FREE PAPER 7

Why a wheelchair - is this always the best solution for specialist seating?

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Summary

The presentation will highlight some of the differences between static and wheelchair seating. It is a reflective account from two services who consider specialist seating when assessing functional need. Case studies will show how this influences prescription in order to meet client goals.

Aims and Objectives

Wider understanding of how seating and environment affects function

Increased knowledge of the differences and similarities in 'static' & 'mobile' seating

Increased awareness of how environmental and personal factors influence seating prescription.

Reflection on practice

Background

We work as part of an integrated Occupational Therapy service, one of us is a clinical specialist for the wheelchair service and the other a clinical specialist for Continuing Healthcare (seating & manual handling). We identified that our clients can require specialist seating to meet postural needs, and that these can be met in different ways.

Postural management is fundamental but becomes vital when individuals have functional limitations. Those with reduced movement are susceptible to secondary problems such as tissue damage, respiratory problems, swallowing and digestive problems, muscular contractures, pain and discomfort. Therapists assess an individual's need for postural management intervention and, if appropriate, correct with the use of specialist equipment. This is done following thorough assessment of function and identifying client goals.

Occupational Therapists consider function in relation to 'activities of daily living'; we established that we work to a wider definition of function. The WHO (2001) defines function as "an umbrella term for body functions, structures, activity and participation…. The positive aspects of the interaction between an individual and their contextual factors".

We considered the International Classification of Function (ICF) to aid our reflections. Farrell et al (2007) identified that the ICF moves away from the negativity associated with disease; focusing on health, looking at "functional disability" highlights the need to look at functional issues and detracts from those "expected" from a particular diagnosis. Foley (2008) also identified the usefulness of ICF to identify functional ability as impairment increases.

From this we recognised that the level of clients' function and their functional goals influenced the type of specialist seating needed ('static'/'mobile'), which in turn determined which service to provide.

We listed the differences and similarities between the types of seating each of us provide, debating the benefits and costs of one over another – for example comfort may be a higher priority and provided by static seating rather than wheelchair seating. We then looked at case examples where clients had been referred to one of the services and, following assessment, they were provisioned by the other, or both services provided. Goals were used to establish whether clients achieved the desired outcomes from their seating

We looked at the role function plays in prescribing for posture and mobility needs, asking the question: "is there a difference between providing static or wheelchair seating in relation to functional need?" We identified differences as well as similarities in posture/mobility seating and reflected whether clients' needs are being met. Those clients seen had multi-factorial complex health and social care needs and as such were under Continuing Healthcare Funding. Some clients were already in receipt of wheelchairs.

Discussion

Part of our reflection considered the features of static and wheelchair seating. Generally both are supportive, with wheelchairs being able to offer greater postural correction. Both static chairs and wheelchairs meet tissue viability needs; can be used for fatigue management and pain management. Tight hamstrings and unilateral variations in hip/knee/foot angle are not as easily accommodated in static chairs due to single calf pad and footboard. Wheelchairs are easier to transfer into using a hoist and it is easier to check for correct positioning.

Both types of chair can be moved; however static chairs are not designed to go over thresholds, are often of greater bulk, and have small castors making them impractical as a mobility device. Static chairs can be used between rooms in the client's home or a nursing/residential care environment. Static chairs cannot be self-propelled; therefore the client is dependent on a carer for movement. Powered wheelchairs can be an option.

Static chairs are more encompassing, this can increase sense of safety or cause isolation. Clients in wheelchairs can feel more exposed, and are at risk from others moving them at will. Wheelchairs enable participation and engagement in activities more easily. Clients can however find themselves participating in groups/activities which they haven't chosen because the carers believe 'it's good for them' or it reduces carer burden.

References

World Health Organisation (2001) International Classification of Functioning, Disability and Health; ICF. Geneva: WHO

Foley G (2008) *Occupational Therapy in Progressive Neurology: a Rehabilitative Approach* British Journal of Occupational Therapy 71(7) pg308-310

Farrell J, Anderson S, Hewitt K, Livingston M H, Stewart D (2007) *A survey of occupational therapists in Canada about their knowledge and use of the ICF.* Canadian Journal of Occupational Therapy 74 pg221-232

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