



**Delivery of Therapy Services  
in Long Term Care  
Winnipeg Regional Health Authority  
March 2026**

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## GLOSSARY OF TERMS AND ABBREVIATIONS

**Terms and abbreviations may be used interchangeably throughout this document.**

Community Therapy Services	CTS
Winnipeg Regional Health Services	WRHA
Occupational Therapist	OT
Physiotherapist	PT
Rehabilitation Assistant	RA
Personal Care Home	PCH
Long Term Care	LTC
Integrated Progress Note(s)	IPN(s)
Vendor/Supplier:	used interchangeably



The WRHA Long Term Care Program provides funding to 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 therapist for the purpose of monitoring CTS services and to provide summaries of the data as required by WRHA.
5. Provide comprehensive general liability insurance on behalf of CTS therapists.



CTS is mandated by the WRHA to provide consultative occupational therapy and physiotherapy services to many Winnipeg PCHs. In this consultative model of service delivery, CTS clinicians work in partnership with PCH 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 PCHs 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 PCH. 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 due to a decline that was a result of an acute condition.
4. **Safety:** Developing a safe environment for the resident. This includes the safety of therapy equipment (e.g. tilt wheelchairs), which by virtue of their design, may also function as restraints. CTS therapists will work with PCH staff to maximize the safety of transfers as well as mobility and exercise programs.
5. **Positioning:** Identifying strategies to increase the resident's comfort and improve position in bed and/or wheelchair.
6. **Adjustment and ongoing adaptation:** Providing life enrichment strategies to correspond to the changing needs of each resident during their stay in the PCH.

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 PCHs, CTS clinicians have the opportunity to work in ongoing collaboration with support personnel who have been designated to provide consistent follow-up on the programs recommended by the clinician. The presence of a rehabilitation assistant or a consistent, designated support person assist the PCH in achieving a maximum level of function, safety and comfort for its residents by ensuring the necessary follow-up required to implement recommendations. The availability of a RA is essential in maximizing 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 PCHs 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 therapist(s) to use as part of the therapy service delivery.

**The contents of this document, including all CTS forms and logos, are proprietary and must not be changed or shared without express, written permission from CTS Management.**

The information contained in this manual is current as of **March 2026**. The content will be reviewed on a regular basis with items added, deleted and modified as necessary.



CTS therapists are expected to consult with facility administration and CTS management to reconcile instances when the guidelines of CTS are not compatible with those of the PCH.

**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 CTS to LTC facilities. 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 may include the following as applicable:

- physical status (e.g. range of motion, strength, co-ordination, skin integrity, pain)
- functional status (e.g. personal care, transfer method, feeding)
- mobility, including aides used for ambulation and/or bed mobility
- wheelchair seating and positioning
- cognitive status
- environment
- falls risk

**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 and/or bed mobility
- walking programs and general exercise programs
- provision of seating systems and/or accessories
- pressure relief management
- orthotics and management of prostheses
- falls reduction strategies

**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 (e.g. 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



**Resource and Education (continued):**

- providing consultation to activity/recreation department regarding general exercise classes
- 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 CTS to LTC facilities 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 PCH 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 and/or range of motion (ROM) 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 PCH may assist the resident and/or the resident's family in making arrangements to purchase services from a private physiotherapist who can provide assessment and follow-up as needed, on a fee for-service basis.

If the PCH is unable to provide in-house follow-up on the CTS physiotherapist's recommendations, and if alternative private services cannot be purchased, the CTS physiotherapist will provide the facility with resident assessments and recommendation. However, there may be little value in establishing comprehensive exercise programs in this situation.

**Resource and Education:** The physiotherapist can provide support and education to complement the rehabilitation philosophies of the PCH. The physiotherapist may contribute in the following ways:

- training of support personnel, including RAs in a variety of exercise programs and transfers
- protocols re: management of fractures and post-operative orthopedic procedures



**Resource and Education (continued):**

- 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 when necessary

## **Position Statement**

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

1. The RA 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 RA assists with the rehabilitation of the resident under the guidance of the CTS therapist(s). This may include interventions such as positioning, graduated weight bearing, transfers, seating, exercise, and walking. The contribution that is provided by the RA is crucial to the restoration of **maximum function and comfort** of the resident.
4. **Support of safe practice measures** by the RA is also an important contribution to the care team. The RA is instrumental in ensuring that seating systems and all associated accessories are used in a safe and appropriate manner. The RA develops an understanding of the various seating components and their proper use, which they are then 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 RA can facilitate the education of health care aides and other co-workers regarding restraint protocols, thereby increasing the safety of the residents.
5. RAs are also instrumental in maintaining the appropriate use of pressure relief products such as wheelchair seat cushions and therapeutic sleep surfaces. 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 CTS therapist(s), the RA will be involved in the correct application of orthopedic equipment.
7. Through a combination of all of the above activities, the RA can be helpful in easing the resident's adjustment to changing needs that occur during their time spent in the facility.



The occupational therapists and physiotherapists of CTS will chart in the IPN of the resident's chart.

**PROCEDURE:**

1. The therapist(s) will consult with the administration of the PCH to discuss the type of charting preferred in the IPN in either paper or electronic charts. For example, there may be a request from the PCH for a certain style of charting, a distinctive ink color, identification stamp or label, or use of an electronic charting program.
2. The therapist will document information related to assessment, interventions, outcomes, and discharge as applicable.
3. Other forms may be used and filed in the consultation or rehabilitation section of the chart. To avoid redundancy, therapists will refer to the other forms in the IPN rather than re-writing the information.
4. Where electronic documentation is preferred by the PCH, the PCH will arrange for and ensure adequate orientation and user authorization(s) are provided to assigned CTS therapist(s) in a timely manner.



The occupational therapists and physiotherapists of 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 CTS.

**PROCEDURE:**

1. Occupational therapists providing regularly scheduled service will complete the ***CTS Occupational Therapy Assessment Form*** on all new resident admissions to the facility within an 8-week timeframe. Care conference documentation is completed as requested by the facility for care conferences in accordance with PCH protocols.
2. Physiotherapists providing consultative services do not necessarily need to complete an initial assessment form and may choose to chart only in the IPN.
3. Prior to use of assessment forms outside of approved CTS forms, facility administration and CTS management will review and discuss to determine approval and use.



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

**PROCEDURE:**

1. The therapist(s) will communicate verbally with the RA, 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 CTS forms to promote efficiency.
3. In some facilities, verbal communication may be used rather than the completion of forms with appropriate documentation in IPN where necessary.
4. Therapists will communicate regularly with the administration of the facility to address general rehabilitation issues as necessary.
5. Therapists will communicate verbally with residents, family members and other care providers as appropriate, regarding assessment and therapy interventions.
6. Relevant information regarding verbal communication will be documented by the therapist in the IPN.

The CTS therapist(s) will contribute to the care conference of each resident by attending the conference and/or by completing a written summary. In some instances, there may be documentation from both the occupational therapist and the physiotherapist if there are issues pertaining to both disciplines.

**PROCEDURE:**

1. Occupational therapist and/or physiotherapist will complete a summary for the care conference as per the standard procedure of the PCH.
2. Attendance at the care conference by the occupational therapist is beneficial as a means of:
  - a) exchanging information with other members of the care team,
  - b) communicating information to family members
  - c) increasing the profile of the therapy programs within the facility
3. If available, it may be more appropriate for the RA to attend the care conference when the therapist is not available.

CTS therapists may provide offsite intervention(s) via telehealth/virtual visit at the request of a facility and approval by CTS management when circumstances do not permit an in-person visit.

Requests for telehealth visits will be considered strictly on a case-by case basis and generally used only for extreme circumstances.

For the purposes of this document, the term telehealth/virtual visit means “the use of digital information and communication technologies such as video conferencing, internet and/or telephone to access health care services remotely and manage care needs of a resident as an alternative to in-person review/interventions”. When therapists engage in telehealth, they are expected to be aware of and comply with regulatory expectations and legislation that apply to their practice. Telehealth services should strive to meet the same expectations for competent care as those delivered in person.

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

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

If the CTS therapist determines telehealth is not appropriate, they will advise the facility and arrange to reschedule the assessment/intervention when reasonable.

If the CTS therapist determines telehealth visit is suitable, they will advise and coordinate the telehealth visit with the facility and notify CTS management.

As the request for telehealth 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 therapist in consult with the facility will review respective professional licencing body requirements (COTM/CPM). Clinical considerations must include informed consent, privacy, safety, competence consideration, and documentation of same.

**COTM:** College of Occupational Therapists of Manitoba

<https://cotm.ca/upload/FACTS-Telepractice.pdf>

**CPM:** College of Physiotherapists of Manitoba

<https://manitobaphysio.com/wp-content/uploads/2025/08/Virtual-Care-Guide-for-Manitoba-Physiotherapists->



Occupational therapy services are provided by CTS to LTC facilities on a consultative basis as per the Service Allocations listed in the WRHA Service Purchase Agreement. The occupational therapist will assess residents upon referral. A referral can be made using the **CTS PCH Program Occupational Therapy Referral Form**, or similar process.

**PROCEDURE:**

1. The person making the referral completes the **CTS PCH Program Occupational Therapy Referral** form, or similar process.
2. The OT will review new referrals at each visit to the facility. Prioritization of referrals will be determined based on collaboration between the OT and facility team members.
3. The OT will respond to new referrals and document findings and interventions in the IPN and/or relevant forms.
4. CTS is not funded to provide coverage in case of therapist's absence(s), both short term (e.g. sick day) or extended (personal leave, medical leave, or other LOA). In the case of an urgent resident issue arising during an extended therapist absence, the RA or a facility staff member may fax a completed **CTS PCH Program Occupational Therapy Referral** form to CTS. CTS management will review the request and endeavor to address the referral as human resources allow. This is on a case-by-case basis and will be considered for urgent matters only. All efforts will be made to address urgent referrals within 10 working days. Collaboration between the facility and CTS management is recommended to review and address these referrals in the most efficient manner. Issues deemed urgent may include:
  - acute and significant pressure injury
  - acute change of transfer status that nursing staff cannot adequately address or manage independently
  - acute and significant change to mobility status, requiring a new mobility device such as a wheelchair, where the temporary loan of facility wheelchair is not adequate



Physiotherapy services are provided by CTS to 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 PCH Program Physiotherapy Referral** form.

#### PROCEDURE:

1. The person making the referral completes the **CTS PCH Program Physiotherapy Referral** form. Variations to this process may occur when there is defined PT service provision/FTE.
2. The **CTS PCH Program Physiotherapy Referral** form is faxed to the CTS office. CTS administration will provide the referral to the assigned therapist who will contact the facility to arrange an appointment. If the concern is deemed urgent, this is to be clearly noted on the referral by the facility staff member, along with rationale for urgent designation. All efforts will be made to address urgent referrals within 10 working days.
3. For those PCHs with defined FTE for physiotherapy, PT referrals will be completed and addressed based on the PCH protocol. Issues deemed urgent may include:
  - acute fracture
  - recent discharge from hospital with change of weight bearing status



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 an assessment to identify the services and/or equipment needed.
2. The therapist makes a referral to the most appropriate agency, following the procedure specific for that agency.
3. The therapist provides necessary follow-up and provides documentation in the IPN.
4. The following is a list of some of the services and agencies to which the therapists may refer:
  - Movement Disorder Clinic
  - Assistive Technology, Products and Services (ATPS)
  - CTS Seating Resource Team (Pressure Mapping)
  - Orthotists and Prosthetists
  - PCH Respiratory Program
  - Wheelchair vendors/suppliers

Each resident shall be assessed by the occupational therapist from CTS following admission to LTC 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 PCH Program Occupational Therapy Referral** form, or similar process.
2. In most cases, the occupational therapist will conduct an initial assessment within an 8-week period after admission.
3. Following receipt of referral, the occupational therapist will complete an assessment, adding relevant documentation to the chart in the consult or rehabilitation section as determined by the PCH.
4. The occupational therapist will chart in the IPN that the occupational therapy assessment has been completed.
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.
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 CTS to Long Term Care 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 PCH Program Physiotherapy Referral** form indicating the need for a physiotherapy assessment. Variations to this process may occur when there is defined PT service provision/FTE.
2. CTS receives the **CTS PCH Program Physiotherapy Referral** form and assigns the referral to a physiotherapist.
3. The physiotherapist will arrange an appointment with the facility to see the resident. Arrangements are typically made with RA.
4. Following receipt of the referral, the physiotherapist will complete the assessment.
5. The physiotherapist will document assessment results and recommendations in the IPN.
6. 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/or 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 include:

- a) change in status of the resident that warrants therapeutic intervention
- b) a request by the nursing staff to collaborate 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 work procedures for safe patient handling endorsed by CTS and the 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 to facilitate safe resident handling methods:

1. Completion of the **CTS Transfer Assessment Tool** (or similar form, as per facility process) will be part of the OT initial assessment. This form is to be completed by a CTS OT or PT, or two (2) of the following disciplines, ensuring one of the assessors has a professional designation.
  - Occupational Therapist
  - Physiotherapist
  - RN
  - LPN
  - Rehabilitation Assistant

\*If a RA is completing this form, the RA requires consultation and co-signing by a LPN or RN. In some facilities, an alternate form/procedure may be used to communicate recommended transfer methods.
2. Documentation of the recommended transfer method completed as per facility procedure.
3. During their stay in the PCH, changes in the resident's function may result in a need to reassess transfers.
4. Documentation of the change in transfer method will be completed. Completion of an updated **CTS Transfer Assessment Tool** whenever a change in method is indicated. The transfer logo and/or MDS Safe Transfer Assessment form 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 CTS clinician(s).



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

**PROCEDURE:**

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 RA, will promote the philosophy of maximum functional independence among the care team.
3. The therapist may assess the need for aids and equipment designed to improve function.
4. A RA will help promote the consistent use of appropriate methods and equipment in the performance of personal care tasks.

The occupational therapist(s) of 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 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 RA where available.
3. Options will be discussed with the POA/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 before any equipment is implemented. Refer to *Section 8.1 Funding for Rehabilitation Equipment*.
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 RA where available, to give valuable feedback regarding benefits and issues/concerns.



**Procedure (continued):**

7. Once the trial period is completed, a decision will be made regarding equipment purchase, and the vendor will be notified.
8. The vendor then follows up with the POA or person responsible for resident's finances for payment, order the equipment and arrange delivery with the OT and/or RA.
9. Follow-up and review are done as needed.

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

- those who are able to follow instructions required to participate and do not pose any imminent safety risk for themselves or staff assisting
- those with sufficient weight-bearing for functional walking
- those able to take a few steps in conjunction with transfers
- those 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 CTS therapist 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 RA and nursing staff as required.
4. Walking programs are carried out by the RA and/or the unit staff of the facility as determined by the CTS therapist.
5. The therapist, RA, and nursing staff all participate in monitoring of walking programs.
6. The therapist modifies walking programs as needed.
7. When the facility has a RA, it may be appropriate to assign the walking programs of those residents recovering from acute injuries to the RA. 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 paused and a re-referral to the therapist may be initiated if deemed necessary by nursing. The therapist will then reassess the resident and determine whether re-implementation of a walking program is warranted and document assessment outcome in the IPN.

The therapists of 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 physician, nursing staff, or RA via written referral.
2. The appropriate therapist(s) conducts an assessment 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 or reassess the transfer method to determine if this changed as a result of injury/illness and the PCH staff would be expected to monitor same.
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 RA or another designated staff member as determined by the facility.
7. The therapist may suggest a referral to a private physiotherapist if the facility does not have a RA or other designate, to follow through with therapist's recommendations.
8. The therapist, RA, and nursing staff will monitor the program to ensure that maximum recovery is achieved.
9. The therapist will document therapy outcomes in the IPN.
10. The therapist will determine the appropriateness of discharge from the program and will document in the IPN.

The 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 RA or other designated trained support personnel in the facility. If there is no RA or designate in the facility, the therapist may suggest that arrangements be made for private physiotherapy so that therapeutic interventions can be implemented appropriately.

**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 RA with information and instruction as required.
4. The RA administers the program as outlined by the therapist.
5. The RA records attendance and other information pertinent to the resident's performance on a tracking form.
6. The therapist, nursing staff and RA monitor the program, and the therapist makes modifications as indicated.
7. The therapist will document therapeutic interventions in the 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** and resident will be **discharged** from therapy with all documentation completed in the IPN. The maintenance program will then be monitored by facility staff.
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 should be made. The therapist will then 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 provided 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

**PROCEDURE:**

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 POA 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, emphasizing the importance of skin checks as per standard nursing procedures.
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 IPN.



CTS therapists may provide intervention(s) for a resident concurrently receiving service from a therapist hired privately by the resident, family, or PCH. The CTS therapist, in their professional judgement, will determine if the intervention is required, appropriate, and congruent with the treatment approach of the private therapist and that the treatment does not constitute an unethical or inefficient use of public therapy services. Effective communication between the therapists is important in establishing the boundaries of treatment.

The CTS therapists will monitor their own intervention(s) to evaluate the benefit(s) and/or adverse effect(s) of their intervention(s).

The CTS therapists will **not** review, evaluate, or modify components of therapeutic intervention(s) which are the responsibility of the privately hired therapist.

The CTS therapist is not involved in providing training to the RA for those interventions prescribed by the privately hired therapist.

The CTS therapist will ensure clear communication of the concurrent intervention is documented in the IPN.

If there is a conflict between the CTS and private therapist's intervention(s), the CTS therapist will bring the matter to the attention of the facility administration and CTS management. The CTS therapist will provide input as appropriate; however, any decisions regarding intervention(s) provided by a private therapist will be at the discretion of the facility administration and/or POA.

CTS therapists will be familiar with and/or refer to their respective regulatory body to review professional duties and obligations pertaining to concurrent intervention(s).

The occupational therapists and/or physiotherapists of CTS may provide in- services related to transfers and body mechanics to facility staff as requested. In-service content will be consistent with the safe work procedures to ensure safe patient handling methods endorsed by CTS and the 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 CTS and the WRHA. 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 non-adherence to 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. The topics may be related to general policies or resident-specific procedures and/or equipment. Topics may include:

- 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 and air cushions
- 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. 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 the amount of in-service time is having a negative effect on direct service provision to the residents. 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.



CTS therapists should be aware of facility guidelines concerning the ordering of rehabilitation equipment on behalf of residents. Authorization from the POA or person responsible for resident's finances individual should be obtained for all purchases. Verbal authorization with documentation in the IPN is acceptable, however written authorization is preferred.

**PROCEDURE:**

1. The CTS therapist will assess the resident to determine the need for rehabilitation equipment.
2. The recommendations are relayed verbally or via providing a completed *CTS Funding Authorization* form to the POA/person responsible for the resident's finances.
3. The CTS therapist will provide the involved parties with necessary information by phone and/or in person, upon request.
4. Once financial authorization is confirmed, the equipment will be ordered by the therapist or by the RA 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.
5. 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 POA/person responsible for finances, rather than through the facility. Permission to provide contact/billing information to vendor will be requested and provided by authorized person in charge of resident's finances prior to therapist sharing these details with the vendor.
6. For those residents who receive third party funding, the therapist will follow procedures according to that specific agency.
7. The therapist will involve facility administration when funding for essential equipment is denied.



The 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 RA.
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 can then be marked in a more permanent fashion when the purchase of the equipment is confirmed by the RA or facility staff member.
6. The therapist, RA, or other facility designate completes the **CTS Rehabilitation Equipment Inventory** form or similar form as designated by the facility and files it on the chart.
7. If the equipment is removed for the facility for any reason, this is to be recorded in the “exit information” section of the form (e.g. repair, equipment no longer in use, resident deceased) by RA, therapist, or facility staff member.



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

**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 POA/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 IPN.



The RA is an employee of the facility and direct supervision of the RA is the responsibility of the facility. The occupational therapist and/or physiotherapist provide clinical support and direction to the RA during their allotted time in the facility. 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 RA.

**PROCEDURE:**

1. The CTS therapist(s) will assign therapeutic tasks to the RA as per their facility guidelines and their professional body regulations around delegation.
2. The CTS therapist(s) 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 RA. The designated supervisor will ensure that the RA:
  - completes assigned tasks
  - manages allotted time to maximize efficiency and effectiveness
  - reports any untoward incidents or concerns to obtain necessary guidance.
4. The CTS therapist(s) may contribute to the evaluation of the RA at the discretion of the facility.

The CTS therapists will provide instruction and clinical guidance to the RA regarding relevant tasks and responsibilities.

**PROCEDURE:**

1. The occupational therapists and physiotherapists of CTS will provide input regarding some/all of the following tasks and responsibilities to be carried out for each resident as appropriate. The therapists will provide instruction and guidance on tasks and responsibilities to be carried out by the RA which may include:
  - walking programs
  - exercise programs
  - use of mobility aids
  - maintenance of therapy equipment
  - installation of therapy equipment (e.g. wheelchair accessories)
  - monitoring of therapy equipment with extra attention during trial periods
  - assistance to the therapist with resident assessments
  - monitoring of restraints
  - participation in care conferences
  - acting liaison between nursing and therapists
  - reinforcing rehabilitation principles
  - safe resident handling
  - assistance to the therapist with in-service preparation and presentation
2. The therapist will not instruct the RA to complete resident assessments independently.
3. The RA should participate in therapy-related activities that have been assigned.
4. If there is any change in resident status that negatively impacts the program, the RA should pause the program until it can be reviewed by the therapist or nursing staff.



The therapists from CTS will provide input to the facility and RA regarding specific recording tasks.

**PROCEDURE:**

1. The RA completes recording tasks as per the policies of the facility. The therapist will provide input as required in a time efficient manner per facility policy.
2. The RA monitors the resident's participation in therapeutic activities to provide valuable information to the therapist and the facility.
3. The RA keeps statistical data as requested by the facility.



CTS policy recognizes that positioning devices (e.g. specialized seatbelts, multi-axial headrests, etc.) may be necessary in some situations to maximize the positioning, function and safety of clients using a wheelchair seating system. Therapeutic considerations may include:

- increased support to the trunk, limbs and/or head to help compensate for abnormal muscle tone, weakness, and/or loss of joint motion
- increased safety
- improved upper limb function
- improved physical function (e.g. swallowing, respiration)
- 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 (e.g. 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 pressure injury

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 CTS will be consistent with the policies and procedures of the 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 therapist 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 secured to the seating system is prohibited. It is recommended that only commercially available positioning devices be used for the safety of the resident.
3. As part of the process of ordering a wheelchair seating system, the OT will advise POA/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



**PROCEDURE (continued):**

that the mobility of the resident is not adversely affected by the introduction of a wheelchair or a component of a wheelchair such as tilt.

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 to preserve maximum function.
5. The therapist may provide information regarding the use of positioning devices to the facility staff. This information may include such topics as:
  - features and benefits
  - appropriate use
  - safety considerations
  - use of a lap tray to provide improved upper limb and trunk support, as well as improve function. This may be indicated at all times, or only at specific times (e.g. during activities and mealtimes, or when the resident is fatigued)
  - use of a positioning belt
6. The RA 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 WRHA and individual facilities.
8. Ongoing monitoring of tilt wheelchair or seating component(s) are the responsibility of facility staff and concerns are to be reported to the CTS therapist.



CTS recognizes the impact that restraints may have on a resident's ability to mobilize. If a resident can walk, every effort should be made to avoid the use of a restraint of any kind. If a resident is at high risk for falls, all other fall-mitigation strategies must be considered by the care team before the use of a restraint is implemented. If the resident requires the use of a wheelchair but can still walk, the therapist may prescribe a walking program to help maintain maximum mobility.

**PROCEDURE:**

1. Ambulation is assessed by the CTS therapist, and any safety concerns are discussed with the care team, including family members/POA as appropriate.
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 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. A rehabilitation program may be implemented to help maintain maximum mobility. This may include a walking program prescribed by the therapist or a maintenance walking program incorporated into the daily care routine.
4. Recommendations regarding the above issues will be charted in the IPN including any input from the resident and/or POA.



The therapists of CTS 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 if 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.
4. Any scheduling change will be communicated to both the facility and CTS management.



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
- policy review/development 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 and consult with CTS management.
2. The therapist will document these activities in terms of time spent and input provided.





# CTS OCCUPATIONAL THERAPY ASSESSMENT FORM

**INITIAL / REVIEW**

CONSENT provided/implied by: Resident  Other  \_\_\_\_\_

OCCUPATIONAL THERAPIST: \_\_\_\_\_ DATE: \_\_\_\_\_

DIAGNOSIS/HISTORY: CHART REVIEWED:  Relevant info as indicated: \_\_\_\_\_

**COGNITIVE STATUS/COMMUNICATION/BEHAVIORS** (orientation, behavior, 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/Trunk Control (static, dynamic) \_\_\_\_\_

Pain (Pain Scale, PainAD) \_\_\_\_\_

Skin Integrity \_\_\_\_\_

Therapeutic Sleep Surfaces \_\_\_\_\_

Orthotics/Prosthetics \_\_\_\_\_

Swelling \_\_\_\_\_

Other Information \_\_\_\_\_

**WHEELCHAIR SEATING: N/A**

Current seating: \_\_\_\_\_

Frame: \_\_\_\_\_

Components/accessories: \_\_\_\_\_

Assessment Findings and Recommendations: \_\_\_\_\_

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	

FUNCTIONAL STATUS- ADL ASSISTANCE	NAME and PHIN:		
<b>RESIDENT PERFORMANCE</b> <b>0</b> Independent-no help or staff oversight at any time <b>1</b> Supervision- oversight, encouragement or cueing <b>2</b> Limited assistance- Resident highly involved in activity. Staff provide guided, maneuvering of limbs and/or equipment or other non weight bearing assistance <b>3</b> Extensive assistance- Resident involved. Staff provide weight-bearing support <b>4</b> Total dependence- Full staff performance every time <b>8</b> Does not occur- Activity not performed	<b>STAFF SUPPORT REQUIRED</b> <b>0</b> No set-up or physical help <b>1</b> Set-up help only <b>2</b> One-person physical assist <b>3</b> Two-person physical assist <b>8</b> Does not occur		
	Resident Performs	Staff Support	Ax Not Needed
<b>Bed Mobility</b> (method, equipment)			
<b>Transfers</b> (method, equipment)			
<b>Walking</b> (equipment, assistance, tolerance, fall risk, footwear)			
<b>Wheelchair</b> (continuation of page 1, including usage, ability to self-propel)			
<b>Bathing</b> (method, equipment)			
<b>Toileting</b> (method, equipment)			
<b>Dressing/Grooming</b>			
<b>Additional Information</b> (include FRAT, MOS as appropriate)			
<b>EQUIPMENT:</b> (e.g. mobility equipment, hip protectors, splints, off-loading AFO's, compression stockings, sliders, transfer pole, transfer belt, Derma-savers, chair/bed alarms, etc.)			
<b>OCCUPATIONAL PERFORMANCE ISSUES:</b>			
<b>RECOMMENDATIONS:</b>			
<b>OT SIGNATURE:</b>			



1601 Buffalo Place, Unit/Bureau 101  
 Winnipeg, MB R3T 3K7  
 Tél./Phone: (204) 949-0533  
 Télécopieur/Fax: (204) 942-1428

(Addressograph here)

<b>PERSONAL CARE HOME PROGRAM PHYSIOTHERAPY REFERRAL</b>			
<b>Date</b>	<b>Unit, Room #</b>		
<b>Name of Facility</b>			
<b>Name, Designation of Referrer</b>			
<b>Contact Person to schedule site visit (i.e. Rehab Assistant, Nurse)</b>			
<b>Phone Number/Email for contact person</b>			
<b>Service Request – complete the information below as applicable</b>			
<p>'ASAP' refers to an acute incident or high safety risk to a resident/staff. Examples include recent fracture, orthopedic surgery, hospitalization, recent CVA or cardiac event. Circle Y (yes) or N (no) below.</p>			
<b>ASAP</b>	<b>Outline reason for referral/ services requested below</b>		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px; text-align: center;"><b>Y</b></td> <td style="width: 50%; padding: 5px; text-align: center;"><b>N</b></td> </tr> </table>	<b>Y</b>	<b>N</b>	<div style="border: 1px solid black; height: 150px; width: 100%;"></div>
<b>Y</b>	<b>N</b>		

**PLEASE FAX COMPLETED REFERRAL TO (204) 942-1428**



Community Therapy Services  
**MAINTENANCE WALKING PROGRAM**

Description of Assistance and/or Aids required: \_\_\_\_\_

<b>MONTH</b>	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
<b>JANUARY</b>																															
<b>FEBRUARY</b>																															
<b>MARCH</b>																															
<b>APRIL</b>																															
<b>MAY</b>																															
<b>JUNE</b>																															
<b>JULY</b>																															
<b>AUGUST</b>																															
<b>SEPTEMBER</b>																															
<b>OCTOBER</b>																															
<b>NOVEMBER</b>																															
<b>DECEMBER</b>																															



Community Therapy Services  
**THERAPY PROGRAM RECORD**

**DATE PROGRAM STARTED** \_\_\_\_\_

**PRESCRIBER** \_\_\_\_\_

**PROGRAM DESCRIPTION** \_\_\_\_\_

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**PROGRAM UPDATES:** (Include details, dates and prescriber's name)

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# OCCUPATIONAL THERAPY REFERRAL RECORD

PERSONAL CARE HOME: \_\_\_\_\_

THERAPIST: \_\_\_\_\_

<b>Resident Name</b>	_____	<b>Room #</b>	_____	<b>Dates and Intervention Details</b>
Person Referring:	_____	Date:	_____	
Issue:	_____			
	_____			
<b>Resident Name</b>	_____	<b>Room #</b>	_____	<b>Dates and Intervention Details</b>
Person Referring:	_____	Date:	_____	
Issue:	_____			
	_____			
<b>Resident Name</b>	_____	<b>Room #</b>	_____	<b>Dates and Intervention Details</b>
Person Referring:	_____	Date:	_____	
Issue:	_____			
	_____			
<b>Resident Name</b>	_____	<b>Room #</b>	_____	<b>Dates and Intervention Details</b>
Person Referring:	_____	Date:	_____	
Issue:	_____			
	_____			
<b>Resident Name</b>	_____	<b>Room #</b>	_____	<b>Dates and Intervention Details</b>
Person Referring:	_____	Date:	_____	
Issue:	_____			
	_____			



## INVENTORY OF THERAPY EQUIPMENT

(All equipment should be recorded when received, loaned, borrowed, or removed from the facility for any reason)

DATES & INITIALS	EQUIPMENT - Describe colour & accessories (eg. arm/legrests, custom seating, safety belts, lap trays)	SERIAL NUMBER	EQUIPMENT OWNER	EXIT INFORMATION

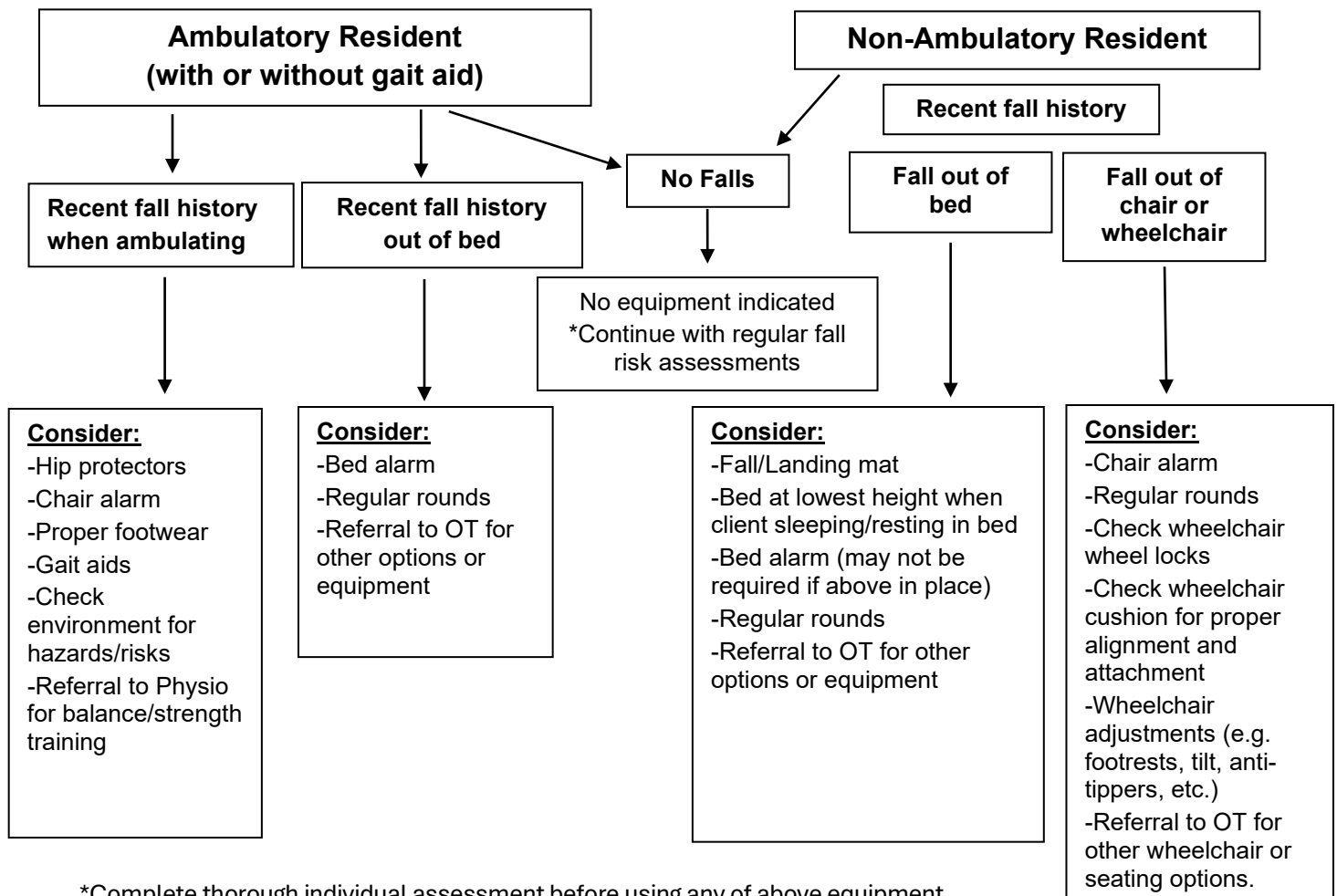
101 – 1601 Buffalo Place  
Winnipeg, MB R3T 3K7  
www.ctsinc.mb.ca  
Fax: 204-942-1428 Phone:  
204-949-0533



101 – 1601 Place Buffalo  
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Fax: 204-942-1428  
Phone: 204-949-0533

## CTS Occupational Therapy & Physiotherapy Falls Intervention Algorithm Guideline

**\*Nursing completes Falls Risk Assessment Tool (FRAT)**  
**\*Refer to & comply with any relevant Falls Policy & Procedures specific to PCH site**  
**\*Interdisciplinary Team creates Individualized Care Plans based on identified risks & communicates Plans to all members of care team**



\*Complete thorough individual assessment before using any of above equipment as equipment may not be appropriate for a particular resident.

**Based on identified risks, further assessment may be appropriate. Consider additional involvement of:**

**Physician** – prior & new medical issues, medications, orthostatic hypotension

**Pharmacy** - medication review

**Nutrition services** – nutrition / hydration

**Social Worker**-Footwear/clothing/environmental aides

**Maintenance**-Repairs/equipment exchange/environment

## Transfer Assessment Tool

Addressograph

RELATED DATA						
Res. follows directions/co-operates:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Never	<input type="checkbox"/>
Res. c/o pain during transfers:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Never	<input type="checkbox"/>
Res. needs help to position equipment:	Always	<input type="checkbox"/>	Sometimes	<input type="checkbox"/>	Never	<input type="checkbox"/>

PHYSICAL STATUS						
Resident has use of arms:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>	No	<input type="checkbox"/>
Resident able to do SLRs:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>	No	<input type="checkbox"/>
Resident able to bridge:	Fully	<input type="checkbox"/>	Partially	<input type="checkbox"/>	No	<input type="checkbox"/>

<b>SPECIAL CONSIDERATION RE: USE OF SIT/STAND LIFT</b>	1. Does Resident have <b>adequate weight-bearing</b> though one/both leg(s)				Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2. Is Res able to <b>grip the handles</b> with 1 or 2 hands?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	3. Does Res <b>understand</b> the transfer method?			
					Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

FUNCTIONAL CRITERIA	RESIDENT INDEPENDENT	1 ASSIST REQUIRED	2 ASSISTS REQUIRED	RESIDENT NOT ABLE
Able to <b>sit</b> on side of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to <b>lift legs</b> onto mattress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to move from <b>lying to sitting</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to <b>lean forward</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to move from <b>sit to stand</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to <b>stand with 1 or both feet flat</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to <b>move feet</b> and turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to <b>walk</b> with or without aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Recommended Lift/Transfer Method</b>	Independent	Stand-by Assist		
	Stand-by Assist	1 Person Assisted Transfer		
		Sit/Stand Lift	2 Person Assisted Transfer	
			Sit/Stand Lift	
		Mechanical Lift	Mechanical Lift	<input type="checkbox"/>

- Complete the **RELATED DATA** section using check marks as appropriate. (At least 1 evaluator must have a professional designation)
- Complete the **FUNCTIONAL CRITERIA** section using check marks in **all columns that apply**.
- Using the column with the majority of check marks, **choose the most appropriate method of Lift/Transfer**. Also use the **RELATED DATA** to help determine method.
- Place a **check mark** in the box beside the chosen method. Decision making required by two health care workers, with at least one having a licensed professional designation.
- Post the appropriate **LOGO** in the resident's room and **chart as per procedure**.

Name/Sig. of 2 Evaluators: 1: \_\_\_\_\_ 2: \_\_\_\_\_ Date: \_\_\_\_\_

Comments/Precautions: (Including rationale for choice of transfer, particularly when a previous method is being discontinued.) \_\_\_\_\_