Community Therapy SERVICES

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Delivery of Therapy Services
In Long Term Care
Winnipeg Regional Health Authority

May, 2018

The Winnipeg Regional Health Authority (WRHA) Long Term Care Program provides funding to Community Therapy Services (CTS) for the provision of occupational therapy and physiotherapy services in designated facilities in Winnipeg. The amount of service in each home is determined through a collaborative process between the WRHA and CTS, taking into account the funding available and the number of facilities requiring service. CTS services include consultation, assessment, interventions and education.

Role of Agency Management

Community Therapy Services will:

1. Recruit, orientate, and provide for the clinical supervision of CTS therapists assigned to work in Long Term Care

2. Collaborate with the Directors of Care (or designates) in the facility on all pertinent aspects of service delivery

3. Be available to advise and collaborate with the WRHA Long Term Care Program in the development and implementation of Regional Policies and Procedures in so far as they pertain to the services provided by CTS

4. Collect workload data from the CTS therapists for the purposes of monitoring CTS services and to provide summaries of the data as required by the WRHA

5. Provide comprehensive general liability insurance on behalf of CTS therapists

Community Therapy Services (CTS) is mandated by the Winnipeg Regional Health Authority to provide consultative occupational therapy, and physiotherapy services to many Winnipeg Personal Care Homes. In this consultative model of service delivery, CTS clinicians work in partnership with Personal Care Home staff to help residents achieve their optimal function, safety and comfort during their stay in the Personal Care Home.

The **consultant roles** of rehabilitation professionals in Personal Care Homes encompass many areas. There is considerable emphasis on education and support to caregivers, both family and staff, but the largest component is related to direct resident care.

The **goals of rehabilitation services** are to help the resident achieve optimal function, safety and comfort during their stay in the Personal Care Home. The concepts and goals of rehabilitation are shared with other members of the resident care team to facilitate consistent practices. The goals as they pertain to individual residents that can be achieved through this consultative role are as follows:

1. **Prevention:** Reducing the occurrence of complications that may interfere with the resident's optimum function. Complications may include disuse, where the resident's activity level is less than their capability, or misuse, where the resident is participating in contraindicated activity.
2. **Maintenance:** Promoting maximum function at any given time in relation to the resident's capabilities.
3. **Restoration:** Promoting recovery that has declined as a result of an acute incident.
4. **Safety:** Developing a safe environment for the resident. This includes the safety of therapy equipment such as seating products and their accessories, which by virtue of their design, may also function as restraints. CTS therapists will work with Personal Care Home staff to maximize the safety of transfers as well as mobility and exercise programs.
5. **Comfort:** Identifying strategies to increase the resident's comfort. For example, one of the goals of wheelchair seating is to increase comfort and reduce the risk of skin breakdown.
6. **Adjustment and ongoing adaptation:** Providing life enrichment strategies to correspond to the changing needs of each resident during his/her stay in the Personal Care Home.

There is a collaborative partnership that exists between Community Therapy Services and each of the Personal Care Homes to which it provides service. Occupational therapists, and physiotherapists provide consultation services while the care teams of the facilities support general rehabilitation philosophies, as well as the client-specific recommendations. In many Winnipeg Personal Care Homes, CTS clinicians have had the opportunity to work in ongoing collaboration with support personnel who have been designated to provide consistent follow-up on the recommendations and programs recommended by the clinician. The presence of a consistent designated support person or "rehabilitation assistant" can assist the Personal Care Home in achieving a maximum level of function, safety and comfort for its residents by ensuring the necessary follow-up required to implement recommendations made by the CTS clinicians. The availability of a rehabilitation assistant is very helpful in improving the effectiveness and efficiency of therapy services.

The purpose of this manual is to outline general rehabilitation guidelines related to the delivery of therapy services. The manual has been developed to promote consistency in the guidelines for CTS clinicians working in all Personal Care Homes receiving service from Community Therapy Services. The reader will note that we have, where pertinent, made certain distinctions in guidelines for those facilities where a designated support person has not been put in place.

As a further strategy to increase consistency, forms have been included for CTS Personal Care Home staff to use as part of the therapy service delivery. CTS forms and logos are proprietary and must not be changed or shared without permission from CTS.

The information contained in this manual is current as of January 2018. The content will be reviewed on a regular basis with items added, deleted and modified as necessary.

Community Therapy Services (CTS) therapists are expected to consult with facility administration and CTS management in order to reconcile instances when the guidelines of CTS are not compatible with those of the Personal Care Home.

PROCEDURE:

1. If the CTS therapist identifies a potential conflict situation with regards to CTS and facility guidelines, the therapist should immediately bring this to the attention of CTS management.
2. CTS management will explore the matter with the therapist and identify a plan of action to address the matter.
3. The plan of action will include a process of consultation with facility administration with goal of achieving a mutually satisfactory resolution to the matter.

Occupational therapy services are provided by Community Therapy Services (CTS) to Long Term Care (LTC). The occupational therapy service activities within each home are determined through a collaborative process, taking into account the service allocation in that facility and the priorities of the Personal Care Home management. Prioritization of referrals will be determined based on collaboration between OT and facility team members. The following is an outline of the occupational therapy services that are available. The list is not all-inclusive, but is representative of those areas where occupational therapy may contribute.

Assessment: The therapist assesses each resident within 8 weeks of admission. Reassessments are done on an annual basis and on an as-needed basis as relevant issues are identified to the therapist. Assessment includes the following as applicable:

- physical status (e.g. range of motion, strength, co-ordination, skin integrity, pain management)
- functional status (i.e. personal care, transfer method, feeding)
- mobility
- wheelchair seating and positioning
- cognitive/emotional status
- environment
- falls prevention

Interventions: Occupational therapy interventions are based on the assessment and may include some or all of the following:

- development of a care plan designed to maximize performance in personal care tasks, including transfers, eating, dressing, toileting
- walking programs and general exercise programs
- provision of seating systems and/or accessories
- pressure relief management
- orthotics and management of prostheses
- falls prevention

Resource and Education: The occupational therapist may contribute to the care team as a resource in the following areas:

- providing consultation to nursing staff re: general and specific therapy issues
- incorporating rehabilitation principles into daily care
- training of staff regarding transfers, body mechanics etc.
- developing protocols (i.e. management of fractures)
- developing exercise programs and revising same as needed
- providing information regarding rehabilitation equipment
- instructing, supervising and supporting rehabilitation assistants and/or health care aides regarding clinical issues

- providing consultation to activity/recreation department
- providing consultation to administration regarding policies that have therapy implications
- providing consultation to administration regarding accreditation
- educating residents, families and other care providers re: therapy issues
- participating in care conferences

Physiotherapy services are provided by Community Therapy Services (CTS) to Long Term Care (LTC) on a consultative basis. The following is an outline of physiotherapy services that are available. The list is not all-inclusive but reflects most of the areas of intervention where physiotherapy may be asked to contribute.

Assessment: The physiotherapist will assess the resident upon referral. Priority intake is available according to the presenting problems of the resident. Assessments will focus on the physical status of the resident and those aspects of function that are pertinent.

Interventions: Physiotherapy interventions will depend on assessment results. It is important to note that in order for the Personal Care Home to implement the physiotherapist's recommendations it should designate **trained** support personnel to carry out the recommendations on a prescribed basis.

Interventions may include some or all of the following:

- specific exercise programs
- specific strengthening programs
- specific weight-bearing programs (e.g. bed mobility, balance, walking, transfers)
- use of appropriate exercise equipment
- monitoring and upgrading of programs as appropriate
- relaxation and stretching
- respiratory interventions
- spasticity management
- orthotics and management of prostheses
- pain management
- overseeing programs designed to restore function following an acute problem

If a trained support person is not available to carry out therapy programs, the Personal Care Home may assist the resident and/or the resident's family in making arrangements to purchase services from a private physiotherapy service, which can provide assessment and follow-up as needed, on a fee for-service basis.
If the Personal Care Home is unable to provide in-house follow-up on the physiotherapist's recommendations, and if alternative private services cannot be purchased, the consultant physiotherapist will provide the facility with resident assessments. There is little value however, in establishing comprehensive exercise programs in this situation.

Resource and Education: The physiotherapist is able to provide support and education to complement the rehabilitation philosophies of the Personal Care Home.

- training of support personnel, including rehabilitation assistants in a variety of exercise programs and transfers
- protocols re: management of fractures and post-operative orthopedic procedures
- information regarding exercise and mobility equipment
- incorporation of rehabilitation philosophies into daily care
- consultation to the recreation department regarding general exercise classes
- consultation to administration as requested
- education to resident, family and other care providers

Position Statement

One of the key components that determines the outcome of therapy services, is the availability of a rehabilitation assistant. A trained designated assistant contributes significantly to all aspects of therapy input:

1. The rehabilitation assistant encourages and guides the resident's daily participation in functional activities and appropriate exercise programs to help **prevent disuse and misuse**.
2. The consistent participation of the resident in these activities and programs will help to **maintain functional ability** at its maximum level.
3. When an acute problem arises, such as a hip fracture, the rehabilitation assistant assists with the rehabilitation of the resident under the guidance of the physical and occupational therapists. This may include interventions such as positioning, graduated weight bearing, transfers, seating, exercise, and walking. The contribution that is provided by the therapy assistant is crucial to the restoration of **maximum function and comfort** of the resident.
4. **Support of safe practice measures** by the rehabilitation assistant is also an important contribution to the care team. The rehabilitation assistant is instrumental in ensuring that seating systems and all of their associated accessories are used in a safe and appropriate manner. The rehabilitation assistant develops an understanding of the various seating components and their proper use, which they are able to communicate to other members of the care team. The area of safety as it applies to restraints is one of paramount importance. A trained rehabilitation assistant can facilitate the education of health care aides and other co-workers regarding restraint protocols, and thereby increase the safety of the residents.
5. Rehabilitation assistants are also instrumental in maintaining the appropriate use of pressure relief products such as wheelchair seat cushions and mattress overlays. Their familiarity with the resident and daily observations assist the therapist and ensures that these products are used as they were intended. This is an important aspect in obtaining **maximum comfort for the resident and helping to reduce skin breakdown and other negative effects of immobility.**
6. Under the guidance of the physiotherapist and occupational therapist, the rehabilitation assistant will be involved in the **correct application and monitoring of orthopedic equipment.**
7. Through a combination of all of the above activities, the rehabilitation assistant can be helpful **in easing the resident's adjustment to the changing needs** that occur during the time spent in the facility.

The occupational therapists and physiotherapists of Community Therapy Services will chart in the integrated progress notes (IPN) of the resident's chart.

PROCEDURES:

1. The occupational therapists and physiotherapists will consult with the administration of the Personal Care Home to discuss the type of charting done in the integrated progress notes. (e.g. There may be a request for a certain style of charting, a distinctive ink color, identification stamp or label.)
2. The therapist will chart information related to assessment, interventions, outcomes, and discharge as applicable.
3. Other forms may be used and filed in the consultation or rehab section of the chart. To avoid redundancy, therapists will refer to the other forms in the integrated progress notes rather than re-writing the information.

The occupational therapists and physiotherapists of Community Therapy Services (CTS) will make use of the various forms contained in the manual for their intended purpose. There may be instances where other forms are used. It is suggested that all forms that are used be sanctioned by the administration of Community Therapy Services.

PROCEDURES:

1. Occupational therapists providing regularly scheduled service will complete the CTS ***Occupational Therapy Assessment Form*** on all new residents upon admission to the facility, and care conference reports according to the conference schedule.
2. Physiotherapists providing consultant service do not necessarily need to complete an assessment form and may choose to chart only in the integrated progress notes.

The occupational therapists and physiotherapists of Community Therapy Services will communicate verbally with all levels of the facility staff.

PROCEDURES:

1. The occupational therapist and/or physiotherapist will communicate verbally with the health care aids and nurses for the purpose of exchanging information that will contribute to the effectiveness of therapeutic interventions and the overall care plan.
2. Therapists will encourage use of the appropriate forms to promote efficiency.
3. In some facilities verbal communication may be used rather than the completion of forms.
4. Therapists will communicate regularly with the administration of the facility to deal with general rehabilitation issues.
5. Therapists will communicate verbally with residents, family members and other involved care providers as appropriate, regarding assessment and therapy interventions.
6. Relevant information regarding verbal communication will be documented by the therapist in the integrated progress notes (IPN).

Either the occupational therapist and/or the physiotherapist will contribute to the care conference of each resident by attending the conference and/or by completing a verbal and/or written report. In some instances, there may be reports from both the occupational therapist and the physiotherapist, particularly if there are issues pertaining to both disciplines.

PROCEDURES:

1. Occupational therapists, and/or physiotherapists, will complete a report for the care conference as per the standard procedure of the Personal Care Home.
2. Attendance at the care conference by the occupational therapist is encouraged as a valuable means of:
    a) exchanging information with other members of the care team,
    b) communicating with family members
    c) increasing the profile of the therapy programs within the facility
3. If available, it may be appropriate for the rehabilitation assistant to attend the care conference if the therapist cannot be present.

CTS therapists may provide offsite intervention(s) via telepractice at the request of a facility when circumstances do not permit an in-person visit.

Requests for telepractice visits are considered on a case-by case basis.

For the purposes of this document, the term "telepractice" is used to describe any therapeutic interaction completed using any form of technology (including video conferencing, internet and telephone) as an alternative to in-person care.

When therapists engage in telepractice, they are expected to be aware of and comply with regulatory expectations and legislation that applies to their practice while delivering therapy services. Telepractice services should strive to meet the same expectations for competent care as those delivered in person.

Prior to engaging in a telepractice attendance, CTS therapists will screen each request and use their professional judgement to ensure the request is appropriate. Each request will take into consideration:

- Whether telepractice is the most appropriate available method to deliver services
- Whether the visit can be reasonably postponed to allow for an in-person evaluation.
- Whether a direct physical examination is required to complete the assessment and/or identify a treatment plan.
- If a telepractice attendance can provide comparable care to an in-person visit.
- If client factors (i.e. physical, sensory, or cognitive deficits) impact the ability to deliver appropriate care via telepractice.

If the CTS therapist determines telepractice is not appropriate, they will advise the facility and arrange to reschedule the assessment when reasonable to do so.

If the CTS therapist determines telepractice is suitable, they will advise and coordinate the telepractice attendance with the facility.

As the request for telepractice is being made by the facility, all aspects relating to coordination of the visit and selection of the technology platform is the responsibility of the facility.

CTS therapists are encouraged to refer to Telepractice Guidelines as outlined by their respective college. These guidelines outline clinical considerations including: informed consent, privacy, safety, competence, and documentation.

College of Occupational Therapists: https://cotm.ca/upload/Telepractice_Guidance_Document-5.pdf

College of Physiotherapists: https://www.manitobaphysio.com/wp-content/uploads/Telerehabilitation_Manitoba-version.pdf

Occupational therapy services are provided by Community Therapy Services (CTS) to Long Term Care (LTC) on a consultative basis as per the Service Allocations listed in the Winnipeg Regional Health Authority (WRHA) Service Purchase Agreement. The occupational therapist will assess residents upon referral. A referral can be made using the ***Occupational Therapy Referral Form,*** or similar process.

PROCEDURE:

1. The person making the referral completes the CTS ***Occupational Therapy Referral Form,*** or similar process**.**
2. The occupational therapist will check for new referrals at each visit to the facility. Prioritization of referrals will be determined based on collaboration between occupational therapist and facility team members.
3. The occupational therapist will respond to new referrals and document findings and interventions in the Integrated Progress Notes (IPN) and/or relevant forms.

Physiotherapy services are provided by Community Therapy Services (CTS) to Long Term Care (LTC) on a consultative basis. The physiotherapist will assess residents upon referral. Priority intake is available according to the presenting problems of the resident. A referral can be made using the CTS ***Request for Physiotherapy Consultation Form.***

PROCEDURE:

1. The person making the referral completes the CTS ***Request for Physiotherapy Consultation Form.***
2. The staff member that makes the referral should include a note in the integrated progress notes (IPN) indicating that the referral has been made.
3. The CTS ***Request for Physiotherapy Consultation Form*** is faxed to Community Therapy Services. Community Therapy Services will assign the referral to a specific therapist who will contact the facility to arrange an appointment.

The occupational therapist or physiotherapist may refer to an outside agency for special services or equipment to help achieve therapy outcomes.

PROCEDURE:

1. The therapist conducts and assessment in order to identify the services or equipment that is needed.
2. The therapist makes a referral to the most appropriate agency, according to the procedure for that agency.
3. The therapist provides necessary follow-up and documents same in the integrated progress notes (IPN).
4. The following is a list of some of the services and agencies to which the therapists may refer:
    - Spasticity Clinic
    - Assistive Technology, Products and Services (ATPS)
    - Seating Resource Team (Pressure Mapping)
    - Orthotics and Prosthetics
    - PCH Respiratory Program

Each resident shall be assessed by the occupational therapist from Community Therapy Services (CTS) following admission to Long Term Care and on request when issues arise that require occupational therapy input.

PROCEDURE:

1. Nursing staff or rehabilitation assistant informs the occupational therapist that there has been a new admission to the facility by completing the CTS ***Occupational Therapy Referral Form,*** or similar process.
2. In most cases, the occupational therapist will conduct an initial assessment within a 6 week period after admission.
3. The occupational therapist will complete the CTS ***Occupational Therapy Initial Assessment Form*** and place it in the chart in the consult or rehab section.
4. The occupational therapist will chart in the integrated progress notes (IPN) that the occupational therapy assessment has been done.
5. The occupational therapist will share pertinent information with nursing staff and the rehabilitation assistant as required.
6. The occupational therapist will take appropriate steps to ensure that there is follow-up on recommendations made in the assessment.
7. The occupational therapist will re-assess each resident according to the care conference schedule. (The therapist will request notification of the care conference schedule)
8. The occupational therapist will re-assess residents on request, if issues arise that require occupational therapy input.
9. There may be instances where other assessment forms will be used, depending on the presenting issues.

Physiotherapy services are provided by Community Therapy Services (CTS) to Long Term Care (LTC) on a consultative basis. The physiotherapist will assess residents upon referral. Priority intake is available according to the presenting problems of the resident.

PROCEDURE:

1. Nursing staff, rehabilitation assistant or occupational therapist faxes the CTS ***Request for Physiotherapy Consultation Form*** indicating the need for a physiotherapy assessment.
2. CTS receives the CTS ***Request for Physiotherapy Consultation Form*** and assigns the referral to a physiotherapist.
3. The physiotherapist will arrange an appointment with the facility to see the resident.
4. The physiotherapist will complete the assessment and chart in the integrated progress notes (IPN).
5. The physiotherapist will take appropriate steps to ensure that there is follow-up on recommendations made in the assessment. This may or may not include additional visits by the physiotherapist to the facility.

As part of the multi-disciplinary team, the occupational therapists and physiotherapists may participate in the assessment of resident transfers. The therapists will evaluate transfers following admission as part of the initial assessment. Indications for re-assessment will include:

a) change in status of the resident that warrants therapeutic intervention.
b) a request by the nursing staff to collaborate in order to resolve a challenging transfer issue.

The therapist will be aware of the facility guidelines regarding transfers and will encourage the use of methods that are consistent with safe resident handling methods endorsed by Community Therapy Services (CTS) and the Winnipeg Regional Health Authority (WRHA). The therapist will encourage the care team to assess transfers consistently and in a timely manner, and to communicate and document the results of the assessment.

PROCEDURE: The therapist will encourage the following procedures in order to facilitate safe resident handling methods:

1. Completion of the CTS ***Transfer Assessment Tool.*** This form may be completed by any 2 of the following disciplines as long as one of the assessors has a professional designation:
    - RN
    - LPN
    - Occupational Therapist
    - Physiotherapist
    - Rehabilitation Assistant

    In some facilities an alternate form/procedure may be used to communicate recommended transfer methods.
2. Documentation of the method as per facility procedure.
3. Reporting of changes in the transfer status of the resident which may indicate that re-assessment is required.
4. Completion of an updated CTS ***Transfer Assessment Tool*** whenever a change in method is indicated. The logo and care plan must be adjusted accordingly.
5. Reinforcement of proper transfer procedures should be a shared responsibility among members of the facility staff (both professional and non-professional), administration of the facility, and Community Therapy Services.

The occupational therapists and physiotherapists of Community Therapy Services may assess residents to help determine the optimal level of performance in personal care tasks.

PROCEDURES:

1. The therapist may participate in functional assessments and the information obtained in these assessments will be used to help establish an appropriate care plan for the resident.
2. The therapist, along with the rehabilitation assistant, will promote the philosophy of maximum functional independence among the care providers.
3. The therapist may assess the need for aids and equipment designed to improve function.
4. A rehabilitation assistant will help promote the consistent use of appropriate methods and equipment in the performance of personal care tasks.

The occupational therapist(s) of Community Therapy Services (CTS) will assess the need for a seating system (e.g. wheelchair and components). The following goals will be considered with all seating system prescriptions:

- facilitating proper body alignment
- decreasing pressure and reducing the risk of skin breakdown
- increasing comfort
- increasing sitting tolerance
- facilitating greater participation in life enrichment activities
- improving resident's sight line so as to enhance awareness and interaction with surroundings
- offering alternate positioning to those residents whose level of alertness is such that they fall asleep frequently throughout the day
- increasing safety
- enhancing the resident's mobility whenever possible, by obtaining a chair which the resident is able to self-propel

It should be noted that the continuation of walking programs will be recommended as long as this is appropriate. In all cases, every effort will be made to ensure that the seating system and its component parts do not restrict the resident unnecessarily.

PROCEDURE:

1. A seating assessment will be completed.
2. Recommendations will be made regarding the most appropriate seating system for the resident, with pertinent information being obtained from the care team, including the rehabilitation assistant where available.
3. Options will be discussed with the person responsible for the resident's finances, either by letter or by phone.
4. Financial issues will be explored and funding approval will be obtained in writing before any equipment is implemented.
5. A trial period may be arranged through a vendor, for the recommended products. (The trial period should be handled in a time-efficient manner.)
6. During the trial period, suitability will be assessed in order to ensure that the seating system provides optimal positioning, comfort, safety and skin protection. Information will be required from the care team, particularly the rehabilitation assistant where available, to give valuable feedback regarding benefits and issues.
7. Once the trial period is completed, a decision will be made regarding equipment purchase and the vendor will be notified.
8. Follow-up and review are done as needed.

Residents requiring ambulatory assistance may be prescribed a walking program to help promote maximum function. Residents who are considered appropriate for the walking program are:

- those who are able to follow the instructions required to participate and do not pose any imminent safety risk for themselves or staff assisting
- those who have sufficient weight-bearing for functional walking
- those who are able to take a few steps in conjunction with transfers
- those who are able to walk more substantial distances with the minimal assistance of one or two staff (walking aid(s) may or may not be indicated)
- residents who are recovering from an acute injury or disease process that is impacting their walking ability

PROCEDURE:

1. The Community Therapy Services (CTS) occupational therapist or physiotherapist identifies the need for a walking program based on assessment results.
2. The therapist may complete and sign the CTS ***Therapy Program Record,*** or similar form.
3. The therapist discusses program details with the rehabilitation assistant and nursing staff as required.
4. Walking programs are carried out by the rehabilitation assistant and/or the unit staff of the facility.
5. The therapist, rehabilitation assistant and nursing staff all participate in the monitoring of the walking programs.
6. The therapist modifies walking programs as needed.
7. When the facility has a rehabilitation assistant, it may be appropriate to assign the walking programs of those residents recovering from acute injuries to the rehabilitation assistant. Once the walking function of the resident has reached a plateau, the program may be transferred to the unit staff to continue as part of the daily care routine. It is recommended that a CTS ***Maintenance Walking Program*** form (or similar form) is used for monitoring purposes.
8. If a decline in function occurs after the resident is placed on a maintenance walking program, the program may be put on hold and a re-referral to the therapist will be made. The therapist will then determine the suitability of discharge from the maintenance walking program, or the re-implementation of a rehab program. Recommendations and any necessary follow-up will be documented in the integrated progress notes (IPN).

The occupational therapists and physiotherapists of Community Therapy Services (CTS) will assess residents with acute injuries/illness whenever there is a rehabilitation component to their recovery.

PROCEDURE:

1. The therapist(s) will be notified of the injury/illness by the nursing staff, by occupational therapy and/or physiotherapy referral.
2. The appropriate therapist(s) conduct an assessment in order to determine the suitable intervention(s). Information will be obtained from other sources as required (e.g. transfer sheet from the hospital, x-ray reports, attending physician, rehabilitation staff providing treatment in the hospital etc.).
3. The therapist may be asked to assess the transfer method, if this has changed as a result of the injury/illness, and monitor same as needed.
4. The therapist may provide information regarding positioning if this is a factor in the resident's recovery.
5. The therapist may complete a CTS ***Therapy Program Record*** outlining the required walking and/or exercise programs.
6. Rehabilitation programs will be carried out by a rehabilitation assistant or another designated staff member.
7. The therapist may suggest a referral to a private physiotherapist if the facility does not have a rehabilitation assistant, or other designate, to follow through with recommendations.
8. The therapist, rehabilitation assistant and nursing staff will monitor the program to ensure that maximum recovery is achieved.
9. The therapist will document therapy outcomes in the integrated progress notes (IPN).
10. The therapist will determine the appropriateness of discharge from the program and will document in the IPN.

The Community Therapy Services (CTS) therapist may prescribe exercise programs for those residents whose assessment has indicated that this would be beneficial. This will apply as long as there is a rehabilitation model of service delivery, with a rehabilitation assistant or other designated trained support personnel in the facility. If there is no rehabilitation assistant or designate in the facility the therapist may suggest that arrangements be made for private physiotherapy so that therapeutic interventions can be implemented.

PROCEDURE:

1. The therapist assesses the resident to determine the need for an exercise program.
2. The therapist may complete a CTS ***Therapy Program Record*** outlining the required exercises.
3. The therapist provides the rehabilitation assistant with information and instruction as required.
4. The rehabilitation assistant administers the program as outlined by the therapist.
5. The rehabilitation assistant records attendance and other information pertinent to the resident's performance.
6. The therapist, nursing staff and rehabilitation assistant monitor the program and the therapist makes modifications as indicated.
7. The therapist will document therapeutic interventions in the integrated progress notes (IPN).
8. Once the appropriate exercise program plan is in place and no further changes are required, the program will be transitioned to a **maintenance exercise program**. The program will be monitored by facility staff. A note will be added to the CTS ***Therapy Program Record*** and the transition of the program will be documented in the IPN.
9. If a decline in function or acute illness/injury arises after the resident is placed on a maintenance exercise program, the program will be put on hold and a re-referral to the therapist will be made. The therapist will determine the appropriateness of continuing or discontinuing the **maintenance exercise program**. Recommendations and any necessary follow-up will be documented in the IPN.

Residents who require splints or other custom made devices, will most often have these made by a suitable professional outside of the facility. Typically these devices could include the following:

- knee braces
- wrist braces
- ankle braces
- hand splints
- "Therapy Carrot" finger orthosis
- spinal supports
- cervical collars

PROCEDURES:

1. The therapist assesses the need for a splint or other custom made device.
2. The therapist completes a referral to the appropriate agency.
3. The physician is asked to sign the referral.
4. The therapist will advise the resident or person responsible for the resident's finances if payment is required.
5. Once approved, the therapist assists with making the necessary arrangements for the device to be provided.
6. The therapist checks the device once it is received and documents its use in the resident's chart.
7. The therapist will request that the staff of the facility report any difficulties with the device that may necessitate further therapeutic intervention.
8. The therapist discontinues the device if/when this is appropriate, and documents same in the integrated progress notes (IPN).

The occupational therapists and physiotherapists of Community Therapy Services (CTS) may provide in-services related to transfers and body mechanics to facility staff. In-service content will be consistent with the safe resident handling methods endorsed by Community Therapy Services and the Winnipeg Regional Health Authority (WRHA). It should be noted that the effectiveness of the in-services will be maximized when the practices and principles of the facility match those of Community Therapy Services. Any discrepancies in this regard should be discussed and strategies made to improve consistency.

PROCEDURE:

1. When in-services are requested, the therapist and facility administration will collaborate regarding content and format.
2. The facility will arrange the following:
    - location of the in-service
    - equipment and resource material
    - notification of staff to attend
    - recording of staff attendance
    - discussion with the staff regarding failure to comply transfer policies
3. Time spent on in-services must be included in the total time allotment to the facility. It may be necessary to evaluate the time spent on in-services if the therapist feels that the amount of in-service time is having a negative effect on direct service provision to the residents.
4. A purchase agreement may be arranged with CTS administration regarding in-service and training requested by the facility if this is to be over and above the time allotted to the facility.

The therapist may conduct in-services at the request of the facility. These may include such topics as:

- positioning
- body mechanics and back care
- management of hip fractures
- management of other acute injuries or chronic conditions
- appropriate use and safe operation of rehabilitation equipment such as wheelchairs
- management of spasticity
- incorporating ROM into daily care
- application of splints, braces and other orthotic devices

PROCEDURE:

1. The therapist will review the request to determine its appropriateness.
2. The therapist may choose to use resources from Community Therapy Services (CTS) to supplement in-service material.
3. The facility will arrange:
    - location of the in-service
    - equipment and resource material
    - notification of staff to attend
    - recording of staff attendance
4. The therapist will document in-service provisions in terms of time and content.
5. A purchase agreement may be arranged with CTS administration regarding in-service and training requested by the facility if this is to be over and above the time allotted to the facility.

Community Therapy Services (CTS) therapists should be aware of facility guidelines concerning the ordering of rehabilitation equipment on behalf of residents. Written authorization from an authorized individual should be obtained for all purchases of rehabilitation equipment over $50.00. Verbal authorization with documentation in the chart may be sufficient for items under $50.00.

PROCEDURE:

1. The occupational therapist and/or physiotherapist will assess the resident to determine the need for rehabilitation equipment.
2. The therapist may complete a CTS ***Funding Authorization Form*** outlining the recommended equipment and the approximate cost.
3. The form is sent to the person responsible for the resident's finances. Included in the form is a request that it be signed for authorization.
4. The occupational therapist and/or physiotherapist will provide the involved parties with necessary information by phone and/or in person, upon request.
5. Once the financial authorization is confirmed in writing for items over $50, the equipment will be ordered by the therapist, or by the rehabilitation assistant under the direction of the therapist. Typically it will be provided on a trial basis until its suitability can be fully determined. It is important that this trial period be handled in an efficient and timely manner.
6. Once the assessment process is completed, the supplier will be informed that billing may proceed. (Most facilities prefer that the billing go directly to the person responsible for finances, rather than through the facility.)
7. For those residents who receive third party funding, the therapist will follow procedures according to that specific agency.
8. The therapist will involve facility administration when funding for essential equipment is denied.

The Community Therapy Services (CTS) therapist will suggest that records of rehabilitation equipment be maintained and that a facility staff member is assigned to do so. Attention to this issue is warranted by its importance to the resident and the cost of repair/replacement.

PROCEDURE:

1. The rehabilitation equipment is received by the therapist or the rehabilitation assistant.
2. The equipment is labeled in a temporary fashion if it is being supplied initially on a trial basis.
3. The equipment is provided to the resident unless otherwise instructed by the therapist.
4. The therapist assesses the suitability of the equipment with input from the care team.
5. The equipment is marked in a more permanent fashion when the purchase of the equipment is confirmed.
6. The therapist, rehabilitation assistant or other facility designate completes the CTS ***Rehabilitation Equipment Inventory Form*** (or similar form) and files it on the chart.
7. If the equipment is removed for the facility for any reason, this is recorded in the "exit information" section of the form (e.g. repair, equipment no longer in use, resident deceased).

The therapist will recommend that there is a process in place to safely maintain rehabilitation equipment throughout the resident's stay in Long Term Care.

Procedure:

1. It is recommended that all rehabilitation equipment be safety-checked by a qualified person on an annual basis.
2. It is recommended that all repair/maintenance work be completed by a qualified person.
3. Repair/maintenance work should be documented.
4. The person responsible for the resident's finances will be contacted to obtain financial authorization to proceed with the work.
5. Arrangements will be made to have the work completed by a qualified person.
6. If funding authorization is denied, this must be communicated with the care team and documented in the chart.

The rehabilitation assistant is an employee of the facility and direct supervision of the rehabilitation assistant is the responsibility of the facility. When present in the facility, the occupational therapist and/or physiotherapist will provide clinical support and direction to the rehabilitation assistant. It is recommended that the facility have a defined process in place to deal with any issues that arise related to the duties and responsibilities of the rehabilitation assistant.

PROCEDURE:

1. The occupational therapist and/or physiotherapist will assign therapeutic tasks to the rehabilitation assistant as per his/her facility guidelines and their professional body regulations around delegation.
2. The occupational therapist and/or physiotherapist will provide instruction regarding specific resident interventions, and other related responsibilities.
3. The facility will assign a staff member to be a designated supervisor of the rehabilitation assistant. The designated supervisor will ensure that the rehabilitation assistant:
    - completes assigned tasks
    - manages allotted time well in order to maximize efficiency and effectiveness
    - reports any untoward incidents or concerns in order to obtain necessary guidance.
4. The therapist may contribute to the evaluation of the rehabilitation assistant at the discretion of the facility.

The occupational therapists and physiotherapists will provide instruction and clinical guidance to the rehabilitation assistant regarding relevant tasks and responsibilities.

PROCEDURE:

1. The occupational therapists and physiotherapists of Community Therapy Services will provide input regarding some or all of the following tasks and responsibilities:
    - walking programs
    - exercise programs
    - use of mobility aids
    - gait training
    - maintenance of therapy equipment
    - installation of therapy equipment (i.e. wheelchair accessories)
    - monitoring of therapy equipment especially during trial periods
    - assistance to the therapist with resident assessments
    - monitoring of restraints
    - participation in care conferences
    - liaison with nursing and therapists
    - reinforcing rehabilitation principles
    - safe resident handling
    - assistance to the therapist with in-service preparation and presentation

2. The rehabilitation assistant **should not be** independently completing resident assessments.
3. The rehabilitation assistant **should not** participate in therapy-related activities other than those assigned, without consultation with the therapist or facility supervisor
4. The rehabilitation assistant must consult with the therapist, or facility supervisor regarding any changes to programs.
5. If there is any change in resident status that negatively impacts on the program, the rehabilitation assistant should discontinue the program until it can be reviewed by the therapist.

The therapists from Community Therapy Services will provide input to the facility and rehabilitation assistant regarding specific recording tasks.

PROCEDURE:

1. The rehabilitation assistant should complete recording tasks in a time efficient manner.
2. The rehabilitation assistant should monitor the resident's participation in therapeutic activities in order to provide valuable information to the therapist and the facility.
3. The rehabilitation assistant should keep statistical data as requested by the facility.

Community Therapy Services (CTS) policy recognizes that positioning devices (e.g. seatbelts, tilt, etc.) may be necessary in some situations to maximize the positioning, function and safety of clients using seating systems. Therapeutic considerations may include:

- increased support to the trunk, limbs and head to help compensate for abnormal muscle tone, weakness, and loss of joint motion
- increased safety
- improved upper limb function
- improved physical function (e.g. swallowing, respiration etc.)
- improved mobility by ensuring that upper and lower limbs are positioned such that resident is able to self-propel whenever possible
- opportunity to offer changes in position (i.e. tilt) according to resident needs throughout the day
- improved visual field which enables resident to better interact with their surroundings
- pressure relief to areas susceptible to skin breakdown

Since the inherent features of some of these devices may also classify them as restraints, every effort will be made in each situation to minimize the restraint component of all positioning devices. The therapeutic recommendations of Community Therapy Services will be consistent with the policies and procedures of the Winnipeg Regional Health Authority (WRHA) regarding restraints. The therapist will work in collaboration with the facility care team when recommending the use of positioning devices on seating systems.

PROCEDURE:

1. The occupational therapist and/or physiotherapist will be familiar with the WRHA policies regarding restraints so that therapeutic recommendations are consistent with these guidelines.

2. The therapist and the care team will ensure that positioning devices are chosen for their therapeutic benefit and do not restrict the resident unnecessarily. Positioning devices must be properly attached to the seating system. The use of any type of positioning device that cannot be safely anchored to the seating system is prohibited. It is recommended that only commercially available positioning devices be used.

3. As part of the process of ordering a wheelchair seating system, the occupational therapist will advise family and care team of the available options, and the reasons for specific recommendations. All concerned are then able to make an informed choice related to the optimal seating system that will best meet the needs of each individual resident. If a wheelchair is considered a necessity, every effort is made to ensure that the mobility of the resident is not adversely affected.

4. Whenever possible, the wheelchair that is provided should be one that the resident is able to self-propel. For those residents who are still ambulatory, walking should be part of their care plan in order to preserve maximum function.

5. The therapist may provide information regarding the use of positioning devices to the facility staff. This information will include such topics as:
    - features and benefits
    - appropriate use
    - safety considerations
    - using the tilt feature of the chair when the resident is having difficulty maintaining upright posture, and is leaning forward or to the side
    - applying a lap tray to provide better upper limb and trunk support, and improve function. This may be indicated at all times, or only at specific times (i.e. during activities and mealtimes, or when the resident is fatigued)
    - fastening a seat belt if the resident is being transported in a wheelchair van for an outing or medical appointment

6. The rehabilitation assistant is valuable in terms of reinforcing the principles regarding the appropriate and safe use of positioning devices.

7. Documentation and monitoring of positioning devices is required as per the policies of the Winnipeg Regional Health Authority (WRHA) and individual facilities.

1. If a resident is able to walk, every effort should be made to avoid the use of a restraint of any kind.
2. If a resident is considered to be a high risk for falls, all other strategies must be considered by the care team before the use of a restraint is implemented.
3. If walking tolerance is limited to the extent that a wheelchair is needed, it may be necessary to have a positioning device on the chair. (Seat belts and lap trays are considered to be restraints, unless the resident is able to remove the item(s) independently.) Clinical reasoning must be used to determine the need for any positioning devices.
4. If the resident requires the use of a wheelchair but is still able to walk short distances with assistance, the therapist may request a walking program to help maintain maximum mobility.

PROCEDURE:

1. Ambulation is assessed by the Community Therapy Services (CTS) occupational therapist and/or physiotherapist, and any safety concerns are discussed with the care team.
2. If resident is at high risk for falls, the options must be considered carefully. It may be preferable to allow the resident to walk independently some or all of the time, rather than impeding mobility through the use of a restraint. The resident and family should be made aware of the risks and the options, so that they are able to contribute to the development of the care plan.
3. When a resident's mobility is limited, a wheelchair with a tilt function or other positioning devices may be recommended to provide safe seating with adequate postural support and pressure relief. Every effort will be made to provide a wheelchair with specifications that will enable the resident to self-propel, if he/she is capable of doing so.
4. A walking program may be implemented to help maintain maximum mobility. This may include a prescribed walking program monitored by the occupational and/or physiotherapist or a maintenance walking program incorporated into the daily care routine.
5. Recommendations regarding the above issues should be charted in the integrated progress notes (IPN) including any input from the resident and family.
6. The therapist will contribute to the safe use of restraints as they apply to resident seating systems.
7. The walking program will be documented and monitored using standard facility and CTS procedures.

The occupational therapists and physiotherapists of Community Therapy Services may participate with the accreditation process of the facility as requested.

PROCEDURE:

1. The therapists may provide input regarding therapy-related issues as requested by the facility.
2. The therapists may attend meetings in preparation for accreditation as long as these are manageable from a scheduling point of view. Time spent must be included in the total time allotment for the facility.
3. The therapists may be asked to attend a survey meeting at the time of accreditation. This may require a scheduling change for the therapist but participation is considered a high priority.

Therapists may engage in other therapy-related activities of an administrative nature, at the request of the facility. These may include participation in activities such as:

- resident care committees
- restraint committees
- falls committees
- review/development of policies which have a therapy focus
- meeting with administration regarding specific or general issues

PROCEDURE:

1. The therapist should consider the time allotment required for this activity to ensure that it does not have an undue negative impact on other therapy duties. Should there be a negative impact, the therapist should discuss the matter with facility administration.
2. The therapist may consult with the administration of Community Therapy Services as needed.
3. The therapist will document these activities in terms of time spent and input provided.

OCCUPATIONAL THERAPY REFERRAL RECORD

PERSONAL CARE HOME: _____ **THERAPIST:** _____

Resident Name _____ Room # _____ Person Referring: _____ Date: _____ Issue: _____	**Dates and Intervention Details**
Resident Name _____ Room # _____ Person Referring: _____ Date: _____ Issue: _____	**Dates and Intervention Details**
Resident Name _____ Room # _____ Person Referring: _____ Date: _____ Issue: _____	**Dates and Intervention Details**
Resident Name _____ Room # _____ Person Referring: _____ Date: _____ Issue: _____	**Dates and Intervention Details**
Resident Name _____ Room # _____ Person Referring: _____ Date: _____ Issue: _____	**Dates and Intervention Details**

Community Therapy SERVICES

OCCUPATIONAL THERAPY ASSESSMENT FORM

INITIAL /REVIEW

OCCUPATIONAL THERAPIST: _____ **DATE:** _____

DIAGNOSIS/HISTORY: CHART REVIEWED: ☐ **Relevant info as indicated:** _____

MENTAL STATUS/COMMUNICATION (orientation, behaviour, speech, visual and/or auditory limitations):

PHYSICAL STATUS: Range of motion/strength/tone/co-ordination:

R upper limb _____

L upper limb _____

R lower limb _____

L lower limb _____

Trunk/pelvis (spinal abnormalities, etc.) _____

Balance (static, dynamic) _____

Pain (Pain Scale, PainAD) _____

Skin Integrity _____

Therapeutic Sleep Surfaces _____

Orthotics/Prosthetics _____

WHEELCHAIR SEATING: **N/A** ☐

Current seating: _____

W/C assessment findings and recommendations _____

Frame: _____

Components/accessories: _____

Measurements	Inches
Hip Width	
Thigh Length	
Leg Length	
Back Length	
Chest Width	
W/C Specs	**Inches**
Seat Width	
Seat Depth	
Back Height	
Seat to Floor	

Funding: _____

FUNCTIONAL STATUS- ADL ASSISTANCE NAME/PHIN:

RESIDENT SELF-PERFORMANCE

0 Independent-no help or staff oversight at any time

1 Supervision-oversight, encouragement or cueing

2 Limited Assistance-resident highly involved in activity, staff provide guided maneuvering of limbs and/or equipment or other non-weight-bearing assistance

3 Extensive assistance-resident involved in activity, staff provide weighbearing support

4 Total dependence-full staff performance every time

8 Does not occur- activity not performed

STAFF SUPPORT REQUIRED

0 No set-up or physical help

1 Set-up help only

2 One person physical assist

3 Two + person physical assist

8 Does not occur

	RES PERFORM	STAFF SUPPORT	AX NOT NEEDED
Bed Mobility-			
Transfers-			
Walk in Room-			
Walk in Corridor-			
Locomotion on unit-			
Locomotion off unit-			
Dressing-			
Eating-			
Toilet use-			
Personal hygiene-			
Additional Information:			

TARGET OUTCOMES:

RECOMMENDATIONS:

SIGNATURE:

Community Therapy Service Inc

REHABILITATION EQUIPMENT FUNDING AUTHORIZATION FORM

Date: _____

Dear Resident/Family/POA

Re: _____

In order to maximize the comfort, function and safety of the above-named resident, the following equipment is recommended: _____

_____

_____

_____

To be completed by person in charge of financial affairs:

I hereby provide authorization to order the equipment and accept responsibility for payment.

Cost is estimated within 10% _____

_____

In most instances, the responsible party will be billed directly.

Date: _____

Authorization by: _____

Address: _____

_____

Signature: _____

Specific supplier preferred? Yes ___ No ____

If yes, please specify: _____

A. To be completed by service provider:

Name and Designation: (please print) _____

Signature of Therapist: _____

B. To be completed by physician:

Name: (please print) _____ Physician Registration #: _____

Signature: _____

COMMUNITY THERAPY SERVICES INC.
101-1555 rue St. James 101-1555 St. James Street
Winnipeg, MB R3H 1B5
Téléphone (204) 949-0533 Telephone Télécopieur (204) 942-1428 FAX

March 18, 2020

Some of the ways that rehabilitation services can help your resident achieve optimal function, safety, and comfort.

1. Prevention: Reducing the occurrence of complications that may interfere with the resident's optimum function.

2. Maintenance: Promoting maximum function at any given time in relation to the resident's capabilities.

3. Restoration: Promoting recovery that has declined as a result of an acute incident.

4. Safety: Developing a safe environment for the resident such as: falls prevention; pressure injury reduction; seating and wheelchair; transfers and mobility; safe resident handling; respiratory interventions; exercise and walking programs; post op instructions, etc.

5. Comfort: Strategies to increase the resident's comfort, which may include: wheelchair seating; positioning; pain management; spasticity management, etc.

6. **Assist with tasks within our scope of practice to respond to current state of possible shortages where the role of the rehab assistant or recreation worker may be limited during COVID-19 response:** Interventions can be modified to ensure basic needs of the resident are being met such as: assisting with essential transfers and mobility tasks; feeding; providing interaction with residents who may be isolated due to lack of family/companion visits, etc.

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