provide you with specific standards for various forms of documentation.

High quality documentation is important for all health services. Every Queensland Health employee must maintain high quality documentation standards to ensure the best outcome for client outcomes and medico-legal accuracy (Queensland Health, 2008).

Accurate documentation of client care is a legal requirement of clinical practice (Queensland Health, 2008). In your role you will be expected to take responsibility for, or at least contribute to, a wide range of documentation including:

- assessment forms
- progress notes
- care plans
- treatment plans
- referral documentation
- handover summaries
- case conference information
- discharge summaries

At different times you will need to use the above documentation formats to provide regular feedback to your colleagues, other Queensland Health services, and external agencies. For example, if you are the sole facilitator for a group session, you must use a reliable and accurate method of reporting back to the supervising Allied Health Professional. The type of information you must provide to the Allied Health Professional includes, but is not limited to:

- significant changes to a client's physical presentation or health condition
- changes in a client's functional status
- client deviation from an activity or task prescribed by Allied Health Professional
- client motivation and overall participation in rehabilitation and overall treatment plan
- any incidents (falls, seizures etc) or 'near misses'
- potential for onward referral within your team or external agencies
- any additional information related to the treatment and healthcare

The only information documented in the client chart should correspond directly to their healthcare. This is consistent with the Privacy Act 1988.

There are a number of record keeping practices applicable to you. These may include:

- documenting in a client's medical record and case notes
- documentation on a client's individual treatment plan and client care plan
- the Allied Health Professional's instructions

Documenting in the Client's Medical Record

Within Queensland Health, a client's clinical record (sometimes called the medical record or chart) has traditionally been the key way for capturing all clinical information relating to delivery of care to a client. The Queensland Health position statement on clinical records outlines Queensland Health's use of the clinical record.

For further information please refer to QHEPS Document 'Records Management for Administrative, Clinical and Functional Records'. This is located on the Queensland Health Intranet.
http://qheps.health.qld.gov.au/srmt/policy/rescinded_pol_rm_2012.pdf

The purpose of the medical record is to provide a:

- Record of continuity and evaluation of care
- Communication tool amongst team members
- Teaching tool
- Research and audits tool
- Medico-legal document
- Tool to evaluate the quality of care

(Staunton & Whyburn, 1997)

High Quality Documentation

The principles that promote the development of high quality documentation include:

- **Objective and accurate**: Factual evidence of the care given.
- **Concise**: Straight to the point and relevant.
- **Relevant**: Appropriate and includes evidence of the care given.
- **Complete**: Contains all aspects of care, the client's needs and provides evidence care has been given.
- **Timely**: The entry is made as soon as possible after an event of care. Recording the time of the event is important.
- **Legible**: All team members must be able to read your notes.
- **Informed consent**: must be obtained and documented.

(Queensland Health Occupational Therapy Clinical Education Program, 2009)

Documentation Standards

Standards in the development of documentation include:

- completion in black ball point pen
- each new page has the client's label on it

- don’t make entries on behalf of another person
- date and time of the entry, your designation, signature and printed surname
- consider confidentiality and accessibility i.e. don’t leave chart lying around
- no blank spaces left in entries
- hospital approved abbreviations only
- medical terminology used only if sure of exact meaning
- check name on medical record cover and on individual sheets before making an entry

For further information on documentation, refer to ‘Guidelines for allied health assistants documenting in health records’ at:

http://qheps.health.qld.gov.au/alliedhealth/docs/aha/ahadocguide.pdf

Format

You may be required to document your sessions in the medical chart or individual treatment plan. There will be specific guidelines relating to this in each individual workplace. Using a format will help you to identify what is important to document in relation to your diagnostic and therapeutic programs/treatments.

One widely used structure for documenting in the client’s notes is the SOAP format.

S = Subjective information or what the client reports

O = Objective information or what you see

A = Assessment of how the client’s going

P = Plan

For example: Mrs B has a goal of improved socialisation. Mrs B has presented to her therapy session for which the plan had been to attend a coffee shop and purchase a cup of coffee.

S	Mrs B reports she is ‘anxious’ about going to the coffee shop.
O	Mrs B has presented to therapy on time wearing appropriate clothing for the visit to the coffee shop as was asked at the previous therapy session. Provided reassurance that Mrs B would be accompanied by the Allied Health Assistant.
A	Mrs B independently ordered her coffee. Mrs B was observed to manage her anxiety by squeezing her therapy ball. Mrs B required assistance to manage her money.

P1	Continue with graded socialisation activities.
P2	Assess money skills.

An example of a review appointment for an orthopaedic patient who has had a fractured neck of Femur (#NOF) and had a Richards pin and plate surgery (no hip precautions) might be:

C/O.	Client having difficulty getting pants on and off with dressing stick as forgot technique. Needing assistance to wash legs as painful when reaching forward. Happy to see AHA today
O/E	Pt SOOB in chair. Functionally, unable to reach past knees due to pain. Not able to use dressing stick.
Rx1	Provided education on dressing lower limbs using dressing stick – pt able to perform independently
Rx2	Provided education on long handled aids (bath brush, easireacher, shoe horn and toe wiper) for lower limb ADL's as per care plan. Information handout provided, pt's wife will obtain when pt discharged from hospital
P.	/ R/V in 1/7 to check dressing stick use, notify AHP of above

Documentation on a client's Individual Treatment Plan (ITP)/Client Care Plan

Once the Allied Health Professional has assessed a client, they will formulate an individual treatment plan (or something of a similar name).

This document:

- outlines the client's goals
- progressively records the treatment the client receives
- is often specific to each workplace
- provides the OT's instructions

You will need to document each occasion of service on this form. Once completed, this form is filed in the client's medical records. This plan may require you to provide a treatment program to address the clients function limitations.

Common standards exist across all medical systems and facilities for writing in medical records. This ensures clear communication between the team, promoting the best patient care and opportunities for evaluation of the care provided. The style of writing you need to use is formal, objective and to the point and as such you will come across a number of common abbreviations.

Ask your supervisor or medical records department for an accepted abbreviation guide available for your facility.

Confidentiality of Client's Records

The use, storage of and access to a client's medical record are subject to clear guidelines by every hospital and health organisation. Part 7 of the Hospital and Health Boards Act 2011 identifies that "there is a strict duty of confidentiality imposed on the Department of Health and HHS staff in relation to the protection of confidential information. Where health information has been collected in the context of providing a health service, use and disclosure is governed by the duty of confidentiality in the HHB Act." https://www.health.qld.gov.au/__data/assets/pdf_file/0027/439164/doh-privacy-plan.pdf

Allied health assistants should follow guidelines related to the use, storage of, and access to health records. Consider the following:

- where you leave charts in the clinical and non-clinical areas
- are they accessible to passers-by including clients, visitors, and other staff who do not require access to them?
- if a client/other body requests access to their/an individual's medical record refer them to the medical records department

Further information about privacy and confidentiality can be found on:

https://www.health.qld.gov.au/global/privacy

Storage

When assisting with the rehabilitation of clients you will often need to refer to individual client files. These files should not be accessible or visible to others. Failure to store client information appropriately is in breach of the Privacy Act 1988. This also includes transfer of client notes between rooms and facilities. If you need to leave the room where a client is waiting, client files should be secured in a lockable cabinet or case.

Case Study

You are required to conduct a group activity for clients to learn basic cooking skills. The kitchen where you are instructed to conduct the group is a short drive from where your office is based. You realise that you need to take several client's files with you to conduct the session. In order to comply with legal and organisational requirements, you use a lockable briefcase from your office to transfer the files.

Filing

It can sometimes be a confusing when you need to file the various documents in a client's file. Each health service district will however have its own 'form filing guide'. Nevertheless, there are some standard rules that you will need to follow:

- documents should be filed in reverse chronological order (most recent on top)
- all documents should be clearly labelled with the client's name, client number, date of birth and contact details
- do not use 'post it' notes or 'unauthorised' forms in the file
- any relevant documents to the client's healthcare that have not been approved by your district's forms committee must be filed in the correspondence section of notes

Electronic Information

This can include e-mails, client reports (saved electronically) and fax messages. If a client prefers to correspond via email rather than on the telephone, be mindful that you should **avoid sending confidential information by e-mail**. This also includes correspondence between health and external services. If you unlawfully forward confidential information, you and the organisation can be held legally responsible.

All fax correspondence should have a 'fax cover sheet' and all emails must include your name and job title. Queensland Health automatically adds a disclaimer on fax cover sheets and beneath your signature on e-mails. You should also ensure you do not use e-mail for critically urgent communication.

Activity 8 - Managing Confidential Information

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

You are working with a patient in the outpatient gym to provide and fit assistive devices as delegated by the allied health professional. Outline 5 ways in which client confidentiality should be maintained. Consider the areas of client notes, telephone calls and communication with clients, family and other health professionals.

Key Points

- Queensland Health has broad policies and procedures that relate to staff members throughout the state. There are also particular policies, procedures and workplace instructions specific to each district.

- When ordering assistive devices it is important to know that some assistive devices will be funded by Queensland Health whereas others will need to be funded by the client.

- Queensland Health (QH) has a web-based tool – Patient Related Incident Management Evaluation PRIME Clinical Incidents (CI) to report and manage clinical incidents. The application is available from every QH networked computer. Any event during which harm occurred or could have occurred as part of the clinical care of a client should be reported on PRIME CI.

- Each district/facility will have its own emergency procedures, including information such as what number(s) to dial and procedures to be followed in the event of an emergency.

- Infection control practices aim to prevent infection transmission by limiting the exposure of susceptible people (hosts) to microorganisms (agents) that may cause infection.

- Hand hygiene is the single most important strategy to reduce the risk of infection.

- Within Queensland Health, a client's clinical record (sometimes called the medical record or chart) has traditionally been the key mechanism for capturing all clinical information relating to delivery of care to a client.

- Confidentiality requirements outline that it is unlawful for any person to disclose any information relating to clients except with their consent, when required by law, or to lessen a serious threat to the life and health of the individual.

2. Assistive Devices

This topic covers information about:

- Movement Mobility and Posture Management
- Fitting and Using Assistive Devices
- Evaluating Client Information

Activities in this topic cover the following essential skills:

- Fit, text and adjust a range of assistive devices
- Educate client in the use of assistive devices
- Identify and mange environment to maximise safe use of an assistive device
- Identify and report adverse effects
- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Work effectively with non-compliant clients

2.1 Disease and Illness

Posture

There are two different types of motor ability critical for motor coordination:

1. voluntary motor control e.g. eye hand coordination
1. postural or equilibrium control. This is the foundation for all voluntary motor skills and is part of almost every movement an individual makes

(Massion & Woollacott, 2004)

There are three tasks of postural control:

1. antigravity function – i.e. Maintenance of upright posture
2. maintenance of equilibrium, and
3. providing mechanical support for motor action.

(Bronstein, 2004)

Optimal Posture

Optimal posture implies balanced distribution of body mass around the centre of gravity where the compression force on spinal discs is balanced by ligamentous tension and there is minimal energy expenditure from postural muscles (Levit, 1999).

Proper positioning and alignment is essential in order to:

- maintain proper skeletal alignment
- manage pressure
- enable limb movement and functional use
- reduce fatigue
- facilitate normal movement patterns
- enhance autonomic nervous system functions such as breathing, swallowing, digestion and cardiac function
- maximise function

(Neuroactive, n.d)

While you are seated, sit up tall, lift your chest up, push your shoulders back and raise your arms above your head. How high can you reach?

Now, slump down in your chair, let your chest drop down, and roll your shoulders forward. Raise your arms as high as you can above your head. Can you reach as far?

This small exercise is to demonstrate how much difference good posture has on your movement. When you are sitting up with a good posture, your upper limb movement is so much better than when you slouch in your chair. Now think what a difference this will make with your clients when they are performing basic activities of daily living such as brushing their hair, putting a shirt on etc.

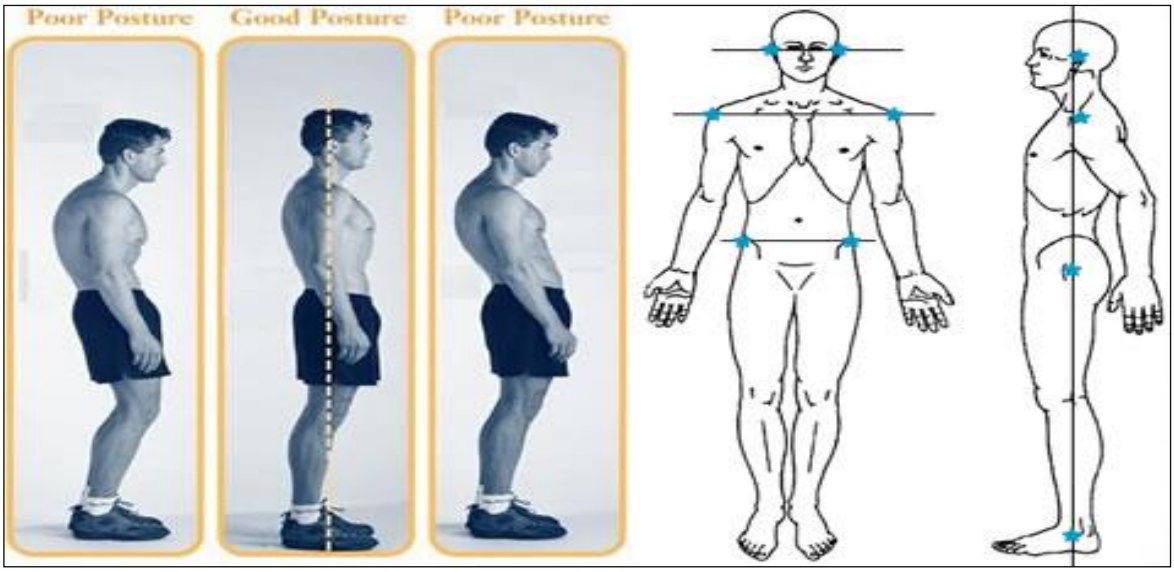


Figure 2 **Examples of good and poor posture & anatomical markers to determine correct alignment or posture (Richard, 2009)**

Seating Posture

Seating Posture is concerned with balance and stability. It is the ability to organise the 'segments' of the body against the forces of gravity in such a way as to allow and facilitate function. 'Good' posture can then be defined as the body attitude (position) that helps create maximum performance for minimal energy consumption and does so without causing damage to the body (Pope, 2007).

Special Seating

Special seating is a specifically designed seat to aid sitting posture e.g. a wheelchair seat that is custom-made. There are clinics that specialise in this and are often referred to as a 'seating clinic'. The purpose of **special seating** is:

- to arrest the progression of deformity through support and control of postural segments (on occasion some correction can be achieved)
- to stabilise the trunk and thereby free the limbs for more efficient and effective movement
- to distribute pressure over the maximum area possible to prevent damage and enhance comfort

(Chunc, 2009)

Optimal Sitting Position for Wheelchairs

Optimal sitting position for most wheelchair users is a seat-to-back angle of 90° -100° and a knee angle of 90° -120°. As shown in Diagram 3 there is a 90° seat-to-back angle and 120° knee angle.

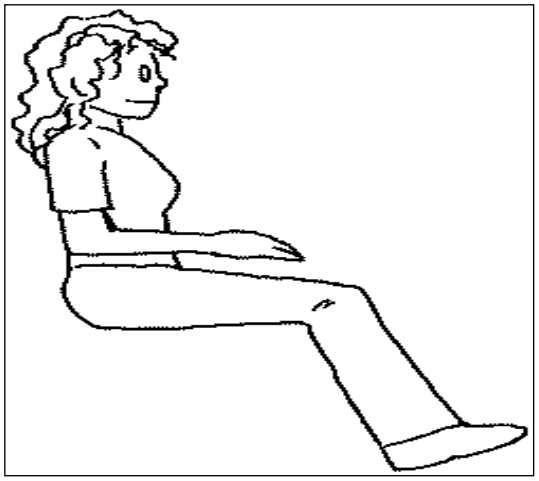


Figure 3 Optimal sitting position (Wheelchairnet, 2001).

For more information on wheelchair positioning and fitting visit the Wheelchairnet website:
http://www.wheelchairnet.org/WCN_Prodserv/Docs/MWTG/Sec2/sec2.html

Gait and Balance

Gait is the medical term to describe human locomotion, or the way that we walk. Every individual has their own unique gait pattern. A person's gait can be greatly affected by injury or disease process (Inverarity, 2007).

The Gait Cycle

The gait cycle is divided into two phases:

1. Stance - defined as the interval in which the foot is on the ground (60% of the gait cycle)
4. Swing - defined as the interval in which the foot is not in contact with the ground (40% of the gait cycle)

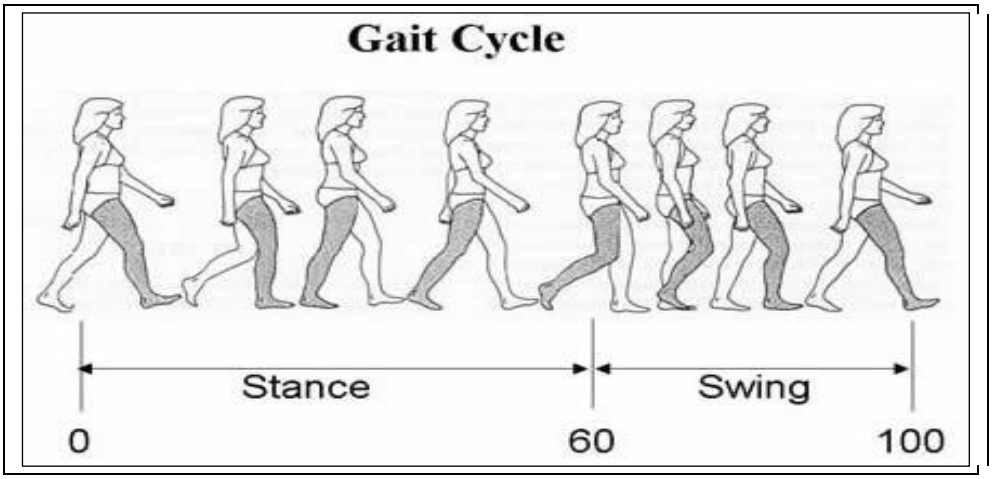


Figure 4 The Gait Cycle (Deluzio, 2001-2009)

During evaluation of the gait cycle, a physiotherapist further assesses each portion of these two phases.

Stance is divided into four phases:

1. heel strike to foot flat
5. foot flat through midstance
6. mid-stance through heel off
7. heel off to toe off

Swing is divided into two phases:

1. acceleration to midswing
8. midswing to deceleration

By evaluating each individual phase of the gait cycle, a physiotherapist obtains clues into specific muscular weaknesses and shortening. Addressing these issues in a rehabilitation program will lead to a more efficient gait pattern, resulting in decreased risk of injury, less energy expenditure, greater functional independence, and improved muscular balance (Inverarity, 2007).

Balance

Balance is the means by which individuals maintain their body position while stationary (static balance) or mobile (dynamic balance) in relationship to the environment. It is the ability to sit, stand, or walk safely without postural deviation, falling, or reaching for external items for support.

Balance, like gait, is a coordinated response of the:

- visual system
- vestibular system
- proprioception – muscular strength, endurance and flexibility.

(Paulsen, n.d)

Gait and Balance Problems

Gait and balance problems exist when a disease process, trauma, or aging result in the inability to control one's centre of gravity over the base of support in static or dynamic tasks and environments (Torpey, 2002).

There are a number of different conditions that can impact on a person's gait and balance. The following is an overview of these processes and conditions.

Visual, vestibular or samatosensory deficits	Glaucoma Cataracts Diabetic retinopathy Spinal cord injury Peripheral neuropathy
Central Nervous system injury	Traumatic Brain Injury Multiple Sclerosis Parkinsons disease Cerebellar ataxia
Musculoskeletal problems	Inadequate range of motion at the ankle

	Muscle weakness
Impaired Cognition	Reduced attention Decreased judgement Slow processing

(Torpey, 2002)

Activity 9 – Gait and Balance Problems

After reading through the section on gait and balance problems, record below which conditions or problems you are unfamiliar with. Complete an internet search and record a definition next to the condition for future reference.

2.2 Fitting and Using Assistive Devices

Assistive devices are specially designed to promote independence in an individual. They enable an individual to reduce their dependence on others and improve their performance of activities of daily living.

Principles of Fitting and Using Assistive Devices

1. Every person has different needs, aspirations, abilities, and potential. Assistive devices are more likely to meet the needs of individual persons when the individual is involved in defining her/his own needs, as well as in designing and testing the devices.
1. The choice and design of assistive devices should take into account client abilities, culture, the physical environment (built and natural, including climatic conditions), economic conditions, and lifestyle of users and their families.
2. Assistive devices must be adapted to fit the individual user; the user should not be forced to fit the device.
3. For many assistive devices, it is essential to provide training in their use and regular follow-up on their continued appropriateness. For children with disabilities, frequent review, involving the use of a series of devices, is necessary to ensure that the devices keep up with the children's progress.
4. Provision of information on assistive devices, correct use, maintenance and where to go if there are problems, are as important as distribution of assistive devices themselves.
5. Cognitive performance, problem solving and memory all play an important role in the use of assistive technologies.

(Cook, Polgar & Hussey, 2008)

Psychological Effects of Disability

Disability impacts at many levels. At the personal level, various basic life functions are altered. At an interpersonal level, relationships with other individuals change. Responses to disability at the social and cultural level have resulted in legislative change and improved services and rights (Marinelli & Dell Orto, 1999).

Adjustment to an illness or disability is an individual experience. We are all individuals with different backgrounds, life experiences, and personal histories. We have different coping styles and handle situations in different ways (Queensland Health, 2002).

People will experience many different emotions:

- frustration
- anger

- fear
- helplessness
- sadness
- loss of control
- anxiety about their future

Individuals with a chronic illness or disease are subject to increased stressful situations. This is due to the need to cope with threats to:

- one's life and wellbeing
- body integrity
- independence and autonomy
- fulfilment of familial, social and vocational roles
- future goals and plans and;
- economic stability

(Falvo, 1999)

The sudden onset of many medical conditions and disabilities e.g. spinal cord injury, traumatic brain injury, or life-threatening diagnoses is highly traumatic. In some cases the psychological consequences of crisis can be long lasting and evolve into conditions such as post-traumatic stress disorder (PTSD) (Dell Orto & Power, 2007).

The crisis experienced following the onset of a chronic or sudden onset disability triggers the onset of mourning or grief and loss similar to that seen when someone loses a loved one. The loss of the body part or function can be exhibited by feelings of grief, bereavement and despair (Wright, 1983),

Body image is the mental picture we have about the way we think we look. It's how we feel about the size, shape, weight, and look of our bodies (Child & Youth Health, 2009). Chronic illness and disease and the impact on physical appearance, functional capabilities, experience of pain and social roles, is believed to alter and even distort one's body image and self concept (Falvo, 1999, Bramble & Cukr, 1998).

Studies have found that being dependent on others is one of the greatest fears of older adults and that maintaining independence is a goal that has been rated by adults as integral to their quality of life (Baltes 1996; Clark 1991). In addition, the major impacts of illness and pain are through their effects on activity limitations, which in turn are related to lowered wellbeing (Kendig, Browning & Young, 2000).

The ultimate psychosocial outcome measure in rehabilitation is quality of life. There are various definitions of quality of life, however it can simply be defined as an individual's

level of comfort, enjoyment, and ability to pursue daily activities (WGBH Education Foundation, 2005). Invariably, disability will impact on quality of life.

The onset of a chronic illness or disease can trigger certain responses. The following are the most frequently experienced psychosocial reactions to chronic illness and disability.

- shock – usually the initial experience
- anxiety
- denial – a defence mechanism that can include wishful thinking or unrealistic expectations
- depression
- anger/Hostility
- adjustment – reconciliation and acceptance

(Dell Orto & Power, 2007)

Allied Health Assistants need to be aware that there is often a psychological impact of disability due to injury or disease and there are certain reactions that people will display.

There are a number of strategies that can be utilised to help your clients work through these things.

- active listening
- demonstrate empathy
- link the client in with a relevant support group
- refer to another team member e.g. social worker or psychologist

Assistive Devices

The next section will review assistive devices to improve independence in the following categories:

- assistive devices for mobility/ambulation
- assistive devices for activities of daily living (ADL) and self-care
- assistive devices for hearing & vision

Mobility Aids

Assistive devices for mobility/ambulation can be referred to as ambulatory aids. Ambulatory aids (e.g. canes, crutches, walkers) are used to provide an extension of the upper extremities to help transmit body weight and provide support for the client. The

type of ambulatory aid needed depends on how much balance and weight-bearing assistance is needed (Mincer, 2007).

Generally, the more disabled the individual is, the greater the complexity required in the walking device. In particular, a walker supplies the most support, and a standard cane provides the least (Deathe et al, 1993).

Mobility aids are prescribed by physiotherapists and used to:

- Redistribute and unload a weight-bearing lower limb
- Improve balance and posture
- Minimise fatigue and energy required for ambulation
- Provide sensory feedback

(Kedlaya & Kuang, 2008)

Kedlaya & Kuang (2008) also explain that the following conditions are required for the proper use of mobility aids:

- Adequate upper limb strength
- Coordination
- Adequate hand function

 To find out more about assistive devices for mobility refer to the LifeTec website to search a wide variety of assistive devices. https://lifetec.org.au/

Assistive Devices for Activities of Daily Living (ADL)

Activities of daily living are the things we normally do each day including daily activities we perform for self-care, work, homemaking, and leisure. The ability or inability to perform ADLs can be used as a very practical measure of ability/disability in many disorders (Medicinenet.com, 1998).

More specifically, ADL's can be categorised into Personal ADL's and Instrumental ADL's:

- Personal ADL's include the more basic self-care activities of daily living such as bathing, feeding, dressing, grooming, transfers, and continence etc.
- Instrumental ADL's are skills necessary to live independently, such as abilities to use a telephone, shop for groceries, handle finances, perform housekeeping tasks, prepare meals, and take medications (Hill, 2008)

Assistive devices for ADL, as well as for work and leisure activities, range from simple objects for daily use (e.g. plate guards, spoons with built-up handles, elastic shoelaces, doorknobs with rubber levers) to complex electronic devices, such as voice-activated environmental control systems (Kedlaya & Kuang, 2008).

Computer Assistive Devices

Assistive devices have been developed as both computer software and hardware. They are designed to improve computer accessibility. Among them are:

- speech recognition software
- keyboards with larger keys
- brain-computer interfaces, which allow a paralysed client's thoughts to control the computer

 To find out more about assistive devices for computers refer to the Lifetec website to search a wide variety of assistive devices. https://lifetec.org.au/

Hearing and Vision

Assistive technology, both hardware and software, is available to assist people who are blind, deaf and blind, or have low vision to access or participate in a particular activity or range of activities.

This includes products such as a:

- signature guide
- large button phone
- magnifier
- DAISY player
- refreshable Braille display
- screen magnification software

(Vision Australia, 2009)

 To find out more about assistive devices for vision locate Vision Australia's Adaptive Technology Guide: http://www.visionaustralia.org.au/info.aspx?page=1230

Occupational therapists generally do not provide assistive devices to people who have a hearing impairment. This is provided by a specialist. It is however important to be aware of these devices as they can help facilitate a therapy session. For more information on hearing aid devices visit: http://www.hearing.com.au/home

Broad Overview of Types of Assistive Devices

Mobility Aids	Lifting and Transfers
Crutches Walker Walking stick Scooters Ramps Modified Vehicles Wheelchair (manual & electric)	Hoist (standing and sling) Slideboard Bathboard Tub transfer bench Bed stick High back chair (height adjustable)
Dressing	**Feeding**
Dressing Stick Long handled shoe horn Sock-aid Button Hook Velcro fasteners	Built-up cutlery Plate guard Non-slip mat Cut out cup
Personal Hygiene	**Daily Living Aids**
Over Toilet frame Bedside commode / mobile commode Grab rails Long handled aids e.g. bath brush, toe wiper, comb etc.	Easi-reacher Jar opener Tap turner Jar-Key Kettle tipper Built up handles
Positioning	**Leisure/Recreation**
Soft Wedges Adjustable beds	Card holder Fishing Harness

Splints	Long handled gardening tools Threading needles
Vocational	
Copy holders Laptop stand Sloped writing tables	

(Elderly Health Service, 2006)

Useful Resources

LifeTec Queensland—a leading provider of information, consultation, and education on assistive technology that can help individuals improve their quality of life and remain independent. This website has fact sheets on available assistive devices and a free product search of their live database which gives information on over 5000 assistive device products available in Queensland. http://www.lifetec.org.au/home/default.asp

Stroke Engine—article on Assistive Devices for Stroke, information for clients and their families with lots of pictures and descriptions http://www.strokengine.ca/patient-info/assistive-devices-info/

Stroke Rehab- online description of adaptive equipment options post stroke with pictures and descriptions. http://www.stroke-rehab.com/adaptive-equipment.html

Case Study: Stroke Patients

You have recently started working in a rehabilitation hospital as an Allied Health Assistant. A large part of your caseload is working with stroke patients. You realise that you don't know a lot about the types of assistive devices that can help stroke patients.

You decide to undertake research and you review the Stroke Engine article on assistive devices for stroke and note any assistive devices that you weren't aware of. For additional information about what a particular device is or looks like, you then search on the LifeTec website to gain more information. Following this you ask you the Allied Health Professional in your workplace.

Department of Veteran Affairs (DVA)

The Department of Veterans' Affairs provides aids and appliances through the Rehabilitation Appliances Program (RAP). The aim of this program is to assist entitled veterans, war widows and widowers, and dependants to be as independent and self-reliant as possible in their own home.

The program provides safe and appropriate equipment according to the specific needs of the entitled person. All Gold Card holders are eligible for Rehabilitation Appliances, while White Card holders may be eligible for appliances relating to their clinical needs.


Review DVA's Factsheet HSV107 on the Rehabilitation Appliances Program: http://www.dva.gov.au/health-and-wellbeing/home-and-care/rehabilitation-appliances-program-rap

Medical Aids Subsidy Scheme

The Medical Aids Subsidy Scheme (MASS) provides access to subsidy funding for the provision of MASS endorsed aids and equipment to eligible Queensland residents with permanent and stabilised conditions or disabilities. The range of MASS aids and equipment is selected to assist people to live at home and avoid premature or inappropriate residential care or hospitalisation.

Aids and equipment are subsidy funded either on a permanent loan basis, private ownership or through the purchase of consumables. MASS provides subsidy funding assistance towards:

- communication aids
- continence aids
- daily living aids
- medical grade footwear
- mobility aids
- orthoses
- oxygen
- spectacles through the Spectacle Supply Scheme

(Medical Aids Subsidy Scheme Homepage: http://www.health.qld.gov.au/mass/default.asp)

Allied Health Assistants may be involved in assisting the Allied Health Professional with trialling equipment, organising quotes from the equipment companies, or completing the written MASS Application.

Activity 10 – Assistive Device Search

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide. You are an Allied Health Assistant working in a small regional hospital. The Occupational Therapist (OT) has a patient on the ward that has arthritis in their hands and has been struggling to open jars and bottles at home. The OT asks you to have a look on the LifeTec Queensland website to find:

- A handout related to opening jars and bottles
- What sort of assistive devices are available to complete this task
- Where their patient might be able to obtain these devices from

Locate the above information on the LifeTec Queensland website and complete the following questions.

1. Is there a handout about opening jars/bottles that would be suitable for patients? Yes/No
2. In the table below, list suitable and unsuitable devices for this client

Suitable Devices	Unsuitable Devices

Please note: it is very important, where possible, to trial a device or to trial an approximation of the device with the client before recommending purchase.

Activity continues on the next page

Activity 10 – Assistive Device Search (continued)

3. Select one of the above devices and record below where a patient could purchase the device from.

4. Access the Stroke Engine and/or Stroke Rehab websites. Read through the information and list 10 personal care and grooming aids/options below:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Fitting Specific Devices

The follow sections contain information or links to information on fitting, testing, and adjusting some commonly prescribed assistive devices. Take the time to review the information for these commonly prescribed assistive devices:

- wheelchairs
- over toilet frame
- mobile shower commode
- hoist
- bathboard
- prefabricated foot drop splints
- bedstick

Wheelchairs

A wheelchair is a movable chair mounted on large wheels for people who either have difficulty walking or are unable to walk. They are frequently propelled by the occupant however electric versions are available.

The assessment and prescription process for selecting the appropriate wheelchair for clients is a long and time-consuming process for both the client and the prescriber. However, this process is vital to ensure that the most appropriate equipment is supplied to achieve both client satisfaction and financial efficiency.

Some of the general issues to consider:

- wheelchairs are becoming more disability specific and some models are more suitable than others for a particular individual client
- a different approach is often required if the client is a first-time user or an experienced user. First time clients and carers often need more education and guidance with wheelchair assessment and prescription
- as a wheelchair is a mobility aid, it is important to consider wheelchair propulsion biomechanics and efficiency

The following steps should be completed to achieve the optimal outcome:

1. assessment – of client, carer, environment of use, product and accessories available on script form
5. trial period
6. prescription
7. follow-up post supply of equipment
8. adjustment of wheelchair to suit the client if required
9. client/carer education in use throughout the whole process

(Queensland Spinal Cord Injury Service, 2006)

Allied Health Assistants will have involvement in all of the stages in the above process or as directed by the Allied Health Professional.

Further Information on wheelchairs

Manual Wheelchair Features:

https://lifetec.org.au/education/fact-sheets/manual-wheelchair-features-0

Comprehensive guide to manual wheelchairs from Spinal Outreach Team and University of Queensland Include the following information:

- Measuring for a Wheelchair
- Wheelchair Prescription Form

https://www.health.qld.gov.au/__data/assets/pdf_file/0026/429911/manual-wheelchairs.pdf

Activity 11 – Measuring for a Wheelchair

Read the following article on Wheelchair Accessories and answer the questions:

https://www.health.qld.gov.au/__data/assets/pdf_file/0026/429911/manual-wheelchairs.pdf

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

2. What would be a good solution for a stroke patient who had minimal movement in their right arm and couldn't quite reach the brakes on their right side with their left arm?

2. What could you recommend if your patient complained that their pants were getting dirty when they mobilised outside in their wheelchair as dirt kept hitting them from the tyres?

Activity continues on the next page

Activity 11 – Measuring for a Wheelchair (continued)

Now that you know how to measure for a standard, basic wheelchair and some of the available accessories read the relevant sections on wheelchair maintenance and adjustment and answer the questions below.
https://www.health.qld.gov.au/__data/assets/pdf_file/0026/429911/manual-wheelchairs.pdf

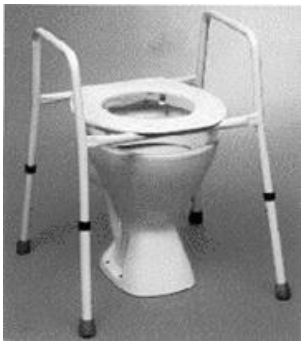
3. What could be the cause of a wheelchair that is hard to push and turn and doesn't move freely? How would you fix it?

4. How do you achieve a correct footplate height?

Over Toilet Frame

An over toilet frame is a useful aid which will make getting on and off the toilet both easier and safer for you. It provides a raised toilet seat height and armrests which are an alternative to rails. The over toilet frame has four legs of adjustable height, a plastic toilet seat and two armrests. The legs are adjustable in 2.5 cm steps. In case the floor is not level, one of the legs has extra holes for adjustment every 1.25 cm. This will assist in stabilizing the chair so that it does not wobble.

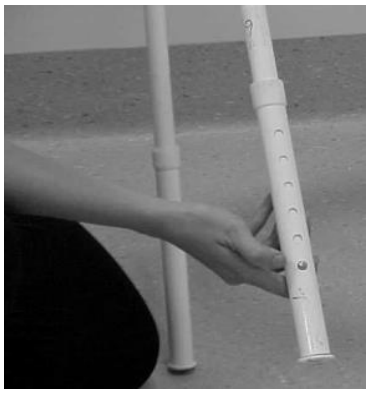
Below is an outline of the key considerations when fitting, testing and adjusting an over toilet frame.



The purpose of an over toilet frame is to help people who have difficulty getting on and off the toilet. The key features are:

- to provide armrests to help make getting on and off the toilet easier
- height of over toilet frame can be adjusted to increase independence

Fitting the Over Toilet Frame

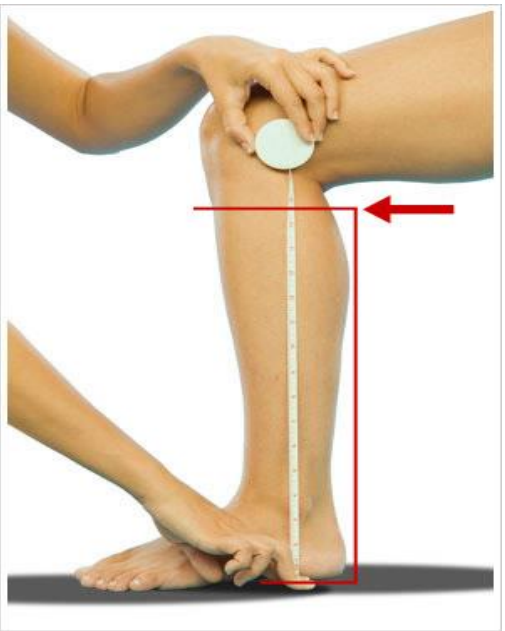


- To adjust the height on the over toilet frame:
  - The surround is height adjustable to match individual user requirements.
  - A series of holes along each leg allow leg height to be adjusted.
  - A brass locking button is used to secure the height of each leg.
  - Press in the locking button to disengage, and turn the leg slightly so the button is no longer aligned with the holes. Move the leg up or down to your ideal height setting, and then turn the leg back to align the locking button with the nearest hole.
  - The locking button must be fully engaged and protruding through the height adjustment hole to ensure a positive lock.
  - Repeat for all four legs, adjusting height evenly or individually to match an uneven floor surface.
- Before use confirm toilet surround is secure for transfers

NOTE: the ideal height is 5 cm above the popliteal crease. The popliteal crease is the crease in the skin at the back of the knee where the joint bends

To measure the popliteal height or crease (see picture below):

- in sitting (heel directly underneath knee) with shoes off.
- measure from the floor to popliteal crease on the outer side of the leg.
- measure on the operated leg if possible



https://www.google.com.au/search?q=jobst+elvarex+measurement&client=firefoxa&rls=org.mozilla:enau:official&source=lnms&tbm=isch&sa=X&ved=0CAgQ_AUoAmoVChMIyp2Mh9v3xwIVhSumCh1MgDg&biw=1920&bih=976#tbm=isch&q=lower+leg+length+measurement&imgrc=Z0yMuqRjGwBVlM%3A

Safety and precautions

- use two hands when transferring on/off over toilet frame to avoid tipping, and ensure feet are firmly placed on the floor
- 100 kg weight limit, unless otherwise stated by the manufacturer

Maintenance

- The leg locking buttons should be regularly inspected to ensure they are fully inserted.
- Regularly check the over toilet frame / commode for damage and wear, paying special attention to the condition of the seat, pan and rubber tips. Do not use the commode if the plastic seat or pan is cracked or deformed in any way.
- Replace the rubber tips immediately if you see evidence of rips, tears, cracks or other general wear.

Care & cleaning

- To clean the seat after each use, wipe clean with a mild soap and warm water solution and rinse well. Dry with a clean cloth.
- For heavier soiling, wipe clean with a diluted bleach solution and rinse well before drying. Do not use water temperatures in excess of 80°C.
- It is recommended the frame be cleaned after heavy use or at least once a week. To clean, wipe with a soft clean cleanser and warm water solution and rinse well.

- For a thorough clean, separate all parts (frame, seat, lid, and pan) and wash individually with warm soapy water. Dry thoroughly before reassemble.
- Avoid harsh, abrasive cleaning agents or utensils (such as a wire brush) as these can lead to deterioration of the frame.

(Evadale Toilet surround user guide, 2017)

Activity 12 – Measuring the Popliteal Height

With a co-worker practice measure their popliteal height as per the instructions in the fitting the over toilet frame section above and answer the following question. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

What height would you recommend for your colleague if they were being prescribed an over toilet frame?

Mobile Shower Commode

Below is an outline of the key considerations when fitting, testing and adjusting a mobile shower commode. These points should be discussed with the Allied Health Professional prior to fitting the assistive device.

Mobile shower commodes are multi-purpose devices which can be used as shower chairs and over toilet chairs. Wheeled shower commodes provide greater independence and manoeuvrability for users, and decrease the number of transfers required for bathroom activities. Mobile shower commodes:

1. Enable people whose mobility and transfers are limited, to safely move in/out of the bathroom/toilet areas, with the aid of a carer or independently.
2. Provide a secure seat so that a shower or wash can be taken safely, whilst sitting.
3. May be used as a portable commode chair when the toilet is inaccessible for the person either due to space or limited mobility.

There are two types of mobile shower commodes available as below: (note the type of mobile shower commode to be trialled will be identified by the delegating health professional).

- Self-propelled mobile shower commode (see below picture):
  - This is made from steel with two small front wheels and two large back wheels that are used by the client using the equipment to propel themselves where they need to go.
  - **The brakes must be applied by the client from sitting position.**

http://cdn1.bigcommerce.com/server5200/y30xh/products/538/images/883/B4025S_Mobile_Shower_Commode_Self_Propelled__19238.1363087854.1280.1280.jpg?c=2

- Attendant Propelled Mobile Shower Commode (see picture below):

- This is made from steel with two small front wheels and back wheels, the client using the commode requires another person to push them in the equipment in order to move around.
- The brakes must be applied by the attendant assisting.

http://www.kcare.com.au/wp-content/uploads/2013/09/ka114s-AttProp-personal-SC_thumb.jpg

The following features are also important to note:

Footplates:

- Weight bearing Footplates (see picture below):
  - A solid footplate at the base of the mobile shower commode that can be used to assist with standing a client to reposition in the chair, they should **not** be used for transferring on and off.
  - They slide back and forward on the base of the mobile shower commode frame.

http://www.kcare.com.au/wp-content/uploads/2013/09/ka123s-selfProp-foot-SC_thumb.jpg

- Swing back Foot plates (see pictures above in self and attendant propelled sections):
  - These are not for weight bearing and simply used for client comfort when sitting in the mobile shower commode and to protect feet and legs during transit in the equipment.
  - The footplates swing back from the side attachment on the frame and should be swung back for all transfers and repositioned when patient is seated in the commode.

Arm rests:

Swing back armrest are attached at the back of the frame and swing up and down to assist with transfers and ADL completion- these should always be in the locked down position for transport in the chair.

Fixed armrests- do not move and are fixed to the back of the frame.

Safety Arms: these have an adjustable hand grip that can be moved 360 degrees with the use of a metal click pin, they can be adjusted to assist the client as recommended by the delegating health professional. (see picture below)

http://www.aidacare.com.au/media/1334233/abr03.14%20-%20ottobock%20bath%20&%20safety%20brochure_distributors_email.pdf

Brakes:

See notes above in self and attendant propelled commode sections.

Considerations when Fitting a Mobile Shower Commode

- is there adequate room in the bathroom, shower and toilet for the chair to be moved around?
- ensure that the mobile shower chair/commode is placed firmly on the floor before use
- when transferring in or out of chair, instruct the client not to stand on the footplates/footboard and ensure the brakes are on
- always lock the brakes before attempting a hoist or standing transfer, or when the chair is stationary
- ensure the client is able to support themselves while sitting (have good sitting balance) to use a mobile shower chair/commode safely
- ensure feet are supported on footplates/footboard whenever chair is in motion
- instruct the client not to bend to reach their feet or the floor when sitting on a mobile shower/commode chair to avoid tipping the chair over

(Domiciliary Equipment Care, 2007)

 To learn more about Mobile Shower Commode Seating Options review the following website:
https://www.health.qld.gov.au/__data/assets/pdf_file/0024/423951/msc-assess.pdf

Maintenance of the Mobile Shower Commode

Queensland Health requires that all Mobile shower commodes receive annual maintenance checks for:

- check seat for tearing, splitting and warping
- check frame for cracking, splitting and corrosion
  - check that castors:
  - are securely attached
  - are freely rotating
  - are free from lint and hair
  - are freely pivoting
  - are braking effectively; adjust if necessary
  - are lubricated with water proof grease if required

Hoists

A hoist is a device used for lifting and transferring people who have poor mobility. Hoists and lifts come in many types and sizes depending on their purpose, and the location they will be fitted if permanent or semi-permanent.

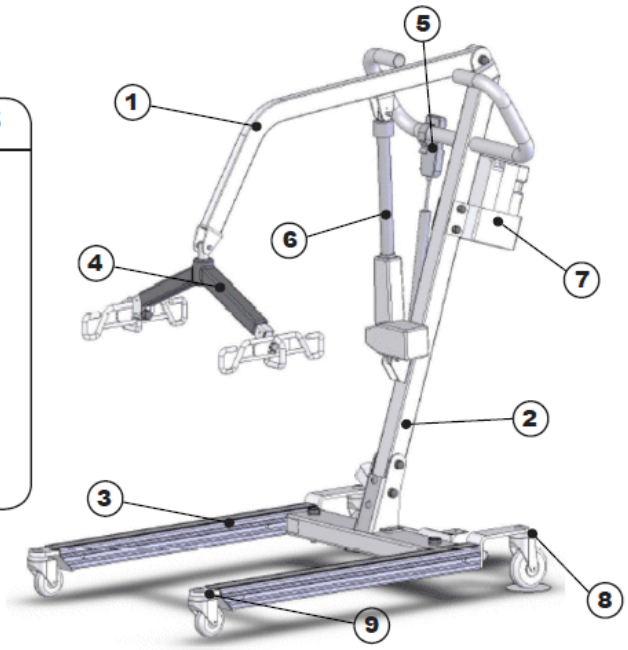
Overhead Hoists – A ceiling track hoist consists of a piece of rail/track that is permanently attached to the ceiling. The track can be fitted to timber joists if available or chemically fixed into concrete ceilings.

Mobile Floor Hoists – Mobile Floor hoists have been designed especially with the domestic care environment and patient in mind. Electric and hydraulic units are available.

(Disabled World, 2010)

Parts List for PL400 SERIES

1. Boom
2. Mast
3. Base
4. Spreader bar w/ Sling hooks
5. Pendant / Hand Control
6. Actuator
7 Control box and Battery Pack
8 Rear Caster w/ Brake
9. Front caster



http://www.phc-online.com/v/vspfiles/assets/images/pl400Ecomponents.gif

Considerations when Fitting a Mobile Floor Hoist

- the weight of the patient – check the hoist's specifications in the operating manual to confirm that it will be appropriate for the patient
- compatibility with the chosen sling – does the hoist have a yoke bar or a pivot frame? The type of frame will determine the type of sling required
- environmental considerations – consider if the hoist be able to fit in around the patient's home. Will it fit under the bed, around the armchair etc.? Is the floor surface carpet or are there lots of loose mats, as a hoist is very difficult to manoeuvre on these surfaces?
- correct sling size – to measure for the correct sling size, hold the sling up to the client's back. It should extend from the coccyx to just above the head

Research the following:

Hoist Selection - Review the Government of South Australia's information for prescribers on hoist selection:
http://www.des.sa.gov.au/__data/assets/word_doc/0015/20931/hoists-clinical-considerations-for-prescribers.doc

Slings – Review the Government of Australia's guideline on slings:

http://svc015.wic006wss.serverweb.com/Shared%20supporting%20documents/Slings%20-%20Clinical%20considerations%20for%20prescribers.doc

Maintenance of Hoists

Hoists should be reviewed regularly. The following are some points to consider when looking after your hoist or instructing a patient of the care of their hoist.

- battery – ensure this is charged using the correct charger and always charge for 4 hours or more
- controls – check that all plugs are plugged in, the cords aren't stretched and the face isn't cracked
- base legs, mast and boom – ensure able to spread full distance, all bolts are in place and there are no cracks appearing
- castors – check for lint or dirt and remove and check castors are moving freely
- sling – should be removed if the fabric is torn or any of the straps or clips are damaged in any way

(Queensland Health, 2009)

MASS – Queensland Health has a more in depth handout that outlines what checks need to take place. Review this information to expand your knowledge:

https://www.health.qld.gov.au/__data/assets/pdf_file/0028/437716/maintenance-hoist-sling-checklist.pdf

Review Government of South Australia's hoist information. This can be accessed at: https://www.sa.gov.au/__data/assets/word_doc/0017/20708/hoists.doc

Activity 13 – Hoist Transfers

Review the online video of a hoist transfer at
http://www.youtube.com/watch?v=ZXzSG9rCLHw

Now practice with a colleague or your supervisor completing a hoist transfer e.g. bed → chair or chair → bed.

Write out your own hoist guideline outlining each step of the process including any tips you've learnt along the way.

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Bathboards

A bathboard is a board that fits across the top of the bath and can be adjusted so it is firm and secure. A bathboard allows a person to sit on the board first, then swivel and lift their legs over the bath side. They are particularly useful with a shower over the bath, as the person does not need to get down into the bath at all.

Considerations prior to fitting a Bathboard

When fitting a bathboard, there are a number of considerations when selecting the type of bathboard and a number of points to consider around setting up the environment safely.

- check the rim of the bath – the rim needs to be at least 2.5 cm (1') wide on each side so that the board has enough support
- check the bath height – if the bath is quite high, a small step next to it may make getting onto the board easier; make sure the step is firmly fixed and is not slippery
- check the length of the board – the board should not be too long so that it overhangs over the side of the bath, as there is a chance that it could tip like a seesaw if someone sits on the end
- bathboards can come in different heights e.g. a raised bathboard – this type of board is particularly useful for people who have a low bath and struggle to stand from low surfaces or for people who have hip precautions and are unable to sit on low surfaces
- it may be difficult to fit a board in an unusually shaped bath – some boards can be used only in baths with straight sides
- ensure the bath is clean and that there is no grease or soap, which could make the fastenings less secure

(Cheshire County Council, 2008)

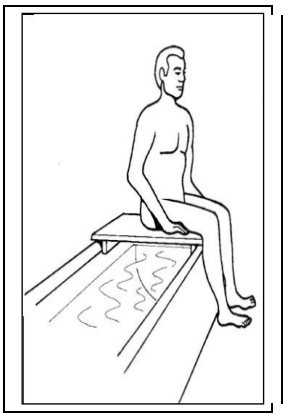
Fitting the Bathboard

The following guidelines may also assist:

- measure the width of the bath and check that it fits in with the bathboard's specifications in the instruction manual
- consider the weight of the patient and if the bathboard is suitable – more heavy duty boards are available
- fit the board at the end of the bath opposite the taps (taps can get in the way when using the board)
- adjust the bracket by sliding it until it is wedged against the side of the bath, and then tighten them so they hold the board firmly in place – in some cases it's easier to adjust the fixing furthermost away from you first
- always check the board is secure before using it

It is advisable to always follow the manufacturer's instructions that come with the product.

Completing the Transfer



1. Sit on the edge of the board with the feet outside the bath on the floor.
2. Slide or wriggle backwards onto the board.
3. Turn to swing the legs over the rim and into the bath. This is similar to getting into bed or the person may need some assistance from another person.
4. Slide or wriggle to the middle of the board using wall-fixed grab rails if needed.
5. From this position you can either lower onto a bath seat or down onto the base of the bath, or stay on the board and use a hand-held shower hose.

Maintenance

- clean the bath board with a mild soap, detergent or household cleaner
- regularly check the adjustable bracket to ensure it is tight and secure – if there is any evidence of damage, discontinue its use and obtain a replacement

Activity 14 – Bathboard Transfers

With a co-worker, practice completing a transfer into a bath using a bathboard. Then practice completing the transfer imagining that you have the case studies:

Case Study

You are on crutches and you are not allowed to put any weight through your right foot (non weight bear), not even to keep balance with the tip of your toe.

You have just had a hip replacement and you are not allowed to bend (flex) your hip joint beyond 90 degrees. You are still mobilising on crutches. You may need to check your popliteal height and see if the bath board height is going to be suitable.

You are a 48 year old lady with some arthritis in your hips and knees. You are on axillary crutches and you only have a 1000 cm opening to get into your bath at home as there is a fixed glass screen. You need a bathboard as you are not allowed to weight bear on your left foot.

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. What difficulties did you face when trying to get into the bath?

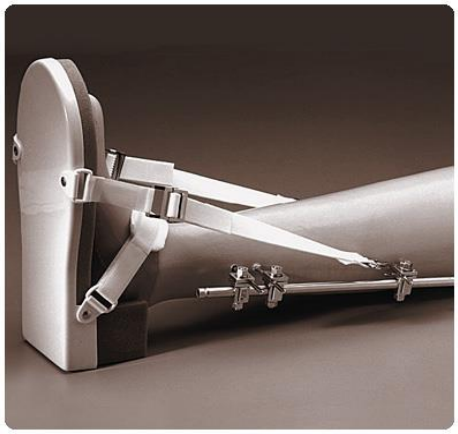
2. Which ‘condition was the hardest to get into the bath with?

Pre-fabricated Foot Splints

Foot drop can be defined as a significant weakness in or absence of ankle and toe dorsiflexion. This can impact on a person's ability to walk as they can be more at risk of tripping as they are not able to clear their foot easily. This can be a temporary or permanent condition. A foot drop splint is a device that holds the ankle in plantargrade (this is the neutral position where the ankle is dorsiflexed to 90 degrees). This helps to prevent shortening of the soft tissues and tendons.

Fitting a Pre-fabricated Footdrop Splint

- firstly decide which prefabricated splint is most appropriate. To do this assess if the patient is able to passively achieve plantargrade (ankle bent to 90 degrees). If they cannot achieve 90 degrees they may need an adjustable foot drop splint. Also, a patient who has an external fixation device may need a pre-fabricated splint that supports this (see image). If none of these options are suitable, then a custom made splint may need to be fabricated
- check the patient's calf size. The foam inserts on the pre-fabricated foot drop splints come in normal and extra wide. Select the appropriate size
- once the appropriate splint and inserts have been selected, gently lift the patient's leg and slide the foot drop splint in place
- ensure the ankle is positioned in as much dorsiflexion as possible (up to 90 degrees). The adjustable splint will need to be adjusted to allow for the patient's ankle range of motion i.e. set the splint at 70 degrees if this is all the patient can achieve



Foot drop splint for an external fixator device.

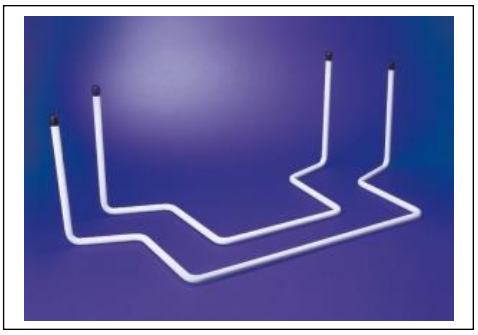
- secure the straps as shown in the diagram above or add an additional strap across the ankle to achieve a cross pattern

Precautions and Monitoring

- it is important to closely monitor splints for pressure areas and skin integrity. If there are pressure areas, consider adding padding or cutting out the foam inserts to relieve the pressure
- if there is nerve involvement, provide education re: sensory loss and protection of skin from injury
- if the patient did not achieve plantargrade, the passive ROM will need to be monitored and the splint adjusted according to gains in ROM

Bedstick

A bedstick or a bed rail is a steel frame that fits under the mattress to enable positioning and transfers in and out of bed by providing vertical support on each side of a bed.



Fitting a Bedstick

- select the most appropriate bedstick design
- ensure the specifications of the bedstick match the bed type e.g. single bed
- position the base of the stick underneath the mattress; the bedstick must fit securely against the side of the mattress - if it cannot, discontinue use
- for two-sided bedsticks the U shape should face the bottom of the bed
- position the bedstick approximately 60 cm from the head of the bed

There have been cases where clients have fallen between the bedstick and the mattress, getting their neck caught and resulting in suffocation and death. If you have any concerns regarding fitting please consult with your supervisor. Review the following guidelines and recommendations regarding safe use of bedsticks and management of risks associated with use of breadsticks:

- Alerts and Advisories | Patient Safety Unit: http://qheps.health.qld.gov.au/psu/alerts/alerts.htm

(Click on heading to expand section and view the alerts and advisories for that year. Patient Safety Notice 08/2010: Entrapment Risk: Incorrect use or installation of Bed Poles/Bed Sticks.)

- Occupational Therapy Australia Position Paper “Provision of Bedsticks and Poles” March 2015 http://www.otaus.com.au/sitebuilder/advocacy/knowledge/asset/files/21/otapositionpaper-bedstickuse(march2015-final).pdf
- Lifetec (2014). Help with using a bed stick safely. https://www.lifetec.org.au/sites/default/files/fact-sheets/Help%20with%20Using%20a%20Bedstick%20Safely_LifeTec.pdf

Precautions

- if the bed has a wire base, it is important to use a board on top of the wire and sit the bed stick on this to prevent movement of the bedstick
- ensure there is a plastic cap on the top of the bedstick for safety
- consult with your Occupational Therapist before providing a bedstick to anyone who has a cognitive impairment as this can increase risk of injury
- bedsticks should be checked regularly for signs of damage/bending. If damaged or bent, cease use and contact the supplier

Activity 15 – Fitting Bedsticks

Practice fitting different types of bedsticks for example, cobra stick and bilateral-sided bedstick.

With a co-worker, practice explaining the following as if you were giving them an education session on how to use the device:

- What a bedstick is and what it is used for
- How to fit it onto a bed
- What the precautions are
- How to look after or maintain the bedstick

Then ask your colleague for feedback on your explanations and record a summary below.

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Adverse Reactions

At times, the client will have adverse reactions that may be related to the assistive device being trialled or another factor. This may occur during or after use. The Allied Health Assistant should be aware of these signs and provide feedback to the Allied Health Professional as soon as possible.

Some general considerations and strategies are:

1. **Reaction to the materials** – Reaction to the material in the assistive device e.g. latex, plastics, foams etc. This may present like an allergic reaction e.g. rash, pain, or swelling around the site of contact with the skin.

   Strategy: consider using another material to prevent direct contact with the skin e.g. cotton sleeve under a foot drop splint or investigate if there are any similar products made out of different materials.

2. **Pressure areas** – Pressure areas from the assistive device, particularly around bony prominences. It is particularly important to monitor assistive devices that involve sitting e.g. wheelchairs, shower commodes etc. or with clients who have reduced sensation or cognition e.g. spinal cord injury patients or patients with dementia.

   Never place a sheet or towel or alternative cover on top of a specially designed pressure cushion. The pressure cushion has been designed with a two-way stretch cover and placing anything over it will prevent it from relieving pressure for the client.

   Strategy: If a device is causing pressure it will need to either be modified or replaced with a different style or specifications.

 For more information on pressure areas, review the following document on skin and pressure area management for Spinal Cord Injuries:

http://www0.health.nsw.gov.au/policies/pd/2014/pdf/PD2014_007.pdf

Activity 16 – Pressure Areas

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. What is a pressure area?

2. Read Queensland Department of Health's NSQHS Standard 8 Pressure Injury fact sheet and complete the following table: https://www.health.qld.gov.au/__data/assets/pdf_file/0029/433478/pip-audit-def.pdf

Pressure Area Type	What does it look like?	What can you do?
Stage 1 pressure sore		
Stage 2 pressure sore		
Stage 3 and 4 pressure sore		

Skin tears – are particularly prevalent in older people who have fragile skin that is more susceptible to tears. Assistive devices with sharp edges can cause these injuries.

Strategy: Apply padding or alter the area causing harm.

Reduced endurance or reduced ability to complete device trial – patients who have had significant medical problems or who have been unwell for a long period of time may be deconditioned and have limited exercise tolerance. They may display fatigue, tire quickly or have general weakness particularly when mobilising or transferring.

Strategy: If completing a treatment program or trialling an assistive device, factor in rest breaks and allow time for the client to sit as well as stand.

Adverse reaction to medications – Adverse reactions to medicines being taken is evident through the client being unwell, drowsy, or having reduced concentration.

Psychological or emotional reactions – Psychological or emotional reactions to the assistive device, for example non-compliant behaviour due to not wanting to be seen as being 'disabled'.

In addition to the above considerations, it is important to always read the manufacturer's information on the device as these will list any precautions to be aware of. Providing education to the patient about potential adverse reactions is also helpful as they can then provide feedback if there are any concerns.

Device Abandonment

In most cases significant energy goes into prescribing an assistive device and training the client how to use it. The reason for prescribing the device is to improve the client's independence or safety. However, in some cases these devices are either never used or quickly abandoned. Abandoned devices are those that are owned but are not in use.

Researchers suggest that the reasons for device abandonment are as follows:

- client's functional ability improves
- client's opinion in device selection not considered
- use of one device contingent on use of another
- lack of knowledge about how to use device
- poor fit with environment or person's need
- device lost, forgotten, or never taken home from hospital
- device failure
- preference for personal assistance (from family/carer)
- feelings of embarrassment
- denial of need

(Gitlin 1995, Phillips & Zhao 1993)

A national survey on technology abandonment found that 29.3% of all devices obtained were abandoned (Phillips & Zhao, 1993).

Activity 17 – Assistive Device Training

Select an assistive device that your Allied Health Professional regularly prescribes e.g. long handled aid such as a dressing stick or an over toilet frame. Assume that the Allied Health Professional has already prescribed the device and given some preliminary education. They have asked you to follow up with the patient and provide more education on the device use including the handout and information on where they can purchase the device from.

With a work colleague, practice explaining the use of the assistive device to them. The purpose of the activity is to practice rapport building and also to integrate the tips for improving compliance.

Be sure to include the following points:

- Make the client feel at ease
- Explain why the device is being prescribed and how to use it
- Explain what to do if something goes wrong with the device
- Explain the use of the device in the client's home context

If your work setting allows, it would be good to practice the above on an actual client. Discuss this with your Allied Health Professional to see if there are any opportunities. You may ask the Allied Health Professional to watch and provide some feedback on how you went.

Reflect on your explanation on the use of the assistive device. List at least two (2) things in each column of the table below.

Things I did well	Opportunities for improvement

Non-Compliant Patients

A non-compliant patient is one that refuses or fails to comply with recommendations given to them. However, keep in mind that all patients have the right to decline any intervention or assistive device.

What do you do with a non-compliant patient? Here are some specific examples of non-compliance and what you can do about it:

- Language barrier – obtain an interpreter. In some cases there may be a family member who can assist but this isn't the optimal solution as they have a vested interest in the patient. Also, people are sometimes less likely to listen to advice from a family member.

- Cultural barrier – a patient may not value the device you are recommending for cultural reasons. In some cultures it is expected that family members will care for the elderly. This would negate any need for an assistive device that promotes independence.

- Unreliability of the health professional – if a patient is expecting to be seen on a certain day or at a certain time, they may become frustrated or angry with the health professional if an appointment is missed or late. It is important to notify the patient if you are unable to see them on that day or if the appointment will be late e.g. if the visit was to their house and you are delayed, make a phone call to explain the situation.

- Refusing therapy – in this case, it is important to continue talking with the patient and find out why they are refusing to be seen. Then, emphasise the importance or relevance of what you were planning to do with them. Utilising rapport building skills and active listening skills will come into play here.

- Documentation – if a patient is still refusing to be seen or refusing your recommendations and you have explained to them why they need to be seen or take on your advice, it is important to document this thoroughly. It is also important to let the Allied Health Professional know straight away.

Tips for Improving Compliance

- expectation of use – encourage a positive orientation to the device from the outset. For example, while the patient is in hospital, present the expectation that they will be using the device at home (Gitlin 1995, Phillips & Zhao 1993)
- education – ensure the client knows why you are prescribing the device and where to go if there are any problems with the device (Gitlin, Levine, and Geiger, 1993)
- family education – so they can promote the use of the assistive device

- knowledge of the client's goals e.g. if their goal is for independence, the assistive device will facilitate this
- sensitivity to how a person with a disability feels about his or her changing self is important, particularly when the client denies the need for technological assistance (Gitlin, 1995)
- ongoing rapport building in each interaction
- re-evaluation of use – refer for follow-up to determine if the device is still appropriate (Gitlin, 1995)

As an Allied Health Assistant, you will have an integral role in providing some of the education on the device use when it is initially being prescribed. It is important to integrate the tips above into your therapy sessions.

Activity 18 - Reflection

This is a reflection activity. Think about a client you have seen that was non-compliant. Answer the following questions about this client. If you have never seen a non-compliant patient you may like to interview another Allied Health Assistant or an Allied Health Professional about their experiences.

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Give a brief description of the client, what was being recommended and how they were non-compliant.

2. How did this non-compliance make you feel?

Activity continues on the next page

Activity 18 – Reflection (continued)

3. What strategies did you employ to gain compliance? Did they work?

4. Is there anything you would do differently next time?

2.3 Evaluating Client Environment

The client's environment could be hospital, home, school, workplace, or residential care facility. Whatever the setting, it must be assessed to determine if the client will be able to use the assistive device safely.

Knowledge of the Client

It is important to have a thorough knowledge of the client prior to them trialling an assistive device. This information should be provided by the Allied Health Professional at the time of the referral. Allied Health Assistants are to confirm with the Allied Health Professional any specific client needs or abilities.

In particular, it is helpful to know the client's past medical history and premorbid functioning. For example, you may be practicing transfers with a client who is in hospital for a total knee replacement. They may also have a premorbid (pre-existing) upper limb weakness and arthritis in their hands. This premorbid condition will impact on their ability to transfer safely.

Evaluating the Environment

Prior to completing an assessment, it is important to firstly set up and check the assessment area. The following are some general points to consider:

- assess for any physical obstacles or trip hazards e.g. large equipment obstructing access, electrical cords, rugs etc.
- check that the area is accessible especially if the client has a mobility aid. For example, if completing a home visit to check bathroom accessibility and transfers, ensure the client can access the home using their mobility aid, or if there are any barriers to access
- check there are no health and safety hazards: noise, lighting, or extreme weather etc.
- ensure you have knowledge of evacuation procedures and locations, especially if working in an unfamiliar environment e.g. client's home or school
- check that the assistive equipment is in good working order and set up for the individual client prior to the assessment
- ensure assistive devices are clean and safe to use
- have a good knowledge of the assistive device and any measurements or data that may be required to make adjustments. This can be obtained from the product information manual in your workplace or as instructed by the Allied Health Professional

Making the environment safe

The following principles can be applied to any of these settings:

- remove obstacles such as rugs, electrical cords, spills and anything else that may cause the client to fall
- if the device is to be used in sitting, ensure a suitable chair of appropriate height is available
- simplify the environment to keep items used most frequently in an accessible position e.g. relocate items to a level between a person's elbows and knees
- if the environment isn't appropriate, notify the Allied Health Professional and assist in organising a suitable environment for the trial/assessment
- orientate yourself with the evacuation/workplace health and safety procedures, particularly in unfamiliar environments
- clean any assistive device equipment according to infection control principles
- remove any trial equipment that is faulty or not safe

Activity 19 – Environmental Review Part A

You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

You are going to do some hoist training with a patient and their family in your work area. This will take place in two work areas e.g. ADL bathroom or on the wards.

1. Select two areas in your workplace where this would potentially take place and using the checklist below; assess each of these areas to identify any environmental hazards that are present.

Evaluating the Environment Checklist

- ☐ Assess for any physical obstacles or trip hazards e.g. large equipment obstructing access, electrical cords, rugs etc.
- ☐ Check that the area is accessible especially if the client has a mobility aid. For example, if completing a home visit to check bathroom accessibility and transfers, ensure the client can access the home using their mobility aid, or if there are any barriers to access.
- ☐ Check that there are no health and safety hazards e.g. noise, lighting, odour or extreme weather conditions etc.
- ☐ Ensure you have knowledge of evacuation procedures and locations, especially if working in an unfamiliar environment e.g. client's home or school.
- ☐ Check that the assistive equipment is in good working order and set up for the individual client prior to the assessment.
- ☐ Ensure assistive devices are clean and safe to use.
- ☐ Have a good knowledge of the assistive device and any measurements or data that may be required to make adjustments. This can be obtained from the product information manual in your workplace or as instructed by the Allied Health Professional

Activity continues on the next page.

Activity 19 – Environmental Review Part A (continued)

2. List possible modifications that you could perform to make the environment safe for the training to take place.

Key Points

- Gait and balance problems exist when a disease process, trauma, or aging result in the inability to control one's centre of gravity over the base of support in static or dynamic tasks and environments.
- Evaluating each individual phase of the gait cycle enables the physiotherapist to obtain clues into specific muscular weaknesses and shortening. Addressing these issues in a rehabilitation program will lead to a more efficient gait pattern.
- Disability impacts on many levels. At the personal level, various basic life functions are altered. At an interpersonal level, relationships with other individuals change.
- Adjustment to an illness or disability is an individual experience. We are all individuals with different backgrounds, life experiences and personal histories. We have different coping styles and handle situations in different ways.
- Allied Health Assistants need to be aware of the psychological impact of disability due to injury or disease and the types of reactions that people will display. Strategies to assist people in this are active listening, displaying empathy and referring to other team members for support.
- Assistive devices broadly fall into three categories:
    - Assistive devices for mobility/ambulation
    - Assistive devices for activities of daily living (ADL) and self-care
    - Assistive devices for hearing & vision
- Assistive devices are specially designed to promote independence in an individual. They enable an individual to reduce their dependence on others and improve their performance of activities of daily living
- At times, the client will have adverse reactions that may be related to the assistive device being trialled or another factor. This may occur during or after use. The Allied Health Assistant should be aware of these signs and provide feedback to the Allied Health Professional as soon as possible.
- A non-compliant patient is one that refuses or fails to comply with recommendations given to them. There are a number of strategies that the Allied Health Assistant can utilise to work on patient compliance.
- The client’s environment could be in a hospital, their home, school, workplace or a residential care facility. Whatever the setting, the environment must firstly be assessed to determine if the client will be able to use the assistive device safely.

3. Service Provision

This topic covers information about:

- Assistive device Services
- Model of Care
- Scope of Practice

Activities in this topic cover the following essential skills:

- Identify and report adverse effects
- Work under direct and indirect supervision
- Communicate effectively with clients in a therapeutic/treatment relationship
- Communicate effectively with supervisors and co-workers
- Work effectively with non-compliant clients
- Apply time management, personal organisation skills and establishing priorities

3.1 Assistive Device Services

Assistive devices are prescribed by Occupational Therapists to maintain or improve functional capacities of people with disabilities (Buckley, 2009). There are a range of online databases and equipment suppliers who provide information about each assistive device and how to obtain them. Each Occupational Therapy department will have a list of local suppliers of assistive devices.

Assistive Device Companies

Company/Website Name	Web Address
Lifetech (Brisbane based company)	http://www.lifetec.org.au/home/default.asp
The National Public Website on Assistive Technology. Search by function or activity	http://assistivetech.net/
Ableware – Independent living from Maddak Inc	http://www.maddak.com/index.php
Active Forever	http://www.activeforever.com/
Aids for Arthritis	http://www.aidsforarthritis.com/catalog/index.html
Stroke Engine	http://www.strokengine.ca/index.php?page=topic&subpage=patient&id=27

Functional Impact of Disability

The following is a brief overview of some functional difficulties that client's may experience with the following conditions. These examples are not exhaustive and do not relate to all clients. There is also a list of aids that may be helpful for each client group.

Condition	Functional Impact/ Difficulties	Common Aids Used
Total Hip Replacement (including hemiarthroplasty surgery).	Has total hip precautions. For example, not able to flex hip beyond 90 degrees and not allowed to cross the midline as per orthopaedic surgeon's instructions. Not able to sit on low heights e.g. bed, chair, toilet. Not able to bend over for lower limb dressing, washing or to pick items up. Reduced endurance	Crutches, walking sticks or 4WW Over toilet frame Shower chair / stool High backed orthopaedic chair Long handled aids (dressing stick, bath brush, shoe horn, toe wiper, easireacher) Home modifications e.g. rails
Total Knee Replacement	Avoid jumping, sudden jolts and kneeling May still have difficulty transferring off low surfaces. May have reduced endurance initially after surgery	Crutches or walking sticks Over toilet frame Shower chair/stool Home modifications e.g. rails or furniture height adjustments
Back surgery or pain	Avoid sitting for long periods Difficulty bending and reaching May have difficulty transferring off low surfaces May need back brace or have movement precautions	Over toilet frame Shower chair/stool Long handled aids (dressing stick, bath brush, shoe horn, toe wiper, easireacher) Home modifications e.g. rails
Stroke	Extremely variable impact on function May just have difficulty with high level balance or alternatively be wheelchair bound. Difficulty performing ADL's due to reduced mobility/upper limb function Psychosocial impacts e.g.	Mobility aid as recommended by physiotherapist e.g. wheelchair Over toilet frame Shower chair/stool or mobile commode Hoist Positioning aids e.g. foam

Condition	Functional Impact/ Difficulties	Common Aids Used
	depression	wedge, foot drop splint ADL aids e.g. plate guard, sipper cup One handed aids Home Modifications e.g. rails or furniture height adjustments Personal alarm system
Impaired Cognition	Difficulty with short-term memory Impaired planning, money management, Reduced concentration	Pill dispensers External memory aids e.g. alarms, diaries Personal alarm
Cardiac	Reduced exercise tolerance/endurance Increased breathlessness	Over toilet frame Shower chair stool Home modifications
Mental health	Depression Reduced ability to perform instrumental ADL's Anxiety Reduced motivation to complete ADL's	Home modifications e.g. rails External memory aids
Arthritis	Reduced hand strength Reduced in hand manipulation Pain with movement	Personal assistive devices e.g. nail clippers, button hook Home assistive devices e.g. tap turner, jar opener, kettle tipper

Activity 20 – Case Study

Read the Case Study below and answer the question that follows. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Case Study: Norma

Norma is a 67 year-old lady who lives alone in her own townhouse and is usually fit and active. She was cooking in the kitchen when she collapsed onto the floor. Her daughter was visiting at the time and called an ambulance and Norma was taken to the Department of Emergency Medicine (DEM).

Norma was diagnosed as having a cerebrovascular accident (CVA or Stroke), and slowly regained consciousness over the next two days. However, when she woke up, she had the following signs and symptoms:

- paralysis of the right face and arm
- loss of sensation to touch on the skin of the right face and arm
- inability to answer questions but ability to understand what was said to her
- ability to write down her thoughts more easily than to speak them
- very poor standing balance, needing two people to assist her

Considering Norma's presentation and function, what assistive devices do you think would be useful for her at present? List them below.

3.2 Client Care Model

Queensland Health (2000) defines a model of care as; '…a multifaceted concept, which broadly defines the way health services are delivered'. It often describes what service will be delivered, how, by whom, and where the service will be delivered. For example, the 'Rehabilitation Unit Model of Care' for The Prince Charles Hospital, outlines the service that clients and their family can expect from the Rehabilitation Unit.

A model of care may describe:

- what services are provided
- who provides the service (which workforces)
- when the services is provided
- how the service is provided

(Queensland Health, 2000)

There are many theories and concepts that drive the general approaches a team will take to rehabilitation. Some are concepts which cross all allied health professions and relate to the idea of rehabilitation in general. Each profession will have their own models and theories from which they work, which is the basis for the differences between the professions and their approach to solving a problem (Pedretti, 1996).

Often, you will operate in a service that follows multiple models of care. Specific model(s) will differ between work settings, so remember to ask the supervising Allied Health Professional to clarify which models are used.

Rehabilitation Model

This model emphasises working with a person on their ability to live and work with remaining capabilities. A patient will be assisted to learn how to work around or compensate for physical, cognitive and perceptual limitations. The focus is on performance areas or occupations such as self-care, leisure and work. There will be less attention to the components that are used to complete performance such as thinking skills or physical abilities.

Using this model, a therapist will work on minimising barriers to role performance such as the physical environment or equipment design. An example of this would be changing the kitchen bench height so a person in a wheelchair can reach to do the

cooking. This approach is often used in combination with other models, for example, a biomechanical model. It is always important to consider the potential for improvement in a person's abilities. A biomechanical model would look at a person's physical abilities and how to improve them. For most patients, restoration of sensorimotor, cognitive and psychosocial functions is required to improve function.

Occupational Therapy Models of Practice

There are a number of different Occupational Therapy models of care, and again, the specific model used will differ between service areas. Some of the models are: The Occupational Performance Model (Australia), The Model of Human Occupation and the Canadian Model of Occupational Performance.

One thing that all of these models have in common is that they view the health of a client as being influenced by many factors including; environment (physical, social and cultural), personal skills and abilities (cognitive, physical, emotional and spiritual) and the task which they aim to perform.

Occupational Therapy models focus on the interaction and balance between the many factors that affect a person's ability to complete a task or perform their chosen 'occupation'. Occupations are often grouped into self maintenance, leisure and work. Self maintenance refers to daily living tasks such as paying bills, managing money, using the telephone, getting around and etc. (Christiansen, Baum & Bass-Hauge, 2005).

Leisure consists of things people do for pleasure including hobbies, sports and reading. Work or productive occupations covers paid or volunteer work, and may include tasks like driving, typing, and communicating with other people.

The models may vary in their view of exactly how the different aspects of people's lives can interact. Aspects of life that are acknowledged in most models include:

- the environment (physical, cultural, social and time)
- the person's abilities, skills or life stage (cognitive, physical, emotional and spiritual)
- the task or occupation (self care, productivity and leisure activities)

All these parts of a person's life interact with each other and a problem in one area can affect all other areas of a person's life. For example, being in pain can mean a person becomes depressed. They may then not bother showering or grooming themselves as well as usual. This can affect relationships with other people, performance at work, or motivation to participate in hobbies.

Similar frameworks are used to analyse a person's performance of their occupation or a task, to identify problem areas such as why someone can't pick up a cup. Your analysis of the situation may include exploring the following ideas:

- is it because they don't want to pick up a cup and drink independently?
- if they are ill, does their cultural background tell them that their family should be doing that for them?
- are they too weak to pick up the cup or can they not see well enough to reach it?

The framework will then be used to plan how to improve performance of a specific task or skills (Pedretti, 1996; Polatajko & Townsend, 2007).

Client Centred

Client-centred practice involves a partnership between you and your client, which promotes client participation in decisions regarding the service they receive (Community Services and Health Industry Skills Council, 2009). It has an important role in rehabilitation as it encourages clients to work towards goals which they have themselves identified.

Ideas for using a client-centred approach to engage clients in a group setting may include asking individual participants about their interests, skills or previous experiences.

When you carry out your work that adheres to the client-centred approach, clients will feel in control of their health care and motivated to participate to their full potential (Community Services and Health Industry Skills Council, 2009).

Goal-Directed

As mentioned above, Queensland Health promotes client participation in all facets of their health care including goal setting.

By assisting clients to set goals, you will need to consider whether the goal is SMART:

Specific – clearly set out and includes the who, what, when, where and why

Measurable – so that you and the client are able to monitor and track their progress

Attainable or Attractive – within likely reach and appealing to the client

Realistic – the client is willing and able to work towards

Time-based – a timeframe for the client to achieve the goal

Example of a SMART goal

Specific	Walk to the dining room independently.
Measurable	Walk for 10 minutes. Other measurable variables could include distance mobilised.
Attainable or Attractive	Agreed goal between the OT and client. Patient is currently able to do this in 12 minutes.
Realistic	Client-focussed goal.
Time-based	By the end of the week. This gives the client adequate time to practice and improve the skill.

The Interaction of Models

As most healthcare services will employ more than one model of care, you will need to understand how models of care link up with one another. The model below shows an example of how several models of care overlap with each other to shape the service that clients receive.

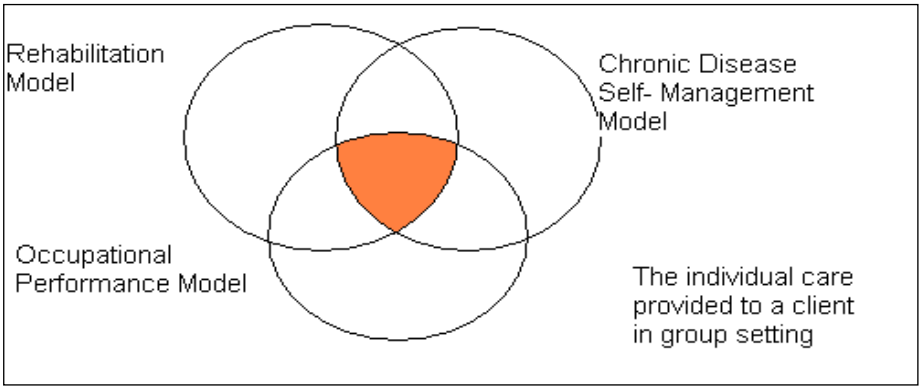


Figure 5 Interaction of Models

It is important note that the models are not always equally aligned. In some services, one model might be more central than others.

Some additional models of care that you may encounter in group work include:

- Case management model
- Slow stream rehabilitation
- Allied health assistant model (still in draft form at present)

Activity 21 – Question and Answer

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Imagine you work in a setting where therapy and intervention wasn't client centred. Discuss:
   a) The implication of this on patients
   b) The benefits of using client centred models when panning interventions
   c) How do you ensure your treatment is client centred

2. You are working with a client who has reduced fine motor coordination in their left hand. This client has difficulty with dressing tasks (buttons, zips), handwriting, and cooking tasks (opening packages, using cutlery). Write 3 SMART goals for this patient.

3.3 Scope of Practice

Scope of practice is the range of responsibility, e.g. types of clients, duties and practice guidelines that determine the boundaries within which an Allied Health Assistant works. All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice.

The activity should be an activity that the Allied Health Assistant is trained, competent and authorised to perform. All delegated tasks must be appropriate for the Allied Health Assistant's role description and responsibilities. It is the responsibility of the Allied Health Assistant to inform the Allied Health Professional if they feel a task is outside their scope of practice.

As an Allied Health Assistant, your role will be varied depending on which profession/s you are assigned to assist. In general, the Allied Health Professional will assess the patient and design programs for you to carry out. Clarifying exactly what is and isn't your job may take a little while to work through when you first start. Your job description and the instructions of staff should give you a clear idea. However, in rehabilitation, there is often no clear end to how much can be done for a patient, which can cause confusion and stress for staff. There is often a lot that can or should be done for a person but limited time to do it in.

A clear timetable or schedule and checking in regularly with your supervisor/s can help you to manage your time. Learning to politely but assertively say 'no' may be necessary at times, particularly if you have a number of different supervisors to work with. An explanation of why you don't have time such as having other commitments, and an offer to negotiate another time or way to complete the task is usually helpful.

The ability to work efficiently and learning to prioritise the most important tasks is often the key to succeed in an Allied Health Assistant position.

Tasks you may be expected to do:

- arrange for patients to complete checklists or help them fill out self-report type assessments and forms
- complete administration tasks such as filling out equipment application forms
- prepare for and run individual or group therapy sessions, with program designed by Allied Health Professional
- make minor changes to therapy programs as required or with guidance from Allied Health Professional
- feedback on patient condition or success of therapy sessions to Allied Health Professional

- order and maintain equipment, supplies and tidy work areas
- complete ADL re-training activities with patients
- monitor patient progress in therapy programs
- accompany therapists on and assist with home visits
- apply assistive aids to patients
- arrange for equipment prescribed by Allied Health Professional
- provide education to patients and families, including practicing patient care with them e.g. dressing and transfers
- attend department meetings and in-house training sessions
- contribute to department quality improvement activities

In relation to the fitting of assistive devices, the Allied Health Assistant's role may include the following:

- confirm assistive device details and fitting requirements against the prescribed information provided by the health professional e.g. case notes, treatment plan etc.
- prepare the setting for the fitting and any required handouts to facilitate instruction for use
- confirm the suitability of fit, size and operation meets expected performance parameters and prescription and conforms to the manufacturer's guidelines
- provide basic education to the client (and carer) on the safe use, transportation, and maintenance of the assistive device ideally within the context of the user environment
- identify incorrect use and give verbal feedback and physical guidance where necessary
- monitor the effectiveness of the assistive device and report any problems to the appropriate person in a timely fashion i.e. Allied Health Professional
- report any adverse effect, client concerns and major progress to the appropriate member of the care team e.g. multi-disciplinary team meeting, case conference etc.
- liaise with health care providers within the immediate team
- complete documentation as directed by the Allied Health Professional in client records/care plans according to organisational guidelines and legal requirements
- clean and store assistive device after use in accordance with manufacturer's recommendations, and the organisation's protocols
- report suggested adjustments to assistive device together with rationale to the responsible Allied Health Professional
- organise or perform any maintenance work for faulty assistive devices

Queensland Health's Public Patients Charter

The Australian Charter of Healthcare Rights booklet will assist you with outlining to the client both of your rights and responsibilities. You will need to ensure your client has received a copy of the brochure and understands their rights and responsibilities at the start of their treatment program.

Copies of The Australian Charter of Healthcare Rights can be found on: https://www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights/

This document is supported by Queensland Health.

Ensure your client has received a copy and understands their rights and responsibilities.

Queensland Health (2008) Models of Care draft role description outlines that the purpose of the Allied Health Assistant is to '…contribute to patient care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'. This explanation of the Allied Health Assistant role highlights some important issues regarding the Allied Health Assistant scope of practice:

- delegation
- supervision
- role within the health care team
- personal organisational skills

Delegation

Working alongside Occupational Therapists (OT) to assist clients to achieve their individual outcomes, will include the OT delegating tasks to you. When delegation occurs, both Allied Health Assistants and Allied Health Professional have responsibilities. The table below summarises some of these responsibilities.

AHA Responsibilities	AHP Responsibilities
• must have the appropriate level of experience and competence (i.e. skills and knowledge) to carry out the activity and the activity should be within the scope of the allied health assistant role. • has responsibility for raising any issues related to undertaking the delegated task, and should request additional information and/or support as required • should be aware of the extent of their expertise and scope of practice at all times and seek support from allied health professionals as required • shares responsibility for raising any issues and requesting additional support throughout the delegation and monitoring process.	• establishes diagnosis, clinical management and treatment plans • should only delegate activities that are within the scope of their own professional practice and • that they are competent to assess, plan, implement and evaluate • must only delegate activities that are within the scope of practice and level of competency, • previously demonstrated experience and/or training and qualifications of an AHA • should determine whether it is appropriate to delegate a task to an AHA and only delegate • If/when it is appropriate is able to provide the type and frequency of monitoring (i.e. task supervision) the activity requires.

(AHA Framework, AHPOQ, 2016)

At no time should you be requested or required to undertake a task that is outside your level of competence or that is not identified by the Allied Health Assistant position description.

Supervision

Supervision refers to the monitoring, advice or instruction from another person to ensure optimal healthcare is provided to clients. The Allied Health Professions Office of Queensland (APHOQ) Allied Health Assistants Framework state that:

- AHA positions are to be clinically supervised by an allied health professional.
- AHA positions will have a designated clinical supervisor.
- Formal supervision sessions will be documented in accordance with local requirements.
- Clinical supervision may be direct, indirect and/or remote.

The two forms of supervision most commonly experienced by Allied Health Assistants are ‘formal’ and ‘informal’ supervision.

Also known as professional supervision (Queensland Government, 2011b), clinical supervision can be defined as a formal process of support and learning that involves:

- developing a mutual commitment between the AHA and allied health professional to reflect on the clinical practice of the AHA
- developing knowledge and skills competence
- clarifying boundaries and scope of practice
- planning and using personal and professional resources
- identifying training and education needs
- developing accountability for work quality (Queensland Government, 2010a).

Though an assistant should only have one primary clinical supervisor, there may be several allied health professionals of the same or different disciplines who delegate tasks to the assistant (Queensland Government, 2010b).Clinical supervision should be undertaken by an allied health professional although a senior AHA may co-supervise in collaboration with an allied health professional in some work units. Where an AHA is new to the service and/or the particular clinical area, they will initially require more frequent clinical supervision. It is the responsibility of the supervising and/or delegating allied health professional (potentially the same person) to:

- assess and verify the AHA's competency within the clinical context
- define and clarify the tasks to be undertaken by the AHA within their scope of practice
- ensure the AHA has a clear understanding of the tasks to be undertaken within that context.

Delivery of clinical supervision

Clinical supervision can be delivered either directly, indirectly or remotely:

• Direct clinical supervision occurs when the supervising allied health professional:

– works alongside the AHA

– observes and directs the AHA's activities

– provides immediate guidance, feedback and intervention as required.

• Indirect clinical supervision occurs when the supervising allied health professional:

– works on-site and is easily accessible, but not in direct view of the AHA while the activity is being performed—the AHA must rely on clear communication from the supervising allied health professional

– is readily available within the same physical area or easily contactable (i.e. by phone or pager) should the need for consultation arise

– designates an alternative contact person (should the need arise) if they will be unavailable.

• Remote clinical supervision occurs when the supervising allied health professional:

– is located some distance from the AHA

– is contactable and accessible to provide direction, support and guidance as required (e.g. telephone or video-conferencing).

(AHA Framework, AHPOQ, 2016)

Working with your supervisor

Communication – Regular communication is the key. Work out with your supervisor the best method of communicating with them. Have an agreement around how often, what method, and where you will meet to communicate.

For example, try:

- telephone, e-mail or weekly meetings if you are at different sites
- use set forms or leaving notes or reports for each other. Make sure there is a special place e.g. desk, pigeon hole, or in-tray to leave any written information
- regular meetings with your supervisor/s to review what you are doing. This provides an opportunity to raise any questions or issues before they become a big problem. It can also be a chance for you to show how much you have achieved. In addition to a regular whole team meeting, try a quick scheduled catch up each morning just with your supervisor

- be aware that your supervisor is not a mind reader - state any concerns clearly as they come up
- if in doubt, ask
- if instructions are not clear to you, ask for clarification or repeat back to check if you have heard or understood correctly

Examples of inconvenient times to try and speak with your supervisor are:

- when they are clearly busy with a client, staff member or task
- right at the end of the day as they are walking out the door
- when they do not have the time or resources available to answer your questions

It may be okay to ask a simple question of someone working with a client, but this is not the time for long complicated questions or reporting a non-urgent problem. In particular, you must not discuss one client in front of another as this is a breach of confidentiality.

For urgent matters, know who else you can contact and how, should your supervisor be unavailable. In terms of what to tell your supervisor, the level of detail they need to know will vary depending on what you are doing. It may take some negotiation with your supervisor over time to establish exactly what they like to know. Each supervisor, Allied Health Assistant and situation will be different.

Key points to report will generally include:

- any risk to, or concerns about safety
- sudden changes, whether in a client's condition, abilities or your roster or demands on your time
- specific commitments e.g. a day off training with another profession
- need for training or if you are not confident with a technique or treatment you have been asked to use
- treatment programs requiring adjustment, whether because they are too easy or too difficult for clients
- queries about prioritisation of tasks and which are most important

Additional information regarding the Queensland Health Allied Health Assistant Framework can be found on the website:
https://www.health.qld.gov.au/ahwac/html/ahassist

Feeding Back About Patients

When providing feedback about patients; clear and concise is best. Plan or think about what you will say prior to feeding back to your supervisor. Try to avoid vague and

irrelevant details. For example, if reporting a chat with a patient you may report that Mrs G is desperate to go home rather than adding in exactly what she said about her cat and how cute he is.

Consider what your supervisor needs to know – usually this is about the general progress of a patient and any changes to their condition. At times specific details may be very significant e.g. if a person could find the items to make a cup of tea without help or not. Your Allied Health Professional should tell you ahead of time which specific details matter and what to watch for, or they may ask for more detail if required.

Activity 22 – Question and Answer

Answer the following questions. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. Do you have set times to catch up with your supervisor? Is that enough? Is it at a convenient time?

2. Who do you contact in an emergency if your supervisor is unavailable?

Activity continues on the next page

Activity 22 – Question and Answer (continued)

3. What is an example of something you would report to your supervisor straight away?

4. Who would you discuss taking recreation leave with, and who would you have sign off the paperwork to approve it?

Working in Care Teams

In your role as Allied Health Assistant, you may find yourself involved in a number of teams at any one time. This may include a ward team, occupational therapy departmental team and a professional team of Allied Health Assistants.

You will find your role varies within each team, but certain behaviours and skills will be necessary for you to be successful in each role. The teams will not be exclusive to client care. You may also find yourself involved in teams relating to projects and your department.

The most common models of teams in healthcare are:

- **The multi-disciplinary team** – In this team health professionals each perform individual assessment and management strategies. Their recommendations are then pooled together to make an overall plan for the client.
- **The inter-disciplinary team** – In this team all health professionals consult with one another at all stages including assessment, planning and evaluation.
- **The trans-disciplinary team** – In this team, one team member acts as the primary therapist, and other team members provide advice and information through the primary person.

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2009)

Most commonly you will find yourself working within the multi-disciplinary team model within the healthcare setting.

Multi-disciplinary Team

A multi-disciplinary team (MDT) is a group of health professionals who meet to discuss all relevant treatment options and develop an individual treatment plan for each client. This joint approach allows the team to make decisions about the most appropriate treatment and supportive care for the client while taking into account the individual client's preferences and circumstances.

Teams can consist of medical staff, nursing staff, social workers, dietitians, speech pathologists, physiotherapists, occupational therapists and Allied Health Assistants (The Cancer Institute NSW, 2010).

Generally, each discipline conducts an independent assessment of the patient. Then each discipline develops their treatment plans independently. One person, usually the physician, orders the services and co-ordinates the care. There may be meetings to discuss progress, however often there is little direct communication amongst team members. Team members work in parallel with one another and often the medical

chart serves as a vehicle to share information (Geriatric Interdisciplinary Team Training, 2001).

It is important for you to understand your tasks and responsibilities within each team you are involved in. Where appropriate you will need to lead departmental and team meetings, case conferences as well as other team projects and activities.

When an OT is unable to attend a case conference you may be required to attend in their place. To assist with this, the OT will provide you with the relevant information for each client. You will need to be able to interpret the information and present it in a manner that is meaningful to the team.

Team Member Roles

Medical practitioners or doctors (MD):

- diagnose, treat and assist in the prevention of human physical and mental illness, disease and injury and promote good human health
- are involved in a wide range of activities including consultations, attending emergencies, performing operations and arranging medical investigations
- work with many other health professionals

Nursing staff (NUM, RN and EN):

- provide care for clients in a variety of healthcare settings
- provide physical and technical care and support for clients
- take part in the daily ward round with other nurses, doctors and allied health
- ensure clients receive treatment prescribed by health professionals
- provide emotional and psychological support and information to clients and their families

Occupational therapists (OT):

- work with people of all ages with a variety of conditions caused by injury or illness, psychological or emotional difficulties, developmental delay or the effects of aging
- their goal is to assist individuals to improve their everyday functional abilities and enable independence, well being and quality of life
- help clients maximise function and enable participation in their own lives

Physiotherapists (PT):

- provide treatment for people with physical problems caused by injury, illness, diseases and ageing

- use a range of treatments including mobilisation and manipulation of joints, massage, therapeutic exercise, electrotherapy and hydrotherapy to reduce pain, restore function and improve an individual's quality of life

Speech pathologists (SP):

- assess, diagnose, treat and provide management services to people of all ages with communication and/or swallowing impairments
- work with people of all ages who have difficulties swallowing food and drink
- people seek the assistance of a speech pathologist if they have speech, language, voice or fluency difficulties which impact on their ability to communicate effectively

Social workers (SW):

- provide information, counselling, emotional and practical support
- their primary concern is to address the social and psychological factors that surround clients' physical and/or medical presentations
- also provide assistance with resourcing care packages, information and referral to community services, advocacy and practical assistance

Dietitians (Diet):

- health professionals who improve the health of individuals, groups and communities by applying the science of human nutrition
- use their skills and knowledge to modify diets to treat medical conditions, and to advise other health professionals about the role of diet in health care, as well as educate the general public about eating for health

Psychologists:

- are experts in human behaviour, personality, interpersonal relationships, learning and motivation
- play an important role in helping individuals to enjoy and improve their quality of life by assisting in the management of many common mental health disorders, and by equipping people with the skills needed to function better and to prevent problems.

(Queensland Health, 2008)

Allied Health Assistant Role within Care Team

Allied Health Assistants are an integral part of a multi-disciplinary team (MDT) and often off act as a 'lynch pin' within the team. This tends to occur when the Allied Health Assistant works collaboratively with multiple Allied Health Professionals. Communication between you and the rest of the team is a vital component for effective team work.

Key responsibilities as a member of a care team:

- have a good understanding of the roles of your colleagues, both Allied Health Assistant and Allied Health Professional
- maintain regular feedback to Allied Health Professionals regarding patient progress
- provide regular feedback to Allied Health Professional regarding your workload levels (are you run off your feet or could you potentially take on additional responsibilities?)
- maintain positive relations including open and honest communication and a constructive climate for discussion
- demonstrate a commitment for the team
- have organised procedures

Effective communication is the ability to convey your message to other people and have that message understood without any misinterpretation. The information transferred should:

- include all relevant data
- be accurate
- be unambiguous
- occur in a timely manner

This information enables actions to be taken to provide the care that a client needs. When providing feedback to the OT and the team about a client, it is important that you are able to provide a summary of the key points relating to your contact with the client. You will need to be able to identify what information is important to the continuing care of the client.

When appropriate, this may include attending ward team meetings and ward rounds with the team to assist with discharge planning and equipment, patient education and home visits. You may also need to report back to the multi-disciplinary team and departmental team meetings as a representative of Allied Health Assistants.

Occasionally you may be required to provide feedback regarding a client's progress during team case conferences. The Allied Health Assistant Model of Care outlines that when an Allied Health Professional is unable to be present at case conference, the Allied Health Professional must supply or pre-approve the feedback that the Allied Health Assistant is to provide at the case conference. The Allied Health Assistant needs to be able to interpret the information and present it in a meaningful manner to the team.

Limitations of Role

The Allied Health Assistant should discuss with the Allied Health Professional if the delegated tasks are outside scope of role and responsibilities as defined by the organisation (role description). This may occur for a number of reasons:

- lack of understanding of the role (by the AHA or the AHP)
- the Allied Health Assistant may be new to the job and not have had all the required training.
- the Allied Health Professional may have worked in another setting where the Allied Health Assistant role was different.

This communication is to ideally take place as soon as scope-of-practice issues come up. However, it may be appropriate to discuss these issues in a formal meeting.

Non-clinical Responsibilities

Managing a complex environment of teams requires good non-clinical skills such as time management, personal organisation and prioritisation.

Time Management – This can be anything you do to organise your time in your day. Suggestions to assist with this include:

- plan and schedule activities e.g. use a diary and schedule in routine activities such as ward meetings
- delegate effectively
- be efficient e.g. one task at a time, handle paper and e-mails once only and learn to say ‘no’ when it is appropriate
- control the small things such as talking, day dreaming and over debriefing

Personal Organisation – Organise yourself both now and in the future. Strategies to assist with this include:

- effective scheduling e.g. block in essential tasks to complete your job, schedule in high priority tasks and ensure contingency time to handle interruptions
- use ‘to do’ lists
- action planning for the day, week and year prioritising what you need to achieve

Prioritisation – Determine which tasks need to be achieved and manage competing demands. Strategies to assist with this may include:

- scheduling as outlined above
- use of prioritisation policies and procedures
- recommendations from OT

(Queensland Health Statewide Occupational Therapy Clinical Education Program, 2009)

Activity 23 - Working with a MDT Part A

Respond to the following activity. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

From a multi-disciplinary team (MDT) perspective draw a flow chart that illustrates your role within your MDT. Include yourself and clients in this model as well as Allied Health Professional, line mangers, dietitians, nurses etc. In this flow chart indicate who you have direct and indirect supervisory responsibilities to.

Activity continues on the next page

Activity 23 - Working with a MDT Part B (continued)

The following is an observation activity to see how effective your team is. Complete the activity after attending a team meeting. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Team Observation Tool	
Team:	Date:
Does this team have an apparent goal?	☐ Yes ☐ No
What it the goal?	
Professional Goals	
Circle the disciplines attending the meeting	MD SW NUM RN Diet SP OT PT
Do team members appear knowledgeable about their roles?	☐ Yes ☐ No
Do team members appear knowledgeable about the roles of other disciplines?	☐ Yes ☐ No
Are there disciplines participating in the team with whose roles you are not familiar with?	☐ Yes ☐ No
If so which ones?	
Leadership	
Who is (are) the team leader(s)?	
Does the leadership change during the meeting?	☐ Yes ☐ No
What behaviours do the leaders use (summarising, initiating…)?	

Activity continues on the next page

Activity 24 - Working with a MDT Part B (continued)

Communication and Conflict	
Is there any open sharing of information?	☐ Yes ☐ No
Note any barriers to communication you observe (side conversations…)	
Is there an opportunity for differences of options to be discussed?	☐ Yes ☐ No
What are the examples of conflict?	
How were they handled?	
Meeting Skills	
How is the meeting organised? (agenda)	

Activity continues on the next page

Activity 24 - Working with a MDT Part B (continued)

Outcome	
What was accomplished or produced during the meeting?	
Are decisions and next steps clear?	☐ Yes ☐ No
Was the meeting efficient? Why	

(Long & Wilson, 2001).

Key Points

- Assistive devices are prescribed by Occupational Therapists to maintain or improve functional capacities of people with disabilities. There are a range of online databases and equipment suppliers who provide information about each assistive device and how to obtain them

- A 'model of care' is a concept, which broadly defines the way health services are delivered. It can therefore be applied to health services delivered in a unit, division or whole of District

- Queensland Health Models of Care (draft role description) outlines that the purpose of the AHA is to '…contribute to patient care by providing clinical support tasks delegated under the direct or indirect supervision of an AHP'

- All care delivered by an Allied Health Assistant needs to be within that individual's scope of practice

- AHA scope of practice:
    - Supervision
    - Delegation
    - Role within the health care team
    - Personal organisational skills

- Scope of practice is the range of responsibility, e.g., types of clients, duties, and practice guidelines that determine the boundaries within which an Allied Health Assistant works. The Allied Health Assistant should discuss with the Allied Health Professional any tasks that are not within the scope of their role and responsibilities

- Multidisciplinary Team may include medical staff, nursing staff, social workers, dietitians, speech pathologists, physiotherapists, occupational therapists and Allied Health Assistants

SELF-COMPLETION CHECKLIST

Congratulations! You have completed the topics for Occupational Therapy Learner Guide: Support the fitting of assistive devices.

Please review the following list of knowledge and skills for the unit of competency you have just completed. Indicate by ticking the box if you believe that you have covered this information and that you are ready to undertake assessment.

Support the fitting of assistive devices

Essential Knowledge	Covered in Topic
Knowledge of how to evaluate the user environment and the importance and methods of making the environment safe for use of the assistive device	☐ Yes
Principles associated with fitting and using specific devices, or where to access information relating to the range of assistive devices, associated systems and purpose	☐ Yes
Knowledge of how to fit, test and adjust assistive devices to meet individual needs, including the range of measurements required to prepare a specification for modification or adjustment to the original prescription	☐ Yes
Knowledge of the principles of movement, mobility, posture management and special seating, including an understanding of balance and gait	☐ Yes
Organisation procedures in relation to assistive devices, including repairs, ordering specific assistive device and modifications	☐ Yes
Knowledge of the range, associated systems and purpose of assistive devices	☐ Yes
A working understanding of the psychological effects of disability due to injury or disease and strategies used to cope with this	☐ Yes
A working understanding of the signs of adverse reaction to different programs and treatment	☐ Yes
Relevant National and State/Territory legislation, guidelines and reporting requirements	☐ Yes

Essential Knowledge	Covered in Topic
Roles, responsibilities and limitations of own role and other allied health team members and nursing, medical and other personnel	☐ Yes
A working knowledge of factors that facilitate an effective and collaborative working relationship	☐ Yes
A working knowledge of record keeping practices and procedures in relation to diagnostic and therapeutic programs/treatments	☐ Yes
OHS policies and procedures that relate to the Allied Health Assistant's role in implementing physiotherapy mobility and movement programs	☐ Yes
Infection control policies and procedures that relate to the Allied Health Assistant's role in implementing physiotherapy mobility and movement programs	☐ Yes
Supervisory and reporting protocols of the organisation	☐ Yes
Basic knowledge and understanding of equipment used to support clients with disability, illness and injury	☐ Yes

Activity 24 - Questions

For this task you are required to answer questions that relate to your work as an Allied Health Assistant assisting with the fitting of assistive devices. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

1. How should assistive devices be cleaned?

2. What aspects should be considered when fitting assistive devices?

Activity continues on the next page

Activity 24 - Questions (continued)

3. How can you find information about how to correctly fit an assistive device?

Activity 25 - Scenarios

For this task you are required to read and respond to the three scenarios provided. You may use the space provided below to write down a draft response. Record your final answer in the Assessment Guide.

Scenario 1

You are fitting a client's bath with a shower chair; however, you are aware that the chair does not fit the shower recess.

What do you do?

Activity continues on the next page

Activity 25 – Scenarios (continued)

Scenario 2

You have been asked to educate a client about the benefits and safe use for an over toilet aid to assist the client with safe toilet transfers. The client refuses to use the equipment, reporting they do not need any help.

What do you do?

Activity continues on the next page

Activity 25 – Scenarios (continued)

Scenario 3

You have been asked to see five clients in one afternoon. All clients need to be seen for installation/fitting and education on different assistive devices. You are aware that time may be an issue as you also have an important meeting you must attend

How do you manage your caseload?

Activity 26 - Workplace Observation Checklist

You will be observed providing support and fitting assistive devices appropriate for individual clients. The learner may choose from the following assistive devices:

Bathroom device (for example shower chair, over toilet aid or a bath board)

Handrails (for example in the bath / shower, next to the toilet, or at a doorway)

Activities of daily living aids (for example spike boards or one handed bread board)

You will need to assist with the rehabilitation of clients on at least two occasions to demonstrate competence.

Activity continues on the next page

WORKPLACE OBSERVATION CHECKLIST

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initials	2nd observation date & initials	Comments	FER
Prepare for fitting of assistive device				
• Demonstrates an understanding of the purpose /role /benefits of the assistive device				
• Demonstrates an understanding of how to correctly fit and use the device				
• Liaises with OT regarding client's current function (including cognitive, physical and psychological)				
• Collects assistive device (including following hospital / centre guidelines e.g. ensure to sign the device out, inform relevant staff)				
• Obtains client's consent prior to fitting device				
Fitting the assistive device				
• Ensures assistive device is safe and appropriate for client to use				
• Shows device to client and explains the purpose / role /benefits of this device				
• Checks the device is the appropriate size for the client and the physical environment				
• Checks the environment is safe and follows OHS policies and procedures				
• Fits / installs the device appropriately and correctly (in accordance with the device's fitting instructions and guidelines).				
• Tests device prior to clients use				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initials	2nd observation date & initials	Comments	FER
• Adjusts device or obtains another device if it is unsafe to use or the wrong size for the client				
• Uses appropriate communication with the client and maintains appropriate client – therapist relationships				
Support the client to use assistive device				
• Provides client with education and instructions on how to safely use the device (including visual demonstrations for safe transfers / safe use and written information.				
• Provide education to family / significant others if necessary).				
• Provides education on how to correctly care and clean the device.				
• Allows client the opportunity to demonstrate safe use of the device under their supervision (e.g. client to complete transfers under supervision)				
• Provides clients with education on the benefits of using this device				
• Monitors client's use of device and ability to use safely and effectively with a trail period.				
• Liaises with OT if it is determined that the device is not suitable for client.				
• Provides information to clients on where to obtain device if a suitable option (hire / purchase this device)				
Clean and store assistive devices after use				
• Cleans any equipment as required by hospital/ centres				

Essential Skills and Knowledge The learner demonstrates the following skills and knowledge	1st observation date & initials	2nd observation date & initials	Comments	FER
policies and procedures				
• Ensures devices stored in an appropriate place whilst not been used by the client (i.e. in a safe storage place so it is not an OHS risk)				
• Returns equipment to correct location once finished, including liaising with appropriate others and signing in of device				
Report and document information				
• Liaises with OT /team regarding outcomes of the above processes				
• Documents all interactions with the client in case notes/ medical records (including client's ability to use device, any difficulties, compliance with device)				
• Documents and report any broken devices				

*FER – Further Evidence Required

RESOURCES

Wheelchairs

Manual Wheelchair Features:
https://lifetec.org.au/education/fact-sheets/manual-wheelchair-features-0

Measuring for a Wheelchair and prescription form:
https://www.health.qld.gov.au/__data/assets/pdf_file/0026/429911/manual-wheelchairs.pdf

Hoists

Hoist Selection - Review the Government of South Australia's information for prescribers on hoist selection:
http://www.des.sa.gov.au/__data/assets/word_doc/0015/20931/hoists-clinical-considerations-for-prescribers.doc

Slings – Review the Government of Australia's guideline on slings:
http://svc015.wic006wss.serverweb.com/Shared%20supporting%20documents/Slings%20-%20Clinical%20considerations%20for%20prescribers.doc

GLOSSARY

Word	Definition
Activities of Daily Living	The things a person normally does in daily living including any daily activity performed for self-care (such as feeding, bathing, dressing, grooming), work, homemaking and leisure
Asepsis	The state of being free of living pathogenic micro-organism
Aseptic Technique	A procedure used to reduce the number of micro-organisms and prevent their spread e.g. dressing technique
Balance	A biological system that enables us to know where our bodies are in the environment and to maintain a desired position. Normal balance depends on information from the inner ear, other senses (such as sight and touch) and muscle movement
Cerebrovascular Accident (CVA)	The sudden death of some brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain. A CVA is also referred to as a stroke.
Chickenpox	Chickenpox (varicella) is a highly contagious viral disease caused by varicella-zoster virus (VZV). The main symptom is a blistering skin rash.
Clinical Incident	Any event or circumstance which has actually or could potentially lead to unintended or/or unnecessary mental or physical harm to a patient of a Queensland Health service facility.
Extended-Spectrum	Extended-Spectrum Beta –Lactamases (ESBLs) are enzymes that can be produced by bacteria making them resistant to cephalosporins eg. Cefuroxime, cefotaxime and ceftazidime which are the most widely used antibiotics in many hospitals.
Gait	Human locomotion or the manner of walking
Hepatitis A, B & C	Hepatitis is inflammation of the liver. It has a number of different causes, but eh most common is damage by a virus. Hepatitis B is one of the viruses which can damage the liver. Others include the hepatitis A, C, D and E viruses
Human Immunodeficiency Virus (HIV)	A virus that attacks the body's immune system
Infection	Invasion by and multiplication of pathogenic microorganisms in a bodily part or tissue, which may produce subsequent tissue injury and progress to overt disease through a variety of cellular or toxic mechanism.
Influenza	Influenza ('the flu') is caused by infection and influenza viruses A, B, and rarely C. It mainly affects the throat and lungs, but can also cause problems with the heart and rest of the body, especially in people with other health problems.
Immunisation	Immunizations are administrations of substances which protect a person from becoming infected by particular pathogens (bacteria, viruses etc).
Measles	Measles is a very infectious illness caused by a virus – the rubella virus. Measles symptoms invariably include fever,

Word	Definition
	together with at least one of the three Cs – cough, coryza (runny nose) or conjunctivitis and a rash.
Methicillin resistant Staphylococcus Aureus (MRSA)	Staphylococcus aureus are bacteria (germs) often call 'staph' or 'golden staph' that live harmlessly on the skin and in the nose. 'Staph' may cause infections on broken skin or wounds. Methicillin is an antibiotic used to treat serious infections caused by 'staph'. MRSA is a 'staph' bacteria that has become resistant to, and cannot be destroyed by Methicillin.
Microorganism	Very small organisms size belonging to various groups: bacteria, fungi, protozoa, algae & viruses characterised by their non-cellular structure. Microorganisms were observed for the first time in 1674 by Van Leeuwenhoek but they were only identified 200 years later.
Mumps	Mumps is an infectious disease caused by the mumps virus. Symptoms include fever, tiredness, headaches, swelling and tenderness of the salivary glands and loss of appetite
Musculoskeletal Disorders (MSD)	Injuries of the soft tissues (muscles, joints, tendons, ligaments, cartilage) and nervous system. The most common examples include repetitive strain injuries such as tendonitis and carpal tunnel syndrome, and back injuries involving muscles, ligaments and/or spinal discs.
#NOF	An orthopaedic condition characterised by a fractured neck of femur (the hip joint end of the bone that extends from the hip to the knee)
Pertussis	Also known as whooping cough, is a bacterial infection that causes a person to have severe coughing fits
Popliteal height	Distance from the underside of the foot to the crease in the skin at the back (posterior) of the knee where the joint bends
Posture	The carriage of the body as a whole, the attitude of the body, or the position of the limbs (the arms and legs).
PRIME Cl (Critical Incident)	The Queensland Health Clinical Incident and Complaints Information Management System
Richards pin & plate	A type of surgical fixation involving a plate and screws to repair a fractured neck of femur.
Rotavirus	Rotavirus causes severe gastroenteritis (vomiting and diarrhoea).
Rubella	Rubella (or German measles) is an infectious viral disease of humans which presents as a mild fever, rash, runny nose, sore throat and swollen lymph nodes
Standard Precautions	Standard Precautions are standard, safe work practices that are to be applied to all patients and clients regardless of their known or presumed infectious status.
Vancomycin resistant enterococcus (VRE)	Enterococci are generally harmless bacteria (germs), which live in the intestines of most people. Vancomycin is an antibiotic that is often used to treat very serious infections. VRE is a bacteria that has become resistant to, and cannot be destroyed by, vancomycin
Vestibular System	A system in the body that is responsible for maintaining balance, posture, and the body's orientation in space.

Word	Definition
Zoff	A universal adhesive remover ideal for the painless removal of adhesive tapes, dressings and acrylics such as hydrocolloids

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