Manual Wheelchairs

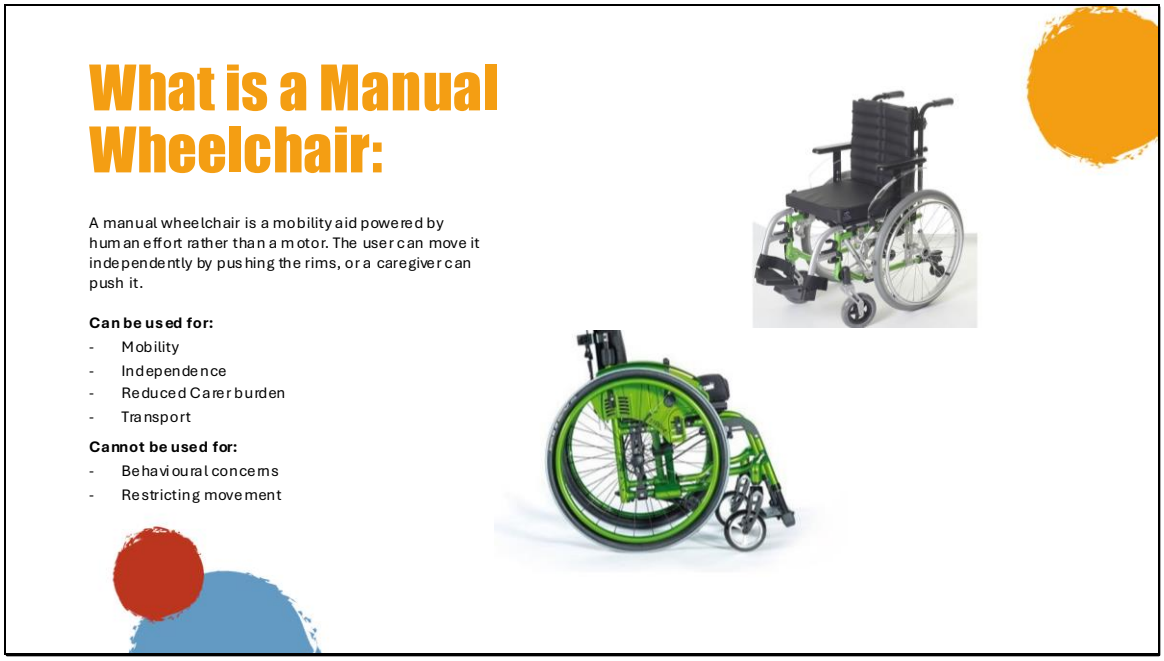
CRC ATSS

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Aims:

- What is a manual wheelchair?
- Who uses a manual wheelchair? And why?
- Types of manual wheelchairs.
- How to measure for a manual wheelchair.
- Seating options – cushions, backrests, hip straps, chest harness, etc.
- Case studies
- CRC ATSS Pathway and referral criteria
- Questions?
- Survey Link





Danika
A manual wheelchair is a mobility aid that relies on human effort for movement rather than a motor. The wheelchair user may propel themselves independently using the push rims on the rear wheels, or the chair may be pushed by a caregiver, family member, or support worker. Manual wheelchairs are available in a variety of designs and can be customised to meet an individual's physical, functional, and postural needs.

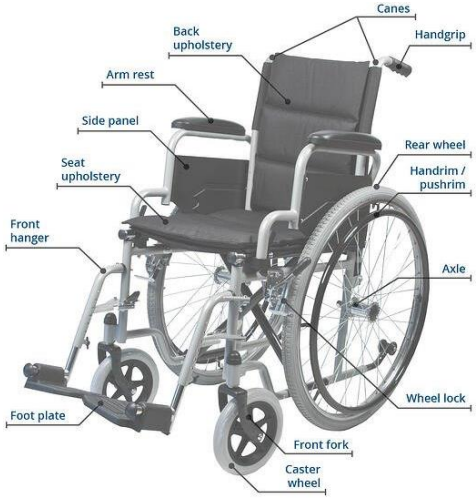
What can a manual wheelchair be used for?
Manual wheelchairs can support **mobility** by enabling people to move around safely and participate in everyday activities. They can promote **independence**, particularly when a person is able to self-propel. They can also **reduce carer burden** by providing a safer and more efficient method of assisting someone with mobility difficulties. In addition, manual wheelchairs are frequently used in transport, allowing individuals to access the community, attend appointments, or travel longer distances when walking is difficult or not possible.

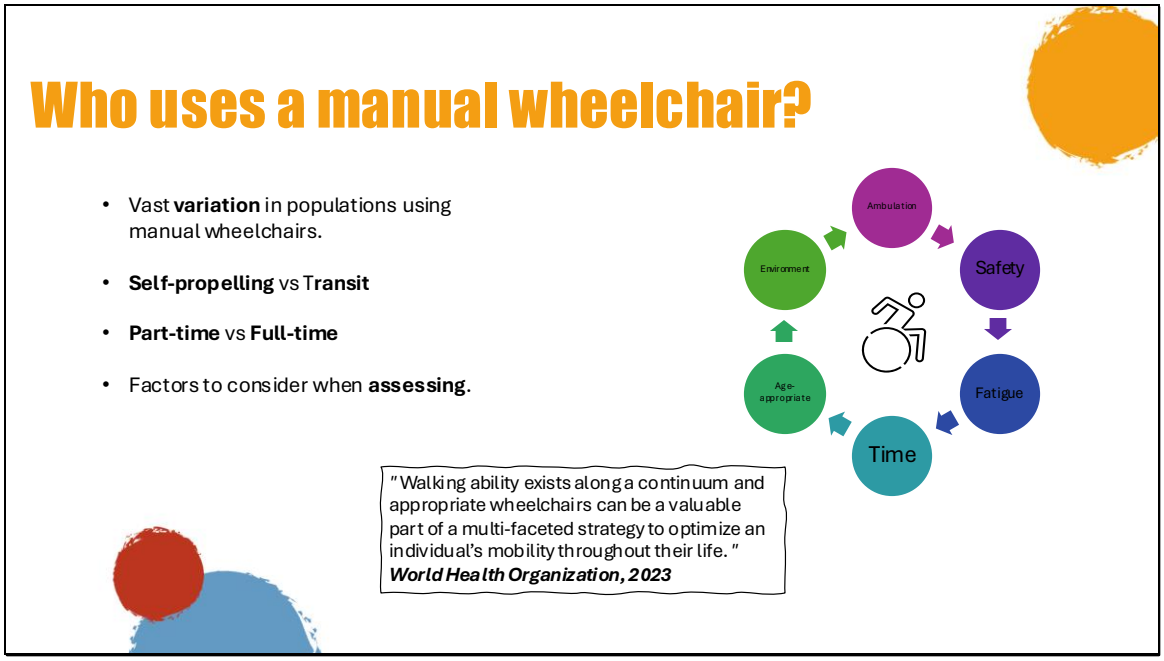
What should a manual wheelchair not be used for?
It is important to remember that a wheelchair is a mobility and positioning device,

not a behavioural management tool. A wheelchair should never be prescribed to manage behavioural concerns. Similarly, a wheelchair must not be used to restrict a person's movement or freedom. Any use that limits an individual's movement without appropriate clinical justification or client consent, may be restrictive practice and should be avoided.

The primary purpose of a manual wheelchair is to maximise function, participation, comfort, safety, and independence while supporting the individual's mobility needs in the least restrictive manner possible.

Anatomy of a Manual Wheelchair





Saoirse

There can be a vast variation in populations who use manual wheelchairs. Some populations that commonly use manual wheelchairs are, but not limited to, those with **spinal cord injuries, neurological conditions** such as cerebral palsy, multiple sclerosis, motor neurone disease, spina bifida, friedreichs ataxia and stroke-related disability, **muscular and neuromuscular conditions** such as muscular dystrophy, and spinal muscular atrophy, **limb differences** such as amputation, and others including autism spectrum disorder, joint, bone or chronic pain conditions, balance and coordination conditions, and fatigue-related challenges etc.

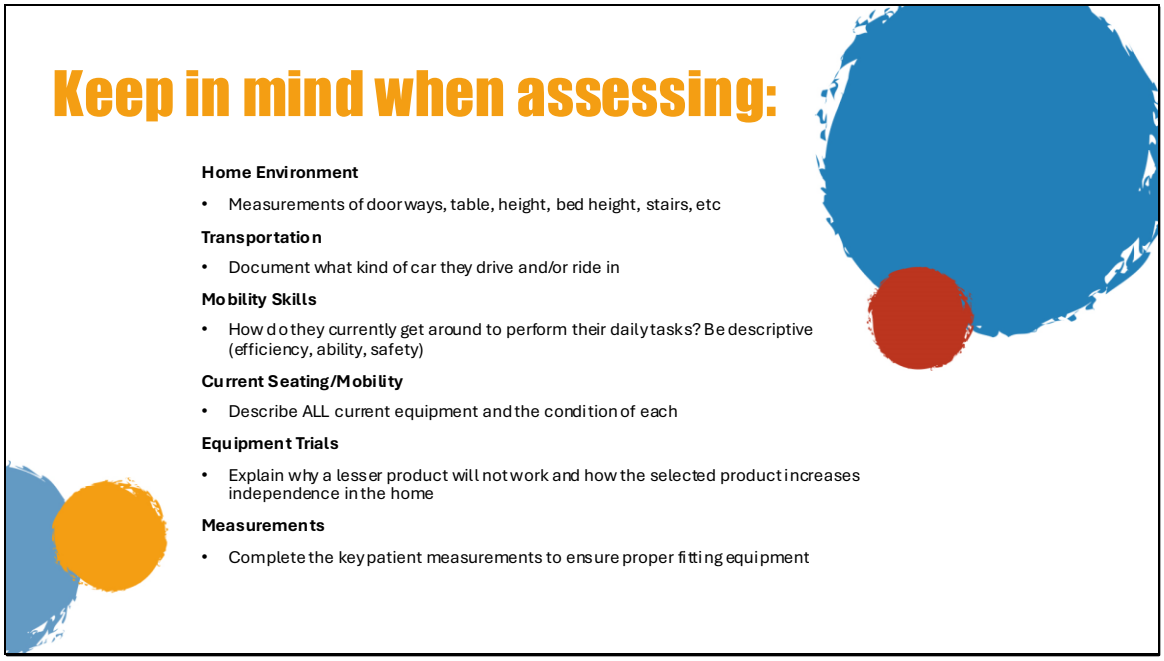
Some people may be part-time wheelchair users, for energy conservation, pain management or safety in certain environments. Others may be dependent on a wheelchair at all times. Wheelchair prescriptions often differ based on part-time vs full-time use.

The methods of mobilising in a manual wheelchair are either self-propelling or attendant propelled. Some people rely on both. Those who use self-propelling manual wheelchairs usually have full head control, good trunk control, good upper limb function, and good hand function. Those who use transit manual wheelchairs are usually unable to self-propel and unable to control a powered wheelchair. However, similarly to people being part-time wheelchair users, some people have the

ability to self-propel while still relying on attendant assistance for longer distances for energy conservation and pain management.

Thinking about assessments... Factors that may influence your clinical decision making in relation to provision of manual wheelchairs would be:

- Is your client non-ambulatory? Maybe they cannot walk without assistance or cannot walk at all. If your client requires assistance with mobility, would a manual wheelchair allow for independence?
- Does your client demonstrate decreased safety with ambulation? Are they at risk of falls or have a history of falls?
- Does the client fatigue throughout the day causing inconsistency with mobilising? Consider the 24-hour period and all of the environments within which they access.
- Does the client take considerable time to mobilise within their home environment? Does this affect their ability to carry out activities of daily living? Quality of life needs to be considered when assessing a clients mobility.
- If your client already has a manual wheelchair, is this wheelchair prescription meeting their needs? Are they as independent as possible while maintaining safety? Can they carry out their activities of daily living? Are they comfortable?
- Is the current mobility equipment age-appropriate? Consider the appropriate timing of transitioning from a buggy to a wheelchair.
- Are there environmental restrictions? Manual wheelchairs often have a smaller footprint than powered wheelchairs.



Saoirse
In addition to your typical evaluation, you MUST assess and document the following:

Home Environment
It is important to consider the client's home environment to ensure the wheelchair will be practical and usable in their everyday life. Measurements such as doorway widths, table heights, bed heights, and the presence of stairs can all influence wheelchair selection and accessibility.

Transportation
Transportation needs should also be explored. Document the type of vehicle the client drives or travels in, as this may influence the size, weight, and transportability of the wheelchair.

Mobility Skills
Assess how the client currently moves around to complete daily activities. Consider the efficiency, safety, and effectiveness of their mobility, as this helps determine the level of support and equipment required.

Current Seating and Mobility
Review all current seating and mobility equipment, including wheelchairs, cushions, and other assistive devices. Document the condition of each item and identify any

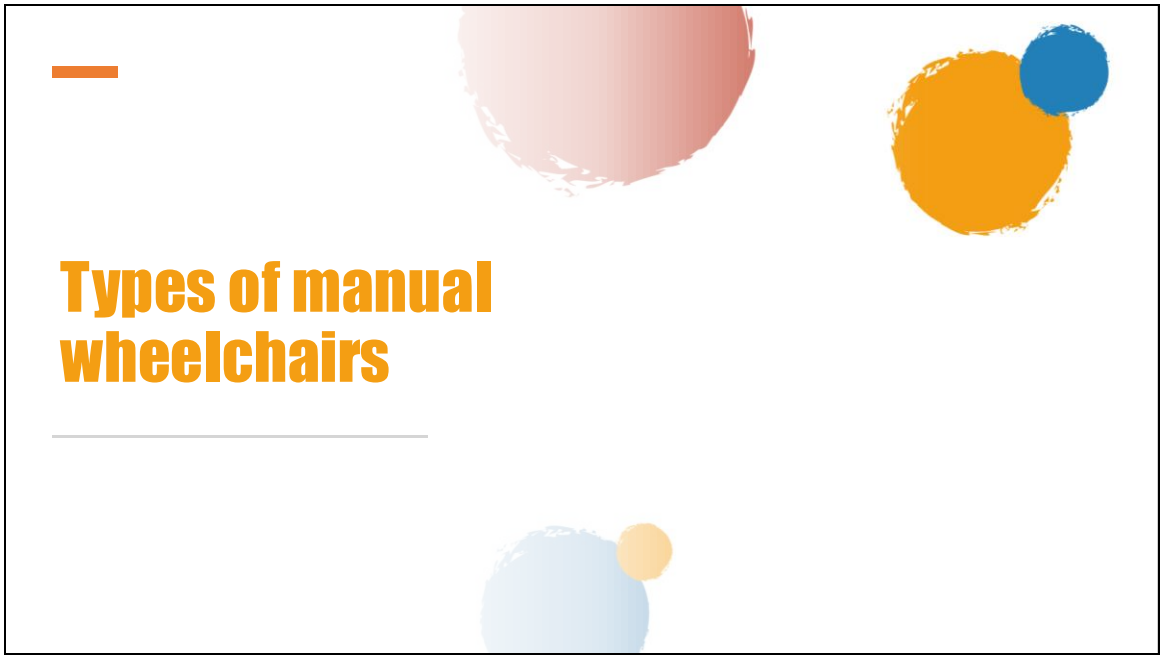
limitations or concerns with the current setup.

Equipment Trials

Equipment trials help demonstrate whether a proposed solution meets the client's needs. They also provide an opportunity to explain why alternative or less supportive products may not be suitable and how the recommended equipment can improve independence, function, and participation within the home environment.

Measurements

Accurate measurements are essential for achieving a proper wheelchair fit. Completing the key client measurements helps ensure the equipment provides appropriate support, comfort, function, and safety.



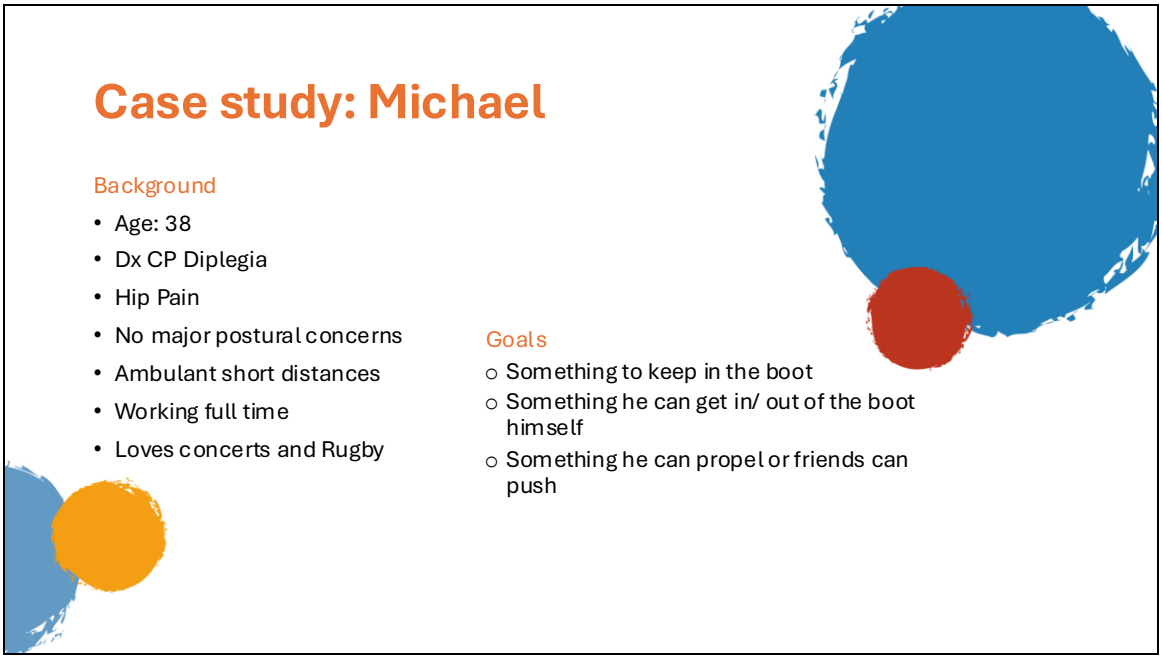
Rachel
Next we're going to talk briefly about some of the most common types of manual wheelchair. We've divided them into three broad categories and will be discussing a case study for each of these categories to give a taste of the type of client who might benefit from each of these.

Basic Chair

Attendant or self-propelled



Rachel
The basic manual wheelchair is the one you will see most often out and about. They are the ones that will be hanging around hospitals, even tesco. The idea is they are for occasional use and get you from A to B. they are not very easy to push, either from behind or from within and have limited adjustabilty for individualisation. They usually fold in the middle and fit nicely into the boot of a car. They are cost effective and have a valuable place when correctly prescribed. In general, the clients coming through CRC would usually have greater needs than would be accommodated in a chair like this.

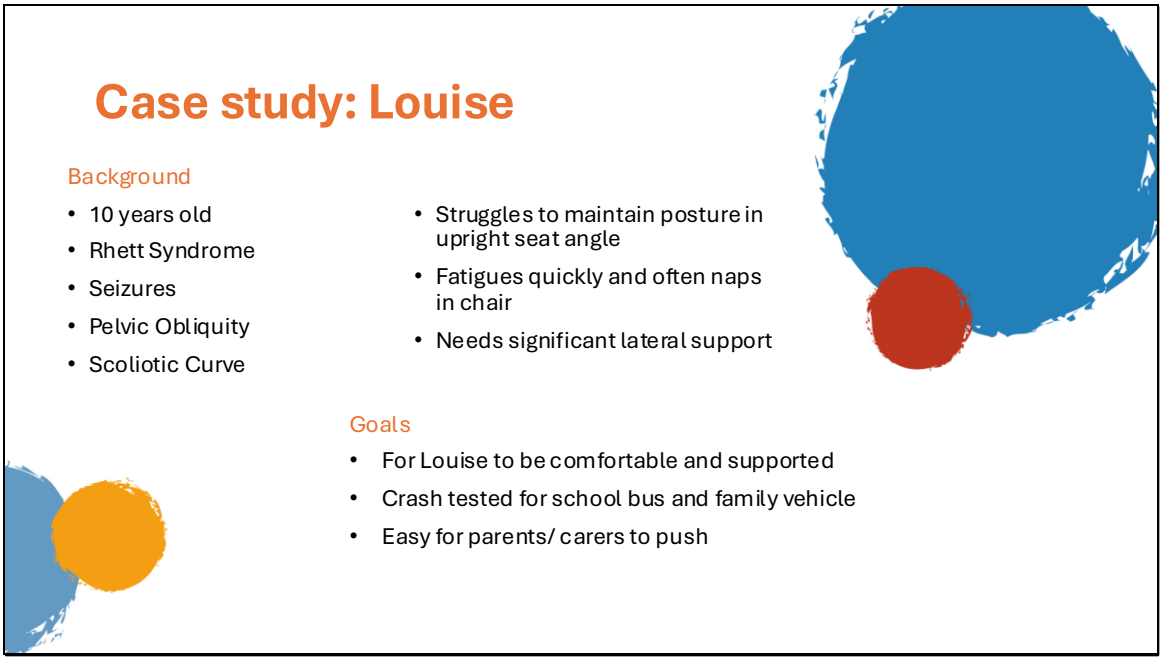


Rachel

Michael (not his real name) is a 38 year old gentleman with a diagnosis of Cerebral Palsy – Diplegia. He works full time and drives independently. He ambulates without aids over short distances .e.g. around the house and his workplace. He can manage getting to and from the car park at work as he has a designated parking space right in front of the building. He has been experiencing increasing difficulty with walking longer distances due to increasing hip pain. This has led to him curtailing his social life – matches and concerts were a big part of his life outside of work. He has been considering a wheelchair for a number of years but has been slow to make the decision. He has now decided that getting back to gigs and matches is the priority. He worked with his Primary Care OT to consider wheelchair options. A folding self-propelling wheelchair was chosen. Michael can remove the wheels and fold the chair. It fits in the boot of his car. Once the wheelchair base was decided on consideration was given to the required seating components. Given he has no significant postural concerns and uses the chair only occasionally a standard foam cushion and tension adjustable backrest provided enough support and comfort.



Rachel
Tilt in space chairs would typically be used for clients who spend most of their time in their wheelchairs. There may be some positional breaks, particulalry in the paediatric population for example floor time or even the use of comfort chairs. there are always some exceptions but for the most part these chairs would be used for clients who are full time wheelchair users. These chairs allow the whole seating system to tilt but maintain the clients' position in the chair. Often clients who need this kind of chair have higher postural needs, the tilt can be helpful getting the best position when transferring into the chair and if the client needs to be repositioned. Tilt is also useful for fatigue management, pressure management and comfort. Using tilt helps to redistribute pressure along the back of the body and therefore offload the ITs and bottom.



Rachel
Louise is a 10 year old girl with a diagnosis of Rhett Syndrome. She is fully dependent on her parents and carers for all aspect of her care. She is hoist transferred and does not self propel.
Lousie is prone to seizures and fatigues quickly.
She presented with fixed pelvic obliquity and rotation – higher and forward on the right as well as a scoliotic curve concave to the left – some correction could be achieved at spine. Louise had no independent sitting balance and struggled to maintain her posture in an upright seat angle.

Her parents main concern was for Louise's comfort and were keen for a chair that would tilt, similar to previous chairs. The chair also needed to be crash tested for use in the school bus and the family's own vehicle. Parents also wanted the chair to be easy to operate and push to get out and about with Lousie and her siblings.

Chair – tilt in space – to support posture, reduce fatigue and allow periods of rest. Given plan to use the chair in tilt, height adjustable push handles also a consideration for when chair tilted support manual handling for parents. Also position of tilt lever. The chair did not need to fold. Zippie TS and Fuze Jnr considered but ultimately

parents chose the Fuze as they felt it was more comfortable to push. Other options Discovery or Dino manual wheelbase. From a clinical point of view the Fuze is a more Robust chair and likely to fare better with



Rachel

These chairs are usually prescribed for client who are in and propelling the chair all/ most of the day. They are very customised.

Not all rigid frame chairs are created equal. Within this category there is wide variation. they can be heavier/ lighter/ more robust, more adjustable. The manufacture times can also vary and rectifying issues if they arise. Some chairs may need to go back to the manufacturer, while others can be adapted by the Irish agents.

Case Study - Luke

Background

- 21 years old
- Spinabifida
- In college
- Just passed driving test



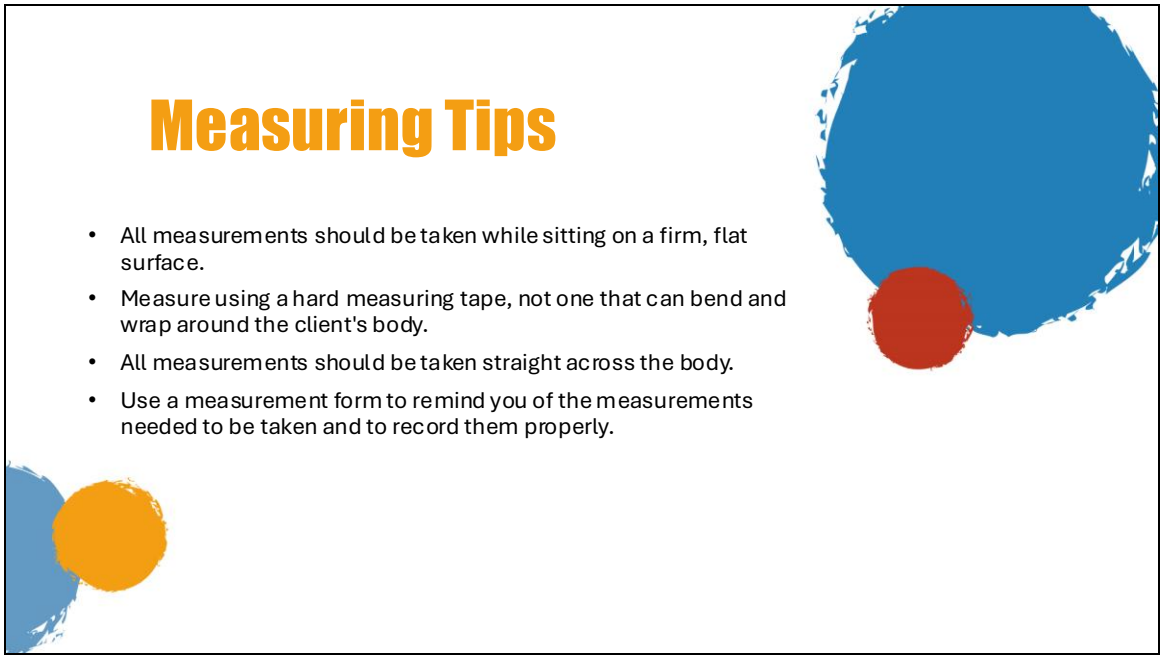
Goals

- Get out in the car with friends
- Maintain independence and ease of self propelling.

Luke is a 21 year old student with a diagnosis of Spinabifida. He has had manual chairs all his life and at this stage is very familiar with what works and does not work for him.



Danika



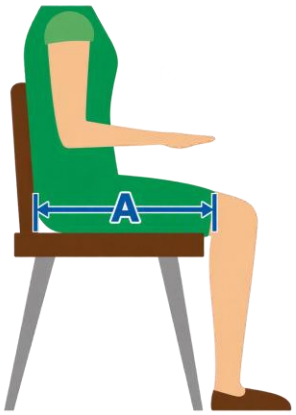
Before taking any wheelchair measurements, there are a few key tips to keep in mind. Always measure the client while they are sitting on a firm, flat surface, as soft surfaces can affect posture and accuracy. Use a rigid measuring tape rather than a flexible one, as flexible tapes can wrap around the body and give larger measurements. Ensure all measurements are taken straight across the body for consistency, and use a measurement form to help record measurements accurately and avoid missing any important information

Seat Depth

- Even distribution of the wheelchairs user's weight
- Avoiding Pressure
- Avoiding Pelvic Tilt

Taking Measurement:

- Sit client on a flat surface.
- Measure the distance from the rear most point of the buttocks/lower back to the hollow end at the back of the knee (popliteal fossa)



SEAT DEPTH: A

Purpose:
Correct seat depth helps distribute weight evenly through the thighs, reducing pressure and improving comfort. It also supports pelvic positioning and helps prevent a posterior pelvic tilt.

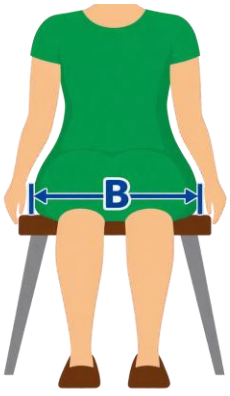
How to Measure:
With the client sitting on a firm, flat surface, measure from the back of the buttocks to the popliteal fossa, or the hollow behind the knee.

Seat Width

- Determines the client's comfort and performance
- Must be wide enough to ensure good positioning and weight distribution
- Must be narrow enough to allow for good self-propelling technique
- Ensure no bending of type

Taking measurement

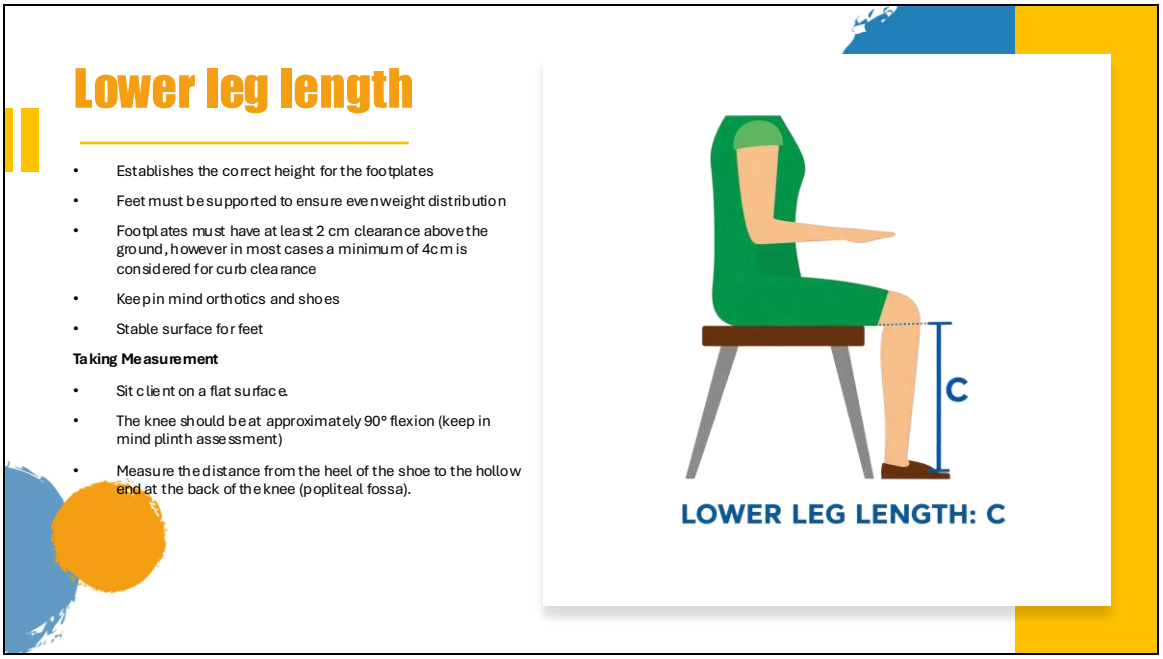
- Sit client on a flat surface
- Measure from GT to GT OR across widest part of hips



SEAT WIDTH: B

Purpose:
Seat width has a significant impact on the client's comfort and functional performance. It should be wide enough to allow for good positioning and even weight distribution, but narrow enough to support an efficient self-propelling technique. An appropriate seat width also helps prevent lateral trunk leaning.

How to Measure:
With the client sitting on a firm, flat surface, measure the distance between the greater trochanters, **or** across the widest part of the hips. This measurement is used to determine the appropriate seat width for the wheelchair.



Purpose:
Lower leg length establishes the correct height for the footplates. The feet must be well supported to ensure even weight distribution and maintain a stable base of support. It is also important to consider the height added by footwear and any orthotics when determining the final footplate position.

How to Measure:
With the client sitting on a firm, flat surface and the knees positioned at approximately 90 degrees of flexion, measure from the heel of the shoe to the popliteal fossa, or the hollow behind the knee. Remember to account for the footwear and orthotics the client will typically use when seated in the wheelchair.



Front Seat Height:
Not to be confused with the LLL; the **LLL** is the **user/body measurement** whereas the **FSH** is the **wheelchair measurement**.

How to measure:

- Measure from the **floor to the front edge/top of the seat (seat rail) upholstery OR cushion**. - The cushion should be considered when an alternative cushion will be used for adding or lowering height that can impact the footplates or self-propelling. cushion needs to be taken into consideration due to canvas or solid seat base.

Purpose:

- Ensures the user's feet are properly supported on the footplates.
- Influences ease of transfers, propulsion, positioning, and pressure distribution.

Relationship Between LLL and FSH:
The front seat height is typically based on the lower leg length, taking into account:

- Cushion thickness
- Footplate clearance from the floor (usually 2.5 to 5 cm)
- Footwear

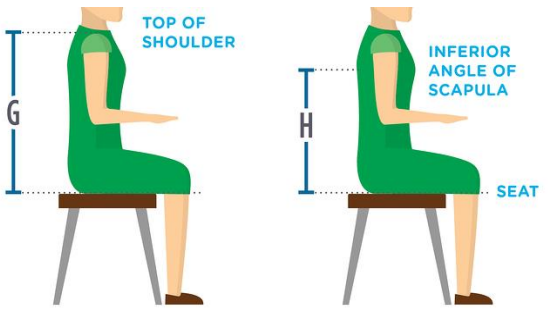
- Any positioning requirements

Backrest height

- Dependent on clients need for postural support
- Maintaining good posture
- Maintaining freedom of movement

Taking Measurement

- Let the person sit on a flat surface.
- Measure the vertical distance from the seat platform to the scapula
- If more trunk support is required, measure from the seat platform up to the required level of support
- If less trunk support is required reduce the backrest height in order to improve activity



Purpose:
Backrest height is determined by the client's postural support needs. It should provide enough support to help maintain good posture while also allowing as much freedom of movement as possible. The level of support required will vary depending on the client's trunk control and functional abilities.

How to Measure:
With the client sitting on a firm, flat surface, measure the vertical distance from the seat surface to the inferior angle of the scapula. If additional trunk support is required, measure to the level where support is needed such as the top of shoulders. If less trunk support is required, a lower backrest height may be selected to maximise upper body movement and functional activity (usually the inferior angle of the scapula).



Seat Depth Too Long
When the seat depth is too long, the front edge of the seat presses into the back of the knees. This can be uncomfortable and may reduce circulation. To relieve this pressure, the user often slides forward in the chair, leading to a posterior pelvic tilt and poor posture. Sliding can also increase the risk of skin breakdown and reduce overall stability.

Seat Depth Too Short
When the seat depth is too short, there is insufficient support under the thighs. This reduces weight distribution and can make the person feel less secure. Users may compensate by widening their leg position, resulting in increased abduction, which can affect posture, alignment, and functional activities.

Seat Too Wide
A seat that is too wide reduces lateral stability and makes it more difficult to maintain a midline position. For individuals who self-propel, arm positioning becomes less efficient because they have to reach further to access the push rims. This can

increase effort, reduce propulsion efficiency, and contribute to shoulder strain over time.

Seat Too Narrow
When the seat is too narrow, the hips and thighs are compressed against the sides of the wheelchair. This can lead to pelvic rotation, discomfort, and increased pressure over the greater trochanters, which are the bony prominences on the outside of the hips. Prolonged pressure in these areas can increase the risk of pressure injuries.

Footrests Too High
When the footrests are set too high, the knees are positioned higher than intended, which can increase pressure through the sitting bones and contribute to a posterior pelvic tilt. The user may feel unstable, and the altered positioning can affect overall posture and comfort. In some cases, it may also lead to increased pressure under the thighs due to the change in weight distribution.

Footrests Too Low
When the footrests are set too low, the feet may not be adequately supported, causing increased pressure under the thighs near the front edge of the seat. This can reduce circulation and create discomfort. Low footrests may also result in the feet dragging on the ground or increase the risk of the footplates catching on uneven surfaces, curbs, or thresholds, affecting both safety and wheelchair maneuverability.

Backrest Too High
A backrest that is too high may restrict shoulder blade movement and upper limb function. This can make self-propelling more difficult and less efficient. It may also create unwanted pressure on the scapulae or upper back, affecting comfort and mobility.

Backrest Too Low
When the backrest is too low, it may not provide sufficient trunk support. This can lead to instability, increased fatigue, and difficulty maintaining an upright posture. Individuals with reduced trunk control are particularly affected, as they may require a higher level of support to sit safely and function effectively.

Key Message
The goal of wheelchair measurement is to achieve the best balance between support, comfort, posture, and function. A wheelchair that is correctly fitted helps maximise

independence, promotes efficient movement, reduces the risk of pressure injuries, and supports long-term health and participation.



Danika



Danika

Basic Adjustments

Basic wheelchair adjustments help optimise comfort, posture, and support while ensuring the wheelchair is set up appropriately for the user's individual needs. These include adjusting the footplates, armrests, backrest, and headrest to promote alignment, pressure management, and functional positioning.

Complex Adjustments

Complex adjustments have a greater impact on wheelchair performance, stability, and propulsion efficiency and should be completed by clinicians or technicians with appropriate training. Changes to rear wheel position, rear seat height, seat depth, and seat width can significantly influence posture, pressure distribution, manoeuvrability, and overall function.

Seating options

Saoirse

More than wheelchair type, you need to consider seating options…



"Inappropriate wheelchairs can lead to poor outcomes for wheelchair users. This may include decreased health and mobility, development of secondary complications, participation barriers..."
Wheelchair Provision Guidelines, 2023

Saoirse
The seating option chosen is equally as important as the method of mobility. Seating should be chosen based on the client's postural support needs, skin integrity needs, comfort needs and function.
Postural needs can be assessed on the plinth in supine lying and in sitting on the plinth, ideally on the edge of the plinth if the person can sit there, with or without support.

Seat Cushions

Off-the-shelf / Non-custom

- Size – width, depth and height.
- Skin integrity – foam, gel, air
- Postural needs – flat, contoured, ischial well, pommel, etc.



Saoirse

It is important to check the pelvis for any obliquity or rotation. An obliquity is when one ASIS (anterior superior iliac spine, the bony prominences at the front of the pelvis) is higher than the other, a rotation is when one ASIS is further forward than the other. Remember that in supine the pelvis may be correctable to neutral, but, with the addition of gravity, the pelvis may be fixed in this position. The seat cushion may need to reflect any fixed obliquity with the addition of obliquity pads to prevent any pressure areas forming over time. The likes of the gel cushion pictured here could be built up on one side with an extra gel pad. The likes of the ROHO can be adjusted to accommodate the pelvis position, as can the Vicair. Getting this right is important to ensure there is equal pressure and there are no points of excessive pressure that could lead to tissue damage or skin breakdown. It is important to check hip abduction and adduction with the knee flexed – this will identify what contouring is needed in the cushion. Is a pommel needed to encourage the hips out of adduction and into a neutral position? Is the contouring sufficient to encourage the hips from abduction into a neutral position?

It is important to check hip flexion. If hip flexion of 90 degrees cannot be achieved, this should be reflected in the seating. It is important to consider the depth of the ischial well in the cushion you are providing if there are any restrictions to hip flexion

– does the ischial well increase the hip flexion angle past what could be achieved during assessment? Cushions such as the Domino, Dreamline STX, Spex cushions, etc are highly adjustable and can bridge the gap between off the shelf and moulded cushions.



Saoirse

Again, in relation to hip flexion, the backrest may need to be in a reclined position if a hip flexion angle of 90 degrees cannot be achieved. Backrests such as basic canvas backrests that are fitted directly to the back posts will likely not have a tool-adjustable recline angle. However, at prescription you can stipulate the angle of back post required – usually 3 degrees, 10 degrees and 15 degrees available but make sure to speak with the supplier. 10 and 15 degree posts may affect the stability of the chair so are not commonly supplied. Solid backrests like the Jay range and Acta range have brackets that are fitted onto the back posts. These brackets usually allow for adjustment of the recline angle. The plinth assessment should also highlight if a person can sit independently or not. Lateral trunk supports would need to be considered if the person required support to prevent leaning during the assessment. Lateral supports are usually part of the backrest ordered. These can be part of the backrest shell, or they can be bolted onto the shell and removable if necessary. The lateral supports can also have a swing-away mechanism if required for hoisting, dressing, and other activities carried out in the chair. In general, integrated lateral supports are stronger, and removable or swing-away mechanisms can be weaker, and move or break over time. There are some backrests out there that bridge the gap between standard backrests and custom moulded backrests in relation to their

adjustability such as the Spex super shape backrest.
When it comes to lateral support it's important to consider appropriate loading – if lateral support is placed at the pelvis only, the spine is not supported. Likewise, if lateral support is only placed at the trunk, and there is space at the side of the hips, then the pelvis is unsupported. If the trunk or pelvis is unsupported, generally that means there is space and it is likely that the pelvis or trunk will start to move to one side and fill that space.
Another consideration for manual wheelchair users with very active lifestyles is the weight of the seating – a low canvas back is going to be significantly lighter than a shoulder height solid backrest with lateral support. This not only affects their stamina for self-propelling long distances, but also the weight of the equipment when doing things like lifting it in and out of the car if they drive independently. Or a gel cushion is going to be significantly heavier than a foam cushion.

Other seating options

- Hip straps
- Chest harnesses
- Headrests
- Thigh guides
- Foot supports
- Calf straps
- Armrests
- Trays



Saoirse

Does the client require a headrest? Remember these are required legally if the person is going to be sitting in their wheelchair while travelling in a vehicle. Headrests can be fitted onto solid shell backrests or onto the back brace bar. Asking about travel is an important question at assessment – depending on the spec of the manual wheelchair, headrests can be challenging to add retrospectively. If the person requires head support due to reduced head control, it is important to ensure the pelvis and trunk are adequately supported also.

Hip straps are crucial in keeping the pelvis in a neutral position, especially for those who tend to rotate the pelvis or slide into posterior pelvic tilt. Ensure at the specification appointment that the hip strap cams can be fitted at the necessary position to provide the desired pull direction on the hip strap. Downward pull direction of back pull direction?

Armrests can be fixed, removable or flip back, depending on how the person transfers and how much weight and force goes through the armrests. Narrow or wide armrests, short and long, etc.

Thigh guides – if cushion contouring is not sufficient to prevent abduction, and the appropriate pelvic support and hip strap is in place, then thigh guides can be used.

It is important to remember that not all equipment discussed will be compatible with

manual wheelchairs. It is best to discuss this with the supplier at the specification appointment. If needs arise post-supply, then we would recommend an in-depth discussion with a supplier with confirmation that the requested item will fit the existing wheelchair, or where possible requesting delivery of trial items to fit to the chair and show the client, or a demo appointment with a supplier.

Custom Seating

- Foam carve moulded seating
- MSI moulded seating
- Matrix adjustable contoured seating
- 3D printed





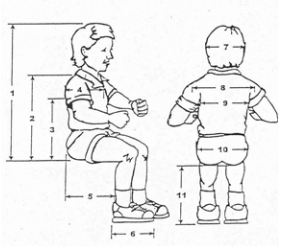

Saoirse
Custom moulded seating options are also available and used in cases where off-the-shelf, modular seating is not meeting the clients needs. There are some examples of types of moulded seating here, however, more specific detail regarding custom moulded seating will be provided in the webinar on this topic hosted by our colleagues Daniel, Nicola and Sharon.


Keep in mind:
For assessment and specification:
• Use your reps, but maintain your clinical autonomy.
• Use your colleagues' experience and knowledge.
• Take your time, mistakes happen when we rush.
• Use a measurement form, our one is attached in the next slide.

Saoirse

Measurement form:

BODY MEASUREMENTS



1. Top of head to seat _____
2. Top of shoulder to seat L ____/____R
3. Under arm pit to seat L ____/____R
4. Trunk depth _____
5. Seat depth L ____/____R
6. Foot length L ____/____R
7. Width of head _____
8. Shoulder width _____
9. Arm pit to arm pit _____
10. Hip width _____
11. Lower leg drop L ____/____R

Saoirse

The same chair with different specs





There's always a trade off

We need to work with the client to weigh the options and decide which compromises are acceptable.



Rachel

Optimise or Compromise?

- Postural Support vs Function
- Lightest possible chair vs most functional chair
- Easy to transport vs easy to use all day
- Factoring growth vs best fit today
- Independent use vs attendant use

Rachel



Rachel

But it was perfect on paper!

The Brief

- 16-year-old
- full-time w/c user with cognitive impairment
- Took up w/c tennis
- More outings
- Goal – more independence and easier to self-propel
- Chair – move to rigid frame with active set up

The issues

- Can self-propel that does not mean the client will/should
- Parents/caregivers still pushing the majority of the time – push handles too low
- Solution – added higher push handles

Rachel

But it was perfect on paper!

The Brief

- Adult (TBI) full-time wheelchair user
- Needs significant postural support and option for tilt
- Needs to support foot propelling for independence

The issues

- Chair is difficult to navigate into the bathroom in residential home due to width
- Chair abandoned and client using basic folding chair with no postural support
- Solution – narrower chair without tilt, postural support through seating.

Rachel

Ali's first chair

How would you describe this client?

Passive, supported, observing, being taken somewhere



Passive or active?

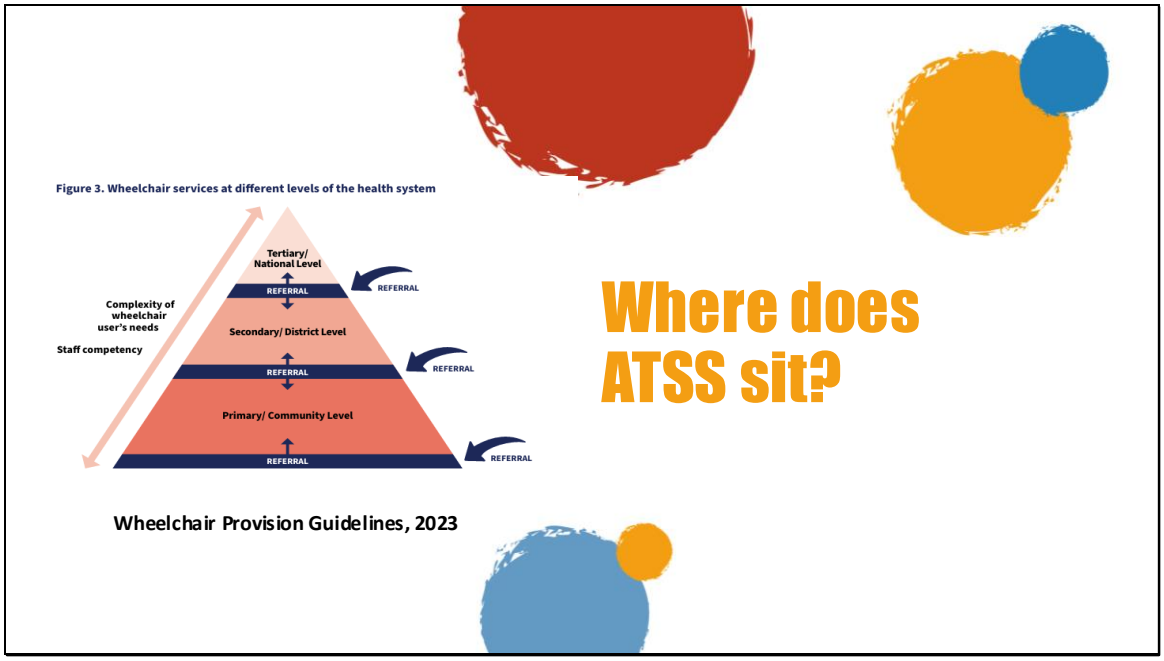
Ali's new chair

How would you describe this client?

Active, self-directed, exploring, going somewhere







Saoirse

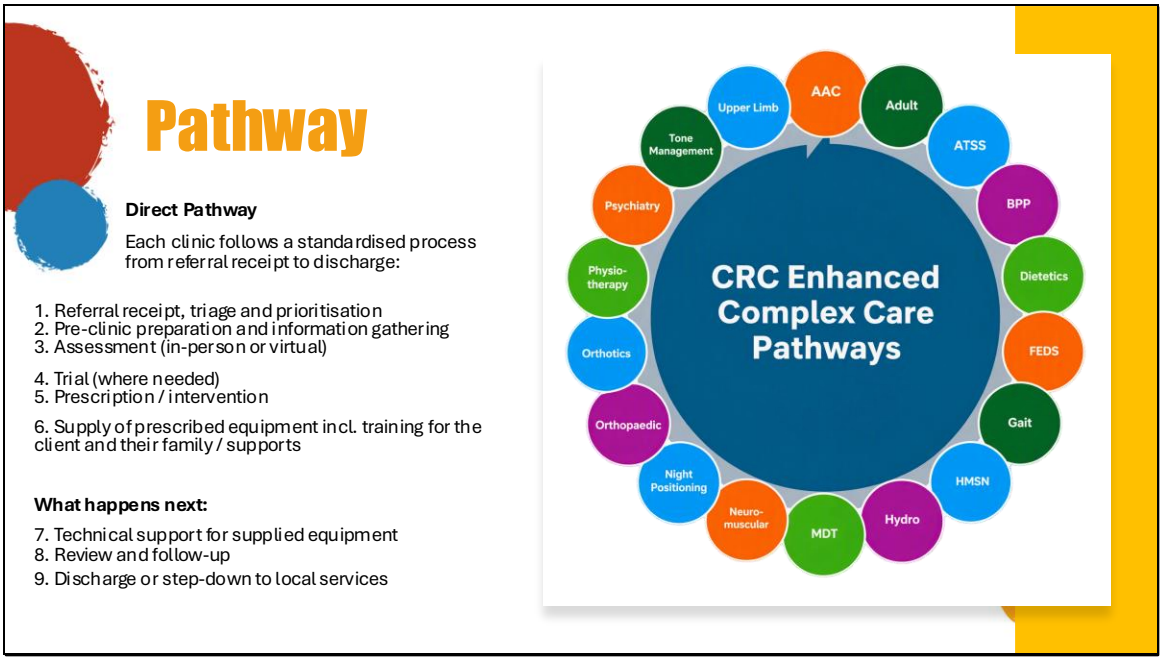
Lets take a look at where the Assistive Technology and Specialised Seating Department fits within our health system. ATSS is considered a specialist service and would be a tertiary or national level support on this diagram. We receive referrals from both primary and secondary level services for clients with complex seating needs.

In terms of paediatrics, at Primary level – primary care services provide intervention and care for children with non-complex needs. At secondary level, Children's Disability Network Team provides intervention for children with complex disability needs. If a child attending these services has non-complex seating needs, it is expected that this would be addressed locally, not requiring a referral to ATSS. Throughout our intervention with children, their primary care or cdnt therapists would remain their primary therapists. We are there to address a specific episode of care or need, with a main focus on prescription.

In terms of adult services secondary supports are less clear and referrals are generally made from primary care services.

It is important to remember that for some cases, we may request that the client's referring therapist attends an appointment, especially if there is likely to be training related to provided equipment involved, or if the client has been referred in a

consultation type appointment has been requested.



Saoirse – refer to Ruth and Sinead's introductory webinar
Enhanced complex care pathways are structured healthcare programs that provide coordinated, multi-disciplinary assessments and treatments for clients with severe, high-need, or multi-layered medical conditions and disabilities. Our Enhanced Complex Care pathways deliver specialist, multidisciplinary assessments, and interventions nationally for children and adults with complex disabilities where specific needs require expertise not solely available through local services.

Direct Pathway
Each clinic follows a standardised process from referral receipt to discharge:
1. Referral receipt, triage and prioritisation
2. Pre-clinic preparation and information gathering by the ATSS team
3. the client would then attend for Assessment (in-person or virtual- where appropriate)
4. They would then attend for Trial (where needed)
5. A Prescription would be completed for the recommended equipment
6. And a Supply appointment would be offered to set up the prescribed equipment. This includes training for the client and their family / supports

What happens next:

7. We also offer Technical support for supplied equipment such as assistive technology devices
8. A Review by phone is completed and follow-up appointment scheduled if required
9. Complete the episode of care and step-down to local services



Future training – This will form the basis of our future training so please do take the time to scan and fill out this brief survey


ATSS TRAINING
LECTURE SERIES
Specialised Seating and Assistive Technology
Building knowledge. Enhancing care. Empowering better outcomes.
A 5-PART TRAINING SERIES DESIGNED TO SUPPORT YOUR KNOWLEDGE AND PRACTICE IN ASSISTIVE TECHNOLOGY
OCTOBER 15TH
TRAINING SERIES 2
Introduction to custom moulded seating
12:30–1:30pm
OCTOBER 21ST
TRAINING SERIES 3
Introduction to manual wheelchairs
12:30–1:30pm
OCTOBER 28TH
TRAINING SERIES 4
Introduction to power mobility and alternative access
12:30–1:30pm
NOVEMBER 4TH
TRAINING SERIES 5
Introduction to assistive Technology
12:30–1:30pm
ALL SESSIONS ARE HELD 12:30–1:30PM
Mark your calendar and join us for each session!
VENUE: ONLINE
Join from the comfort of your home or workplace.
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ATSS DEPARTMENT, CENTRAL REMEDIAL CLINIC



Any Questions?
Feedback form

Thank you

