ADAPTATION GUIDE

Wheelchair & Limited-Mobility Adaptations

Everything reworked for seated-only, one-handed and very low-energy participants.

🔑 **What this adds that the cards don't.** Every page of the main kit already carries a seated adaptation and a memory-loss adaptation. This book covers the cases those two lines cannot: **one working hand, a wheelchair that is the wrong height, almost no energy at all, a tremor, or somebody who cannot leave the bed.** It is organised by the person in front of you, not by the activity.

⚠️ **Read this first.** Adapting an activity is not the same as making it easier. The goal is that the person does **the same thing everyone else is doing**, by a different route. An adaptation that turns participation into watching has failed, even when it is safe. **And nothing here overrides a care plan, a therapist's instruction, or a clinician's restriction.**

PART 1 · The four questions, before you adapt anything

Ask these in order. Most adaptation problems are solved by question 2 or 3, not by changing the activity.

1 · Can they see it and hear it?
More "refusals" are sensory than motor. Before you rework a task, move it into their field of vision, raise the contrast, and speak from their better side. A tray moved eight inches solves more than any rewrite.

2 · Is the surface at the right height?
For a wheelchair user, the table is usually too high. If they cannot rest their forearms on it comfortably without lifting their shoulders, **the table is wrong, not the activity.** Use a lap tray, an overbed table, or a cushion under the elbows.

3 · Is it inside the reach envelope?
Seated reach is roughly the arc their fingertips draw without leaning. Anything outside it is a task about leaning, not the task you intended. Bring the materials in.

4 · Only then: does the task itself need changing?
Usually less than you expected.

📌 **The single most common mistake** is adapting the activity while leaving the person badly positioned. Position first. It fixes more than any substitution.

PART 2 · One working hand

The most common real gap, and the one the per-card lines do not cover. Usually after a stroke, sometimes an injury, sometimes pain that makes one side unusable.

The principle: stabilise, don't substitute. Most two-handed tasks are one hand doing the work and one hand holding still. Replace the holding hand with an object and the task survives intact.

THE TASK NEEDS	REPLACE THE SECOND HAND WITH
Something held steady	Non-slip matting, a damp cloth, a clamp, your own hand
Something held open	A bulldog clip, a clothes peg, a weighted bag
A bowl that slides	A bowl with a suction base, or set it inside a drawer
Cards to be held in a fan	A card holder, or a slot cut in an upturned sponge
Paper to be held down	Masking tape, a clipboard, a heavy book
A jar to be opened	Wedge it between the knees, or a jar opener screwed under a shelf

Specific reworkings

- **Folding (Block 4.1):** works one-handed against the edge of the table. Start the first fold for them and let them finish it. Do not fold *for* them.
- **Card games (Block 2.4, and the games book):** a card holder changes everything. Deal by sliding, not lifting.
- **Ball and balloon work (Block 3.5):** one-handed is not a downgrade here — a balloon is genuinely easier with one hand than two.
- **Bilateral movement cards (Block 3.2):** the affected arm is moved by the working arm, or rests supported on a pillow while the working side does the range. **Never move somebody's affected arm through a range they have not been cleared for**, and never above shoulder height. A subluxed shoulder after stroke is easily injured.
- **Sorting and threading (Block 4.1):** ideal one-handed. Use a tray with raised edges so nothing escapes.

⚠ **A neglected side is not a lazy side.** After some strokes a person genuinely does not perceive one half of the space. Placing materials on the neglected side and waiting is not encouragement — it is an activity they cannot see. Put the materials on the side they attend to, and raise neglect with their clinician, not with them.

PART 3 · The wheelchair itself

Before the session

- Brakes on. Feet supported — on the plates or on the floor, never dangling.

- Pull up to the table so the forearms rest without the shoulders rising.
- If the armrests stop them reaching the table, a lap tray beats fighting the chair.
- Check they are not sitting on a bunched sling or a rucked cushion. Ask; do not assume.

During

- **Reposition every twenty to thirty minutes** if they cannot shift themselves. Pressure matters more than the activity does.
- Watch for sliding forward. A person who has slid down is working against their own posture, and will look "disengaged" long before they say anything.

Set-up that changes participation

- Put wheelchair users at the **corners** of a table rather than the long sides — more legroom, better sightlines.
- In a circle, leave the gaps for chairs rather than parking chairs behind the ring. Behind the ring is out of the group.

⚠️ **Never move somebody's chair without telling them first**, and never tilt or push without their agreement. It is their body you are moving, not furniture.

PART 4 · Very low energy

For the person who manages four minutes, not thirty. Late-stage illness, profound fatigue, or a bad week.

The reframe: the unit is the minute, not the session. Four good minutes is a complete activity. Stretching it to fifteen does not make it more valuable; it makes the next one less likely.

What works

- Sensory over cognitive: **Block 4.2** almost entirely. Smell, texture, warmth. Nothing to produce, nothing to answer.
- Music with no task attached: **Block 4.3**, playing, not participating.
- A single hand movement repeated: **#094** winding wool, **#092** wiping.
- Being read to. One paragraph, not a chapter.
- **#300 Sit Outside** — the highest return in the whole kit for the least demand.

What to stop doing

- Asking questions that require an answer to be a success.
- Offering choices. A choice is work. Bring one thing and offer it.
- Announcing the end. Just stop, and stay a moment longer.

🔑 **With very low energy, your presence is the activity and the task is the excuse for it.** Nobody needs to finish anything.

PART 5 · In bed

- Raise the head of the bed if permitted; a flat person cannot participate.
- An overbed table brings almost all of **Block 4.1** and **Block 4.2** into reach.
- Movement: **Block 3.1** ankle and hand work adapts to bed directly. Skip everything in **3.4**.
- Keep materials in a shallow tray with a lip — anything that rolls is lost.
- Sit where they can see you without turning their head.

⚠️ **Movement in bed is the place where a care plan most often has restrictions on it.** Check the plan before starting, every time, not once.

PART 6 · Tremor and weak grip

PROBLEM	WHAT ACTUALLY HELPS
Tremor worsens on reaching	Bring the object to them; support the elbow on the table
Drops small items	Larger, heavier items — weight damps tremor more than size does
Cannot grip a pen	Thick barrel, foam tubing, or a weighted pen
Cannot grip cards or tiles	A holder; or lay everything face up and point instead
Spills drinks mid-activity	Lidded cup, half-filled, placed on the non-dominant side
Fatigues within a minute	Support the whole forearm on the table and work from the wrist

📌 **Weight helps tremor; speed makes it worse.** Never introduce a timer or a race to someone with a tremor — it converts a manageable task into a visible failure.

PART 7 · Block by block — what changes

BLOCK	SEATED-ONLY	ONE HAND	VERY LOW ENERGY
1.1–1.6 Talk & Remember	No change	No change	Ask one question, not three

BLOCK	SEATED-ONLY	ONE HAND	VERY LOW ENERGY
2.1 Word fluency	No change	No change	You alternate answers with them
2.2 Visual & working memory	No change	Lay items out, point	Two items, not six
2.3 Numbers	No change	Use coins on a tray	Skip
2.4 Sequences & logic	No change	Card holder	Skip
2.5 Orientation	No change	No change	Window and weather only
2.6 Attention & speed	No change	No change	**Skip — speed is the wrong demand**
3.1 Seated warm-up	Native	Working side leads	Ankles and hands only
3.2 Arms & shoulders	Native	Supported, below shoulder	Hands only
3.3 Legs & ankles	Native	No change	Ankle pumps only
3.4 Standing balance	**Omit entirely**	Omit unless cleared	Omit
3.5 With an object	Native	Balloon and scarf work best	Scarf only
3.6 Breathing	Native	Native	**Ideal — start here**
4.1 Hands & fine motor	Native	Non-slip mat, clips	Winding, wiping
4.2 The senses	Native	Native	**Ideal — start here**
4.3 Music & rhythm	Native	Tap on the thigh	Listening only
4.4 One-session crafts	Table height	Stabilise the work	One step, over days
4.5 Nature on the table	Native	Tray with a lip	Hold and smell only

📋 What not to adapt

Do not adapt away the point. If an activity exists so somebody uses their hands, an adaptation where you use your hands and they watch has removed the activity.

Do not adapt down before you have tried. The commonest error in a care setting is deciding in advance what somebody cannot do. Offer the real version first, positioned

properly, and adapt from what you see — not from the diagnosis in the file.

Do not adapt the craft, adapt the tools. Somebody who spent forty years doing something can usually still do a piece of it. Remove the danger, not the activity.

🔑 **And say it out loud when you adapt.** *"I'm putting this mat under here so it stops sliding."* Silent accommodation reads as being managed. Named accommodation reads as being helped, which is a different experience entirely.

⚠️ **None of this is medical advice, physiotherapy, or occupational therapy.** These are practical adjustments for recreational activities. Positioning, movement restrictions, pressure care, swallowing and falls risk are clinical matters: follow the person's care plan and their treating professionals, and ask them before changing anything physical.