Clinical Care Pathway; ODFS® Pace

Patient Details Front Sheet

Name…….…… DOB……	Address *(Attach label if available)*
Contact telephone numbers; Home…….…… Work……...…… Mobile……..……..	Emergency contact details; Name…….…… Contact number…… Relationship to patient.……

GP details — Referring doctor? Y N

Name; Address;

Telephone number;

Consultant details — Referring doctor? Y N

Name; Address;

Telephone number (if known);

Details of other professionals to be copied into correspondence

Changes to medication (give dose where known) **since Initial assessment**

Primary Diagnosis:

Date of First Set-up

Initial Outcome measures: NS Speed:_____ NS Borg RPE: _____

Odstock Medical Limited
National FES Centre
Salisbury District Hospital
Salisbury, Wiltshire, UK
SP2 8BJ

Tel: +44 (0) 1722 429065
Fax: 44 (0) 1722 425623
Enquiries @odstockmedical.com
www.odstockmedical.com

Leading Rehabilitation Through Technology

Patient Contract

1. I agree that staff employed by the National Clinical FES Centre, Odstock Medical Ltd, Salisbury District Hospital, Salisbury, UK may provide me with FES treatment.

   Patient/carer initial ……..

2. I understand that my equipment remains the property of the FES Centre and I agree to return it when I am no longer receiving treatment from the FES Centre.

   Patient/carer initial ……..

3. Should I find that I am unable to attend an appointment, I agree to inform the FES centre at the earliest opportunity. I understand that should I fail to attend 2 or more appointments ***without letting the FES Centre know***, I will be discharged and asked to return my equipment.

   Patient/carer initial ……..

4. I am aware that should I cancel and rearrange more than 2 appointments **without a valid reason agreed with my clinician**, I will be discharged and asked to return my equipment.

   Patient/carer initial ……..

5. I understand that should I fail to return my equipment after being discharged I will be charged for its value.

   Patient/carer initial ……..

Patient/ carer sign ……Print ……Date……

Clinician sign……Print……Date……

Equipment Type	**ODFS® Pace**	Other	Other
Serial Number			
Instructions Supplied			
Signature of User			
Signature of Clinician			
Date Equipment Returned			
Name and Signature (received by):			

PHOTOGRAPH
OF PATIENT

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UK

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VIDEO and PHOTOGRAPHIC CONSENT FORM

In the course of your treatment at the National Clinical FES Centre it may be useful to use video or still photography to record your condition or performance. This may be for 3 reasons:

1. To record your present condition so a comparison can be made at a later date to monitor your progress.
2. To illustrate the type of treatment you are receiving for the purpose of teaching other clinicians.
3. To illustrate the type of treatment you are receiving for the purpose of promoting FES.

If the video or photograph can be taken without revealing your identity by showing your face, this will be done. However, this is not always possible and it may be that you might be recognisable. You do not have to give your permission to be videoed or photographed and refusal will not affect your treatment at Salisbury District Hospital in any way.

Please initial the items to which you give consent

1. I confirm that I have read and understand the above and have had the opportunity to ask questions. …….
2. I understand that my participation is voluntary and that I am free to withdraw at any time, …….
   without giving any reason, without my medical care or legal rights being affected
3. I understand that I may be recognisable from the video recording or photography …….
4. I give my permission for video recordings or photography to be used to monitor my treatment. …….
5. I give my permission to use video recordings or photography for educational purpose …….
6. I give my permission to use video recordings or photography for promotional purposes …….

Patient/carer sign……Print……Date……

Clinician sign……Print……Date……..

ODFS® Pace Set-up	Date
Patient name…….……. DOB ……..……..…… *(Attach label if available)*	Clinician sign …… Print name……. Designation……...

Treated side: **L** **R**	**Clinician Initial**	**Not required**
Implied consent		
Changes to patient details/medication recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Electrode care		
Skin care		
Footswitch positioning and insertion		
Written/photographic instructions issued		
Precautions given		
Skin checked on day 1		
Skin checked on day 2		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
Consent forms completed and COPY of contract given to patient		
Photo taken of patient		
GAS and VAS form completed		
10 metre walks completed		
Patient Handling Profile completed		

CONSUMABLES ISSUED
Electrodes (no. + type) Blue Pals 50 x 50 …….. Other…….
Footswitch
Electrode leads (length)
Footswitch leads (length)
Insoles (size + side)
Accessories: Pouch Leg strap

Parameter	**Setting**
Set up	
Current	mA
R. Ramp	ms
Extn	ms
F. Ramp	ms
Time Out	ms
Delay	ms
Waveform	ASYM / SYM
Freq	Hz
Sounder	SETUP / OFF / ALWAYS
Beeps	ON^{+} / ON / OFF
Timing	ADAPTIVE / FIXED / NTO
Lock	OFF / 1s / 3s
Exe	OFF / ON Time: …….
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Software	
Serial Number	

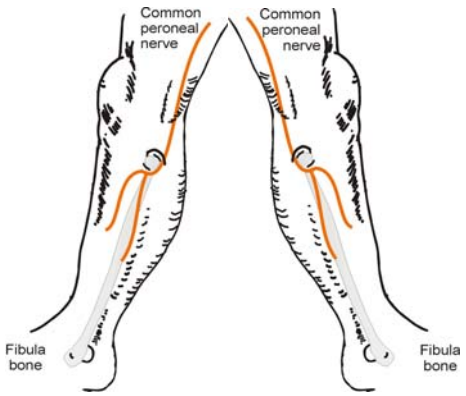
ODFS® Pace Set-up	Date
Patient name…….…… DOB….. ……. *(Attach label if available)*	Clinician sign …… Print name……. Designation……..

10 METRE WALK *(state reason if not completed)*

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (with FES)			
Walk 4 (no FES)			
Change with stimulation (Orthotic effect)		%	Absolute value e.g. +/- 2

Pt's perception of benefits using FES:

WALKING AID: _____UNAIDED:☐



F/S POSITION: _____

Goal Attainment Scale (GAS)

Patient name: ……	DOB:……

DESCRIPTION:	**GOAL 1** ……..	**GOAL 2** ……..	**GOAL 3** ……..
Much more than expected (+2)			
More than expected (+1)			
Most likely outcome (0)			
Less than expected outcome (-1) (START)			
Much less than expected (-2)			
Timescale			
Sign, print and date:			
Review Date and level achieved			

TOTAL GAS SCORE:_____ *(use table)*

- At the -1 level insert patient's current ability/symptom
- At the 0 level insert the most likely level of improvement
- At +1 and +2 write even further improvements and at -2 if things got worse
- Aim to set one functional goal with patient
- Use the Visual Analogue Scale to identify 2 other subjective symptoms you hope will improve with FES treatment
- Setting goals to be achieved at 18 weeks is normally best

Visual Analogue Scale (VAS)

Patient name: …….	DOB:……

Use a blank Visual Analogue Scale when asking patients to rate their symptoms.

When recording here circle number, state with or without FES and date.

		Highest quality of life	**High fear of falling**
10	**10**	**10**	**10**
9	**9**	**9**	**9**
8	**8**	**8**	**8**
7	**7**	**7**	**7**
6	**6**	**6**	**6**
5	**5**	**5**	**5**
4	**4**	**4**	**4**
3	**3**	**3**	**3**
2	**2**	**2**	**2**
1	**1**	**1**	**1**
0	**0**	**0**	**0**
		Lowest quality of life	**No fear of falling**

At beginning of treatment: Select a couple of subjective symptoms and use the Visual Analogue Scale to rate their perception of those symptoms WITHOUT FES. e.g confidence walking, muscle tightness, pain, frequency of trips/falls. ALSO ask them to rate the 2 set measures of quality of life and fear of falling.

At follow-up appointments ask them how they rate these symptoms WITH FES (do not tell them what they scored at the beginning of treatment WITHOUT FES).

ODFS® Pace	Treatment stage:	Date:

Patient name…….……

DOB/ PID ……
(Attach label if available)

Clinician sign ……

Print name…….

Designation……..

Treated side: L R	Clinician Initial	Not required
Implied consent		
Changes to patient details/medication recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Electrode care		
Skin care		
Leads checked		
Footswitch positioning and insertion		
Written/photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
Electrode positions found/recorded		
Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		

CONSUMABLES ISSUED
Electrodes (no. + type) Blue Pals 50 x 50 …….. Other…….
Footswitch
Electrode leads (length)
Footswitch leads (length)
Insoles (size + side)
Accessories: Pouch Leg strap

Parameter	Setting
Set up	
Current	mA
R. Ramp	ms
Extn	ms
F. Ramp	ms
Time Out	ms
Delay	ms
Waveform	ASYM / SYM
Freq	Hz
Sounder	SETUP / OFF / ALWAYS
Beeps	ON^{+} / ON / OFF
Timing	ADAPTIVE / FIXED / NTO
Lock	OFF / 1s / 3s
Exe	OFF / ON Time: ……..
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	*Updated?* ☐
Serial Number	*No change* ☐

ODFS® Pace	Treatment stage:	Date:
Patient name……. DOB/ PID …… *(Attach label if available)*	Clinician sign …… Print name……. Designation……..	

10 METRE WALK ***(state reason if not completed)***

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (with FES)			
Walk 4 (no FES)			
Change with stimulation today (Orthotic effect)		%	Absolute value e.g. +/- 2
Change since 1st assessment (NS) (Carry over)		%	Absolute value e.g. +/- 2

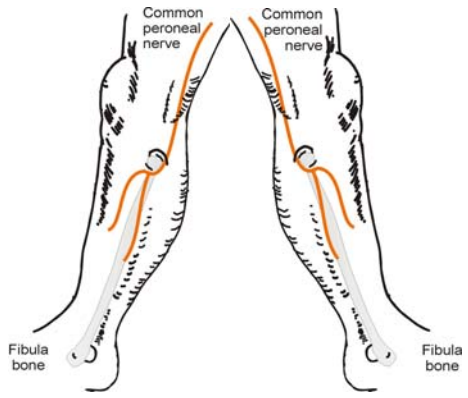
Pt's perception of benefits of FES:	
Patient-specific VAS scores: *e.g. confidence in walking $^{x}/_{10}$ no FES, $^{y}/_{10}$ with FES*	
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



F/S POSITION: _____

ODFS® Pace	Treatment stage:	Date:

Patient name……

DOB/ PID ……
(Attach label if available)

Clinician sign ……

Print name…….

Designation……..

Treated side: L R	Clinician Initial	Not required
Implied consent		
Changes to patient details/medication recorded on front sheet		
Procedure for donning and doffing		
Test procedure		
Electrode positioning		
Electrode care		
Skin care		
Leads checked		
Footswitch positioning and insertion		
Written/photographic instructions issued		
Precautions given		
Skin checked		
Skin irritation form completed		
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Stimulation parameters set/recorded		
VAS discussed		
10 metre walks completed		
Patient Handling Profile completed		
CONSUMABLES ISSUED		
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Footswitch		
Electrode leads (length)		
Footswitch leads (length)		
Insoles (size + side)		
Accessories: Pouch Leg strap		

Parameter	Setting
Set up	
Current	mA
R. Ramp	ms
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F. Ramp	ms
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Waveform	ASYM / SYM
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Lock	OFF / 1s / 3s
Exe	OFF / ON Time: ……..
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	*Updated?* □
Serial Number	*No change* □

ODFS® Pace	Treatment stage:	Date:
Patient name……. DOB/ PID …… *(Attach label if available)*	Clinician sign …… Print name……. Designation……..	

10 METRE WALK ***(state reason if not completed)***

	Time	Speed m/s	Borg RPE
Walk1 (no FES)			
Walk 2 (no FES)			
Walk 3 (with FES)			
Walk 4 (no FES)			
Change with stimulation today (Orthotic effect)		%	Absolute value e.g. +/- 2
Change since 1st assessment (NS) (Carry over)		%	Absolute value e.g. +/- 2

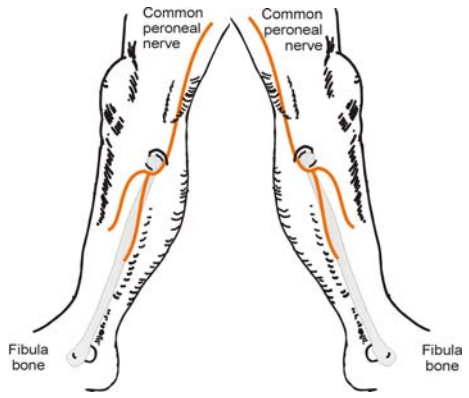
Pt's perception of benefits of FES:	
Patient-specific VAS scores: *e.g. confidence in walking* $^{x}/_{10}$ *no FES,* $^{y}/_{10}$ *with FES*	
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



F/S POSITION: _____

REMEMBER GAS form $^{18}/_{52}$

ODFS® Pace	Treatment stage:	Date:
Patient name…….……. DOB/ PID …… *(Attach label if available)*	Clinician sign …… Print name……. Designation……..	

Treated side: L R	Clinician Initial	Not required
Implied consent		
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Software version	*Updated?* □
Serial Number	*No change* □

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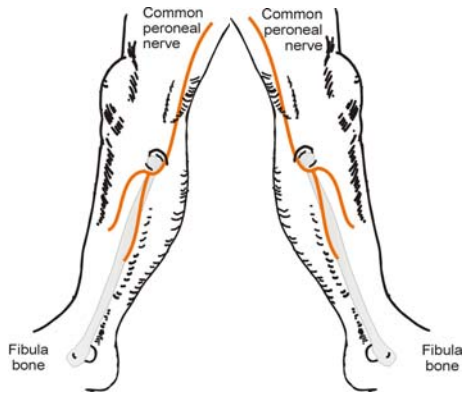
Pt's perception of benefits of FES:	
Patient-specific VAS scores: *e.g. confidence in walking* $^{x}/_{10}$ *no FES,* $^{y}/_{10}$ *with FES*	
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



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Walk Time	
No. Exe.	
Exe. Time	
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Software version	*Updated?* □
Serial Number	*No change* □

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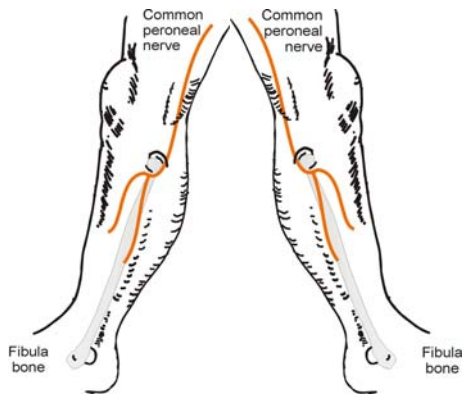
Patient-specific VAS scores: *e.g. confidence in walking* $^{x}/_{10}$ *no FES,* $^{y}/_{10}$ *with FES*	
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



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Exe. Time	
Log reset today?	Y / N
Software version	*Updated?* □
Serial Number	*No change* □

ODFS® Pace	Treatment stage:	Date:
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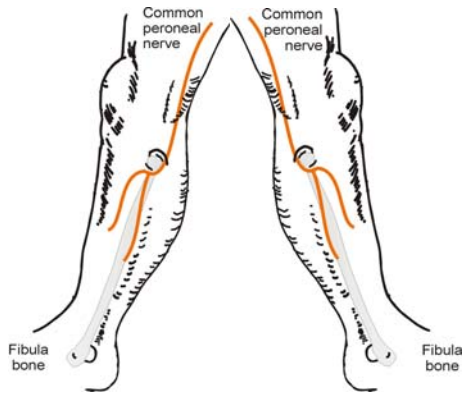
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



F/S POSITION: _____

ODFS® Pace	Treatment stage:	Date:

Patient name…….……

DOB/ PID ……
(Attach label if available)

Clinician sign ……

Print name…….

Designation……..

Treated side: L R	Clinician Initial	Not required
Implied consent		
Changes to patient details/medication recorded on front sheet		
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Test procedure		
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Patient Handling Profile completed		

CONSUMABLES ISSUED
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Footswitch
Electrode leads (length)
Footswitch leads (length)
Insoles (size + side)
Accessories: Pouch Leg strap

Parameter	Setting
Set up	
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R. Ramp	ms
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Time Out	ms
Delay	ms
Waveform	ASYM / SYM
Freq	Hz
Sounder	SETUP / OFF / ALWAYS
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Timing	ADAPTIVE / FIXED / NTO
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Exe	OFF / ON Time: ……..
Exercise set up	R ON OFF
Steps	
No. Walks	
Walk Time	
No. Exe.	
Exe. Time	
Log reset today?	Y / N
Software version	*Updated?* ☐
Serial Number	*No change* ☐

ODFS® Pace	Treatment stage:	Date:
Patient name……. DOB/ PID …… *(Attach label if available)*	Clinician sign …… Print name……. Designation……..	

10 METRE WALK ***(state reason if not completed)***

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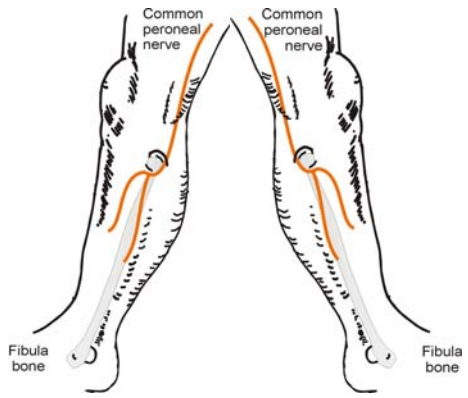
Pt's perception of benefits of FES:	
Patient-specific VAS scores: *e.g. confidence in walking* $^{x}/_{10}$ *no FES,* $^{y}/_{10}$ *with FES*	
Frequency of FES use:	

WALKING AID: _____ UNAIDED: □

Standard VAS: Quality of life: …./10

Fear of falling: …./10

(Both to be quoted *with* FES)



F/S POSITION: _____

Patient Handling Profile

Patient's name …….…	DOB ……
Handling Considerations	Mental status/comprehension:……
Height:…….	Pain:…….
Weight:…….	Motor deficit:…….
Eyesight:…….	Skin integrity:……
Hearing:…….	Falls history:…….

Transfer	Independent	**Requires Assistance**	Additional Aids
Sitting to standing	☐	Handling belt plus 1 person ☐ Handling belt plus 2 people ☐	
Bed/chair to chair	☐	Handling belt plus 1 person, step around ☐ Handling belt plus 2 people, step around ☐ Hoist ☐	
Walking	☐	Handling belt plus one person ☐ Handling belt plus 2 people ☐	

Name…… Signature…… …….

Designation…….. Date of assessment…….

P.T.O. for amendments

Patient Handling Profile Amendments

Patient name……	DOB ……

Date of amendment	Task amended	Reason for change	New recommendation	Name / signature / designation

Discharge Summary
ODFS® Pace

Name:_____DOB:_____Date: _____

1. When was the use of the stimulator discontinued? _____

2. Why was treatment stopped?
   Please put crosses by **any** response that was relevant.
   Please **ring** the most important reason.

   a. The stimulator did not help the users walking.

   b. The equipment was unreliable.

   c. Problems with skin allergy to the electrodes.

   d. Problems finding the correct electrode positions.

   e. The equipment was too difficult to use.

   f. The equipment was too much bother to use.

   g. The equipment was cosmetically unacceptable.

   h. The user's mobility improved so they no longer needed the stimulator.

   i. The user's mobility deteriorated so was no longer able to use the stimulator.

   j. The stimulation was too painful.

   k. The stimulator caused an increase in spasticity.

   l. Autonomic dysreflexia

   m. Death. Cause: _____

   n. Lost to follow up

   o. Unrelated medical complication. Please specify. _____

   p. Other reasons, please specify. _____

   q. Discharged to a local clinic, please specify. _____

3. Equipment returned? Y / N Discharged? Y / N

Clinician sign…… Print…….. Designation……

Continuation Sheet

Patient name: ……

DOB: ……..……

Clinician sign, print and date for each entry

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