# ASSOCIATION OF

# PAEDIATRIC

# CHARTERED PHYSIOTHERAPISTS

# NEWSLETTER

Association of Paediatric Chartered Physiotherapists

Newsletter No. 65 **FEET AND FOOTWEAR PART I** November 1992

CONTENTS

Talipes Equino Varus. Management Strategy and Case Study
*Penny Rennie and Sara Sandford* ..... 3

Treatment of C.T.E.V. at North Tees General Hospital
*Liz Hardy* ..... 8

Role of the Physiotherapist in Prescription, Supply and use of Orthotics
*Madeline Szadurski* ..... 12

Physiological Cost of Gait
*Jane Pyman* ..... 14

Evaluation of the Multidisciplinary Approach to Integration
*Jeanne Lacey and Angela Jacklin* ..... 16

Programme of A.P.C.P. Annual Conference 1993 ..... 21

You Too Can Lecture!
*Susan Rochat.* ..... 25

Working for the Relief Fund of Rumania.
*Kathy Thomas and Janet Molyneux.* ..... 26

Appreciation ..... 29

P.R.O.Reports ..... 31

Abstract Gill Riley ..... 32

Courses and Results ..... 33

Here and There ..... 36

Regional Reps. Reports. ..... 38

## Officers of the Association

*Chairman*
Mrs. Jill Brownson
23 Vallence Road,
Hove
E. Sussex BN3 2DA

*Vice Chairman*
Mrs. V. Williams
5 Larch Grove,
Lisvane
Cardiff CF4 5TH

*Secretary*
Mrs. Fiona Corkhill
3 Severn Gdns.
Oakley
Basingstoke, Hants RG23 7AT

*Treasurer*
Mrs. L. Weekes
37 The Cedars
Milton Road
Harpenden, Herts AL5 5LQ

*P.R.O.*
Mrs. C.L. Dunn
The Haven
Knightwick Rd.
Martley, Worcs. WR6 6PQ

*Editor*
Mrs. J. Lacey
43 Withdean Road
Brighton
E. Sussex BN1 5BP

*Membership Secretary*
Mrs. J. Lamond
22 Whernside Road
Cross Hill
Lancaster LA1 2TA

*Editorial Board*
Mrs. G. Riley, Miss C. Young, Mrs. C. Dunn,
Mrs. J. Saunders, Mrs. A. Lyon

# EDITORIAL

**Jeanne Lacey, Editor and Community Physiotherapist,**
**Royal Alexandra Hospital for Children, Brighton.**

Jenny McKinlay has retired as Editor of the Newsletter after four years of extremely dedicated hard work. The Associatoin owes her an enormous debt. I hope to build upon the excellent work of Jenny and of her predecessor Jeanne Lamond.

I see the Newsletter as a disseminator of knowledge and information and as a forum for discussion between members.

We are not all able to attend or become involved in our regional meetings but we do all receive a copy of the Newsletter, which is therefore a vital link between the membership.

As a profession we have a wealth of knowledge, both practical and theoretical, to share covering the whole spectrum of our speciality. Other issues such as the rapidly changing structures within the NHS may be causing concern to members. Let us also discuss shared concerns like these.

As Editor I will be co-ordinator of a team, working closely with core-group members Gill Riley and Chris Young; the Editorial Board and Regional Reps. Hopefully this team will be enriched by the greater involvement and participation of individual members. I know this was an aim shared by Jenny McKinley.

The Newsletter needs YOUR contributions and feedback to remain vital and relevant. I have been heartened this month to receive so much material from members that the title of the Newsletter is "Feet and Footwear - Part 1". The foot is obviously a subject dear to every paediatric physiotherapist's heart!

*Jeanne Lacey*

**COPY FOR THE FEBRUARY 1993 NEWSLETTER MUST BE WITH THE EDITOR BY FRIDAY 18TH DECEMBER 1992.**

*The Editorial Board does not necessarily agree with opinions expressed in articles and correspondence and reserves the right to edit material submitted.*

# TALIPES EQUINO VARUS - MANAGEMENT STRATEGY AND CASE STUDY

**Penny Rennie, Senior I Physiotherapist, Jenny Lind Unit**
**Norfolk and Norwich Hospital**

## TALIPES EQUINO VARUS

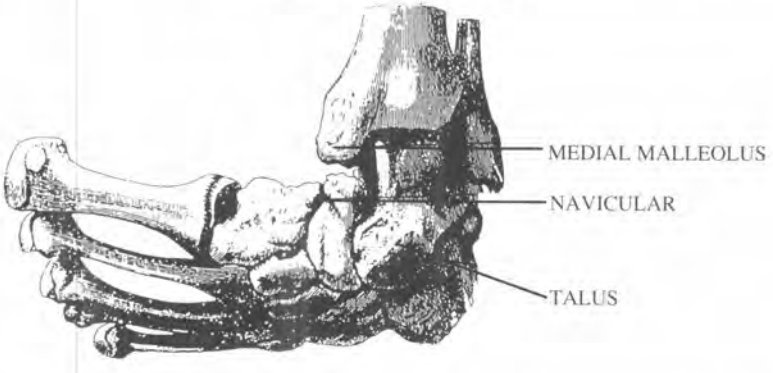
At birth the main clinical features of this triple deformity are adduction of the forefoot, varus of the heel and equinus of the ankle. In addition to this the more severe examples have variable forefoot varus and supination with creases on the inner surface of the sole and above the calcaneum. The diameter of the calf is invariably reduced.

The deformity may be bilateral, in which case one foot is usually worse than the other.

The incidence is said to be of the order of one in 1,000 live births and it occurs in all races and is more common in males[1].

### Pathological anatomy

TALIPES EQUINO VARUS




The talus appears to be the hub of the deformity. It is smaller than normal and directed excessively into a plantar and varus direction. The articulation with the ankle is incomplete, the talus lying more anteriorly than it should. The remaining structural anomalies appear to be secondary to the deformity of the talus. The calcaneum in equinus swings and tilts medially. The navicular and cuboid move medially with the talus and calcaneum respectively. The rest of the foot moves medially but retains its normal shape. Often the navicular is markedly deformed and locked between the talus and the medial malleolus.

The normal neonatal foot permits contact between the little toe and the lateral border of the leg when moderate force is applied. If, however, dorsiflexion is not possible beyond 90 degrees, a structural deformity is present and the following regime is used for the treatment of idiopathic talipes equino varus.

When possible the baby is seen by an orthopaedic consultant before treatment starts and photographs of the dorsal and plantar aspects of the feet are taken. The baby's hips are ultrasounded as there is a direct correlation between congenital dislocation of the hip and talipes equino varus.

**Treatment**

1 Begin as early as possible.

2 Manipulate trying to remould the foot into a more normal shape. Gentle repeated manipulation must first concentrate on the forefoot varus in the hope that the varus deformity of the talus and the associated medical displacement of the navicular will improve. The body of the talus can easily be palpated on the lateral border of the foot and with gentle pressure and manipulation medially it can be realigned. Manipulation should be performed with the foot in equinus. No attempt to correct the equinus should be made until alignment of the forefoot has been achieved. If dorsiflexion is attempted prematurely, a rocker bottom foot will result due to forced dorsiflexion of the forefoot against a plantar flexed hindfoot. The improved position is held by a plaster of Paris cast.
Three people are necessary for the correct application of the cast. A parent to hold the baby still, (the baby will not like the procedure and a dummy to pacify him at this stage is often helpful,) and two trained operators, one to apply the materials and the other to hold the foot in the corrected position and mould the cast as it is applied.

3 Paint the skin with tincture of Benzoin. This helps to maintain the condition of the skin and helps to hold the padding in position.

4 Apply a thin layer of cotton wool padding from the toes to below the knee.

5 Apply a plaster of Paris below knee cast. The first application of plaster of Paris is in the form of an anterior slab. A neonate's circulation takes a few days to become adequately established. If the baby's circulation is compromised in the early days the parents can easily remove the slab. Subsequent casts are split down the front to allow easier removal. After application of the cast the baby waits for one hour with his feet elevated to ensure that the circulation in his feet is not affected by an over tight cast.

6 The casts are changed twice a week for the first 6 weeks. After a few applications it may be necessary to apply above knee casts to prevent slippage and control internal tibial torsion.
At this stage the foot should be well corrected but the tendoachilles may be tight and the calcaneum high.

ROBERT JONES STRAPPING

7 Modified Robert-Jones strapping now applied directly onto the leg covered with tincture of Benzoin. This method of splintage permits repeated manipulations at very short intervals and as the strapping is extended above the knee a lively component is introduced.

This is applied weekly with overstrapping after a few days to take up the slack. The mother is taught the technique of manipulation and is sometimes entrusted with the overstrapping. She removes the strapping and baths the baby the day before it is due to be re-applied. This allows time for the skin to recover before the re-application of the strapping,

8 When the foot is sufficiently well corrected and the baby can actively dorsiflex with eversion beyond the neutral position, posterior plaster of Paris slabs are made to maintain the correction. These should be worn constantly at first apart from washing and exercise periods. Later, after walking begins, daily stretching and night splints should continue for at least 2 years.

The orthopaedic surgeon will be alert for signs of relapse throughout the treatment and surgical intervention may be undertaken at any stage after the first 4 or 5 months.

The child is supervised by the physiotherapy staff throughout its childhood as this condition tends to revert especially during growth spurts. At these times periods of corrective serial plastering lasting 3-4 weeks should be sufficient to obtain adequate correction. A small lateral wedge (1/8") on the outer border of the heel of the shoe is often helpful in maintaining the foot position on weight bearing if there is any residual varus of the heel. When the condition is unilateral, it may be necessary to buy two different sizes of shoes as the affected foot may be smaller than the other. A shoe size difference of half a size usually creates no problems, but if the difference is more than this the smaller foot has little support and will slip out of the shoe.

The outcome in club feet is dominated by the success or failure to correct the deformity (especially the hindfoot) within the first 6 months of life. Every effort should be made within the first 3 months for time is short and early days are the most valuable. It is a busy time for everyone involved, especially the parents who are committed to bringing their young baby for treatment twice a week for 6 weeks and often once a week for another 6 weeks, and in this Health Authority often travelling great distances. It is a time consuming treatment regime but one which gives good results.

**References**

1. The Foot in Childhood by John Fixsen and George Lloyd-Roberts.

---oooOooo---

## CASE STUDY

**prepared by Sarah Sandford**

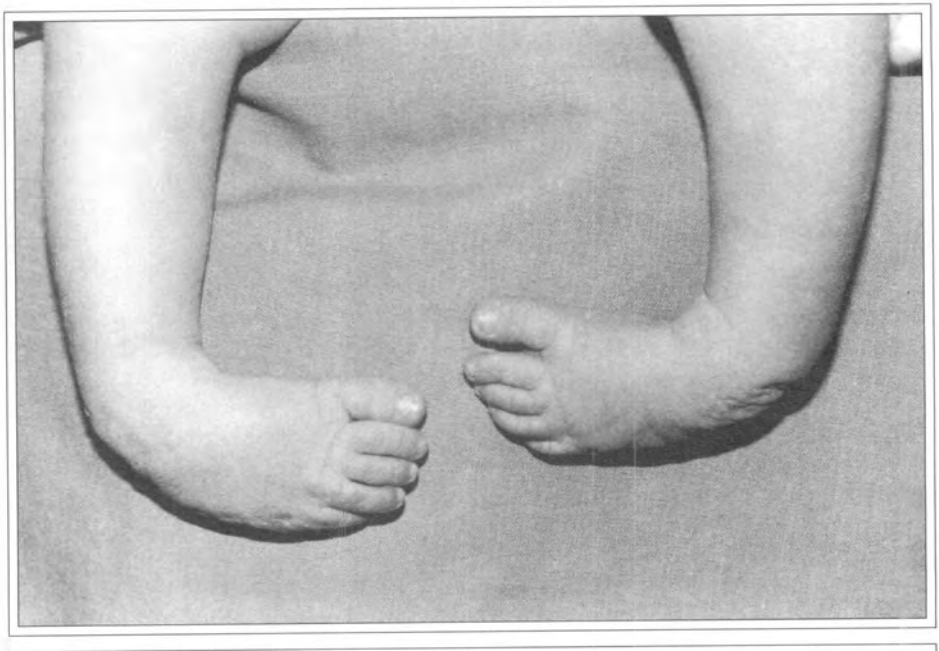
Emily is now 5 1/2 months old. She was born with the aid of Wrigley's forceps and weighed 3.32 kg. She was the first child born to this family and there was no family history of foot problems.

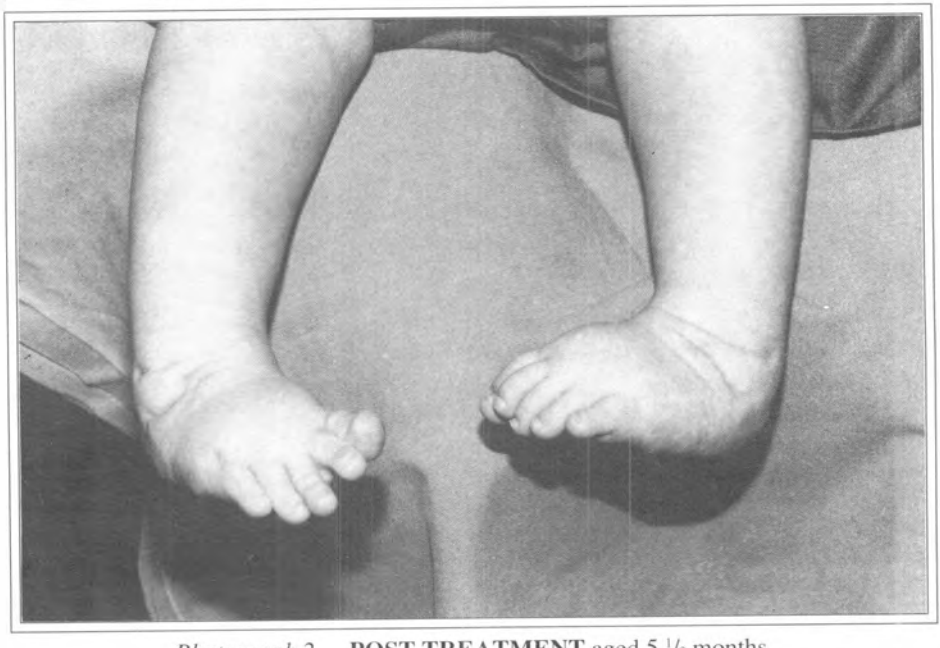
Emily presented with bilateral talipes equino varus with the left foot worse than the right. It was possible to correct the varus to a neutral position on the right but not the left.

She was referred to the orthopaedic consultant who referred her to us and an ultrasound of her hips was carried out. Photographs were also taken to provide a visual record.

Physiotherapy treatment commenced when Emily was 2 days old. Anterior slabs of plaster of Paris were put on to start the correction by bringing the forefoot into a more neutral position.

*Photograph 1* - **PRETREATMENT**





*Photograph 2* - **POST TREATMENT** aged 5 $^{1}/_{2}$ months.

**NOTE:** Left foot: Creases at ankle where there is excess skin.
Right foot: Ankle & toes pulling actively into dorsiflexion & extension.

| | |
|---|---|
| **DAY 4** | Slabs removed and complete below knee plaster of Paris applied. At this time Emily was discharged from hospital. |
| **DAY 8** | Foot position beginning to show some improvement. New below knee plaster of Paris applied. Now starting to introduce some dorsiflexion, but mostly working on forefoot varus. |
| **DAY 11** | Previous plasters removed and new ones applied. |
| **DAY 15** | Both plasters had slipped slightly so less of the toes were visible. It was noticed that there was gross internal torsion of both tibiae and as a consequence to this it was decided to apply the next plasters over the knee. |
| **DAY 18** | Position of tibiae and feet had improved and above knee plasters were applied again. |
| **DAY 22** | Greatly improved. Internal tibial torsion less marked. Above knee plasters applied. |
| **DAY 25** | Both feet now correcting very well. It was decided to progress to Robert-Jones strapping to maintain the position of forefoot and to get some active stretch of the tendoachilles. |
| **DAY 29** | Both feet holding well and heel coming down. Overstrapping applied. Mum instructed to remove strapping and bath baby before coming to next appointment. |
| **DAY 32** | Holding position quite well but tending to turn toes in and therefore plan to try plaster of Paris splints next week. |
| **DAY 36** | Overstrapping. |
| **DAY 39** | Plaster of Paris splints made to be worn most of the time. |
| **DAY 43** | Feet holding well but considerable tibial torsion again. Robert-Jones strapping applied. |
| **DAY 53** | Strapping again reapplied. Mum to overstrap 3 days later, remove completely after one week and use splints for one week. |
| **DAY 64** | Plaster of Paris splints too small. Feet over correct very easily. New splints made. |
| **DAY 78** | Feet holding well in splints. To be worn just at night for 2 weeks to allow feet to loosen up a little. |
| **3 MONTHS** | Feet holding well. Continue night splints. |
| **3 ½ MONTHS** | Feet holding well. New splints made. |
| **4 MONTHS** | New splints made with a little more eversion. |
| **4 ½ MONTHS** | New splints made. Mum will now bring Emily to see us when she feels it necessary, when either the splints are too small or if she is concerned that the feet have relapsed. |

# TREATMENT OF CTEV AT NORTH TEES GENERAL HOSPITAL

**Liz Hardy....Senior I Physiotherapist. North Tees General Hospital.**

Infants with either positional or structural talipes deformities usually begin physiotherapy treatment within 48 hours of birth. Referrals are accepted from paediatric and orthopaedic doctors, midwives and from the physiotherapist on the post-natal wards.

Treatment consists of passive stretching, strapping and splinting, often in combination, and always follows thorough assessment. Full and frank discussion with both parents is of paramount importance, and is usually carried out by the physiotherapist and orthopaedic consultant together.

**Assessment**

1. Parity, pregnancy and birth history.
2. Family history of CTEV or other skeletal abnormalities?
3. Brief general assessment of the skull, spine and hips.
4. Detailed examination of the feet, including general appearance, skin condition, length of foot from tip of great toe to posterior margin of heel, position at rest, and orientation of hindfoot and forefoot.
5. Passive correction available - abduction, eversion and dorsiflexion.
6. Active movements.
7. Photograph.

Following assessment a treatment plan is formulated. This is dependent upon the degree of 'stiffness' of the affected foot. Aims of treatment are the achievement of:

- a plantigrade, mobile and forward-facing foot;
- a painfree foot with no callouses;
- a functional foot which fits into commercially available footwear.

**Positional Deformity**

If the foot is passively fully correctible, the deformity can be described as 'positional' and the prognosis for full correction is excellent. The only treatment required is frequent passive stretching, taking the foot gently but firmly to the limit of available range, in each direction. Care is required to prevent damaging structures, eg. inferior tibial and fibular epiphyses. Parents are taught, and advised to carry out the procedure at every nappy change.

**Structural Deformity**

* **When the affected foot does not correct to plantigrade**, the following strapping technique is used, after passive stretching as described above.

1. Apply generous amount of tincture of benzoin to skin.
2. Strapping applied as follows :

(a) Whole of lower limb, from fibula head to metatarsal heads is covered with 1" elastoplast strapping (for protection). Tape is wound without stretching. This layer protects the delicate skin of the newborn.

(b) 1" zinc oxide tape makes a stirrup from just below the medial knee joint line, under the calcaneum (thus derotating it), then pulling tape up towards lateral knee joint line.

(c) Zinc oxide tape is attached to dorsum of forefoot, starting at lateral aspect, and wound carefully under plantar aspect of foot (taking care to flatten mid-plantar crease) and taping finished at lateral knee joint line. This pulls the foot into eversion with abduction of the forefoot.

(d) Other reinforcing stirrups may be attached as appropriate.

(e) Strapping is completed with fixing turns of elastoplast at level of fibula head and above malleoli.

Layers (b), (c) and (d) of strapping are pulled into maximally corrected position - the toes may become cyanosed, but with patience, colour should return satisfactorily. If not, zinc oxide tape is loosened and reapplied a little more conservatively.

This correction is overstrapped with zinc oxide tape the day after strapping has begun (day 2), and then on alternate days. The strapping is completely removed and reapplied, as described above on day 3 and alternate days, until a plantigrade position has been achieved. Previous strapping is usually better cut off rather than peeled off. Skin is then to be cleaned carefully and thoroughly with Zoff (plaster remover), and no residue left on the skin.

* **When a plantigrade position has been achieved** splinting can be commenced. This method is attributed to Denis Brown and should be applied after passive stretching.

1. An aluminium splint, of suitable size is prepared with zinc oxide tape covering the footplate and self-adhesive wool felt covering the upright. One or more wedges, wide at the toes and tapering gradually towards the heel are applied to the lateral side of the footplate.
2. Tincture of benzoin is applied to the skin - particular care is taken over pressure points, eg. medial side of 1st MT head, posterior of heel.
3. Strappings is applied as follows :

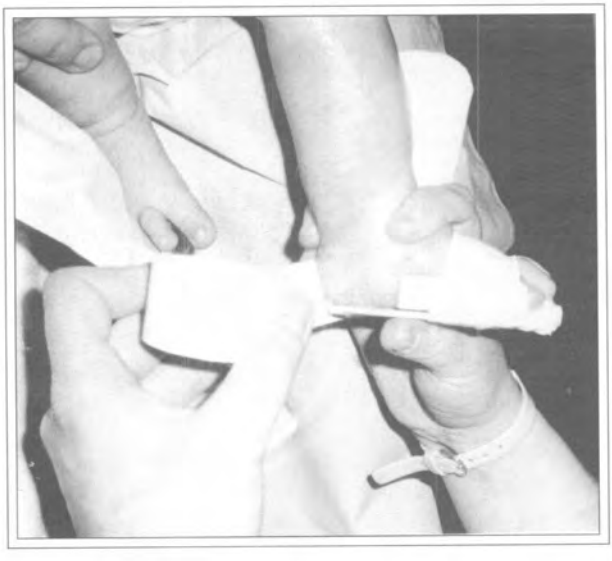
   (a) Small piece of felt is applied to medial side of 1st MT head.

   (b) Foot is held firmly down onto splint, with heel as far back as possible. Fig. (1)

   (c) 1" zinc oxide tape is applied to splint under medial side of forefoot, and pulled laterally over dorsum of foot then wound under splint (creating a circle of tape), back to starting point. It is then pulled over dorsum towards lateral malleolus, around heel (taking care to ensure that heel is derotated by being in contact with splint medially and the felt laterally) and back to 1st MT head, before cutting tape. This corrects any adduction of the forefoot.

   (d) Tape is attached under lateral side of forefoot and immediately pulled over dorsum towards medial malleolus, then around the heel as before and tape cut next to 5th MT head. This corrects the inversion deformity.

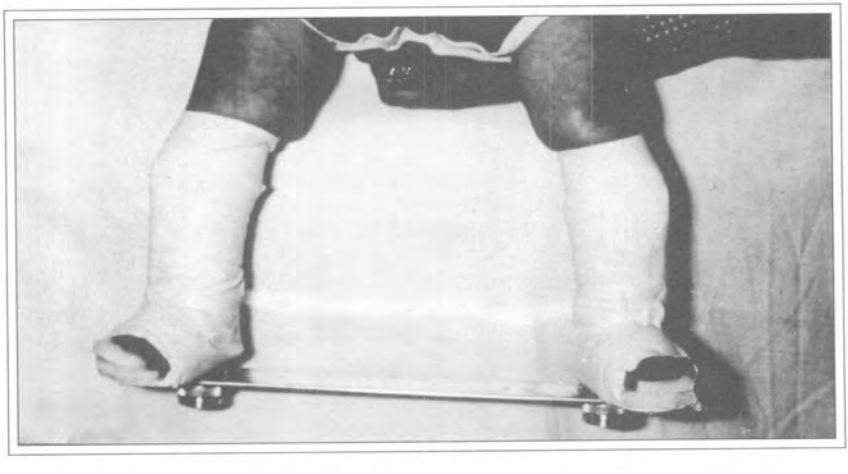
(Fig. 1)



*The heel should be held firmly down onto the splint.*

(e) The infant's knee is flexed and the upright of the splint pushed gently backwards until it is slightly posterior to line of fibula. Tape is attached to splint and wound around infant's leg (not too tight) until this tape meets that used to correct the foot. Any gaps in the tape are covered. This corrects the plantarflexion.

If both feet are affected, or there is a significant amount of tibial torsion a bar can be applied to maintain the position of the feet in slight external rotation. (Fig. 2)

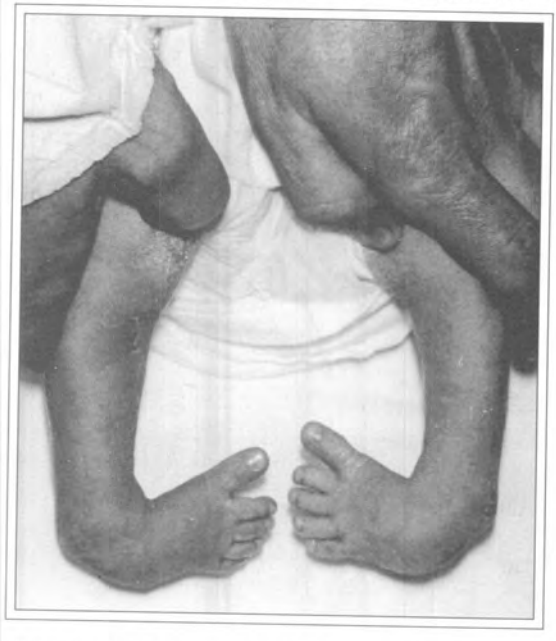


(Fig. 2)

*If both feet are affected the splints are held together with a bar.*

This splint and strapping is removed and reapplied once weekly, and the skin cleaned as before. This form of treatment is discontinued when overcorrection of all components of the deformity has been achieved.

*Photographs showing* **RESULTS OF TREATMENT**



*(Fig.3)*
*Photograph taken after one day's treatment with 1st stage (very conservative) strapping.*

*(Fig.4)*
*Photograph showing the same feet 6 weeks later, following 5 weeks on splints.*

# ROLE OF THE PHYSIOTHERAPIST IN PRESCRIPTION, SUPPLY AND USE OF ORTHOTICS

**Author: Madeline Szadurski, Superintendent Physiotherapist, Scottish Council For Spastics, Edinburgh**

Over the past decade the management of foot and gait disorders has been greatly enhanced by the advances made in the field of orthotics. The range of possible orthoses has increased along with the application of new gait analysis technology. The application of this new technology has broadened our understanding of normal and abnormal gait cycles. There is still much we need to find out and many eminent people are currently working to further our knowledge both in the sphere of gait analysis and the effects of orthoses. Whilst this research continues the paediatric physiotherapist working at a grass roots level has to cope with the day to day management of a case load, and attempt to implement the current state of knowledge. How best can this be achieved?

The physiotherapist must use basic skills to analyse as precisely as possible, the key problems in both dynamic and static weight bearing situations as presented by the patient, in addition a sensitive and precise anatomical examination of foot and lower limb is essential to give a base line for possible orthotic management.

One key factor in any planned orthotic management regime will be the possible parameters for correction; an orthosis should not be expected to correct a deformity which the physiotherapist cannot personally manually correct or sustain.

There are many variations in orthotic design available and a good orthotist should help and advise the therapist to arrive at the most appropriate choice, however, it will always be wise for the therapist to have some background knowledge of the particular application of each device and potential contraindications. This will lead to a more evenly weighted debate and encourage the orthotist into serious discussion with the therapist and entering into the "challenge" presented by each individual case.

Most prescriptions for orthoses require some attention to the position of the forefoot, hindfoot and the toes. It is important to appreciate that not only the structure of the orthosis can offer control over deforming forces but that the straps can be a very important addition to the function. The direction and pull of the straps has a marked effect on the foot so be careful to check that these forces are transmitted in the direction required. The control of inversion and eversion in the forefoot is not just a cosmetic exercise, but is vitally important to obtaining gait correction as is achieving a heel strike. It is not sufficient in these cases to rely on toe straps to control in or eversion, the side wings of the orthosis must be extended past the first metatarso-phalangeal joint to give adequate control. A foot, securely held by an orthosis, is less likely to move out of position than one held by velcro which can be applied with a varying amount of tension and accuracy. For too long the lenght of the TA has been our prime concern yet in some cases we have compromised forefoot alignment in our efforts to achieve the magical 90 degrees. The inverting forces in the spastic foot can disturb the balance of a cerebral palsied child and even create overflow reactions in the upper limbs. Torsion in the hip is

exaggerated and unnecessary strain on the knee can even give rise to ligamentous damage, yet attention to details within the orthosis can markedly reduce tone and so improve gait and balance.

Observing the direction of forces transmitted through the foot to the knee and hips is another key issue to be considered when considering an orthotic prescription. A common problem in cerebral palsied children is hip adduction and internal rotation and often associated knee flexion. The foot accommodates this limb position through talocrural and subtalar joints resulting in a collapsed medial arch. Lines of weight transmission are of course linked to the centre of gravity which in these situations shifts anteriorly and medially. It is intially important to correctly align the medial arch and restore correct balance before muscle shortening further compromises this complex picture. This is just as important in the non ambulant child who uses AFOs in a standing frame as in the more active child who needs good balance to obtain an efficient gait. If we stand children braced in standing frames for perhaps 1 hour at a time and have failed to ensure good foot alignment we will not have achieved the positive goals of weight bearing and may be compounding deforming forces at hips and knees.

The most positive input a physiotherapist can give to an orthotist is a clear indication of the precise function expected from an orthosis. The orthotist can indicate if the therapists goals are achievable and explain the limitations of orthotic function, however, if a prescription to achieve agreed goals is arrived at, then the physiotherapist must be certain that the final product fulfills the agreed goals. It is always advisable to adopt a minimal intervention policy than to overprescribe and hamper beneficial motion with unnecessary plastic. Be clear regarding the positive aspects of the patient's gait and function and be cautious not to compromise these when correcting other structural faults.

In conclusion, the success or failure of an orthosis will depend on how much it is worn. Patient compliance is vital. If therapists are positive and enthusasitc about a device, then parents, carers and hopefully the child will feel the importance of it. Time spent on explanation and instructions, plus praise of improvement is never wasted any more than time discussing non compliance and finding acceptable solutions.

# PHYSIOLOGICAL COST INDEX OF GAIT

**Jane Pyman is the Superintendent Paediatric Physiotherapist**
**Bristol Childrens Hospital St. Michaels Hill Bristol.**

A calculation of the energy cost of walking at the subject's chosen comfortable speed.
The PCI is derived from the difference between resting heart rate and that while walking at a measured speed. This gives an index with units of 'heart beat per metre walked'.

McGregor - Strathclyde 1979
Stallard & Rose 1980

We have found an error in our standard normal PCI due to an incorrect conversion from metres per minute to feet per minute.

The correct normals should be:-

For **metres** walked in shoes 0.4
For **feet** walked in shoes 0.12

The PCI can be done in AFO's, in casts and with different walking aids to see if we are actually making gait less effort for the child.
It can be used as an indicator in a child with Cerebral Palsy of the likelihood of going off their feet. In these cases the PCI will be significantly higher than normal.

$$PCI = \frac{Hw - Hr}{S} \text{ (bts per metre/foot)}$$

Hw - Heart rate while walking (bts/min) averaged from the heart rate at the end of each 25m or 82ft.
Hr = Heart rate at rest (bts/min)
S = Average speed (m/min or ft/min)

We use two methods of assessing, both very crude in comparison to sophisticated gait laboratories but adequate for local assessment needs.

**A) Less Heavily Handicapped**

Base line pulse rate taken after the child has been seated for 5-10 minutes. Do not then walk to the test site.

5 walks of 25 metres or 82 feet.

Time each walk.

Take pulse for 15 seconds after each walk (multiply x 4 for bts/min).

**30 seconds standing rest** in between walks.

Calculate PCI.

**EXAMPLE IN METRES**

Base line heart rate at rest = 80 bts/min.

| | | Distance | Time Taken | Heart Rate |
|---|---|---|---|---|
| Walk | 1 | 25m | 71s | 85 |
| | 2 | 25m | 73s | 86 |
| | 3 | 25m | 85s | 93 |
| | 4 | 25m | 98s | 97 |
| | 5 | 25m | 123s | 109 |
| Total | | | 450s | 470 |
| Average | | | 90 secs = 1.5 mins. | 94 |

$$\text{Average speed} = \frac{\text{distance}}{\text{average time (mins)}} = \frac{25}{1.5} = 16.67 \text{ metres/min}$$

$$\text{PCI} = \frac{Hw - Hr}{S} = \frac{94 - 80}{16.67} = 0.84$$

Compare with normal 0.4

For additional information the number of steps taken for each walk can also be counted.

**EXAMPLE IN FEET**

Base line heart rate at rest = 86 bts/min

| | | Distance | Time Taken | Heart Rate |
|---|---|---|---|---|
| Walk | 1 | 82ft | 128s | 97 |
| | 2 | 82ft | 124s | 104 |
| | 3 | 82ft | 117s | 115 |
| | 4 | 82ft | 118s | 120 |
| | 5 | 82ft | 133s | 119 |
| Total | | | 620s | 555 |
| Average | | | 124 secs = 2.07 mins | 111 |

$$\text{Average speed} = \frac{\text{distance}}{\text{average time (mins)}} = \frac{82}{2.07} = 39.6 \text{ ft/min}$$

$$\text{PCI} = \frac{Hw - Hr}{S} = \frac{111 - 86}{39.6} = 0.63$$

Compare with normal 0.12

**B) MORE HEAVILY HANDICAPPED**

For the more heavily handicapped child who cannot walk 25 metres we use a shorter distance of 6.1 metres or 20 feet.

Taken from Stallard, Rose, Tait & Davies 1978.

This will give a PCI for that individual patient which can be used as a comparison for pre and post operative intervention, in casts, with orthoses and walking aids, and to monitor deterioration during fast growth.

The method is the same as for the less heavily handicapped except that the child carries out five 6.1 metres or 20 feet walks. They are allowed **one minute standing rest** inbetween walks.

Normal values for this (B) test are not available but would be expected to be the same or less as for the (A) test.

Acknowledgements - Bobath Centre, Kathy Badlan and Kathy Strawbridge.

---

It would be interesting to receive feedback from members who have had experience of using the Physiological Index of Gait. Editor.

# EVALUATION OF THE MULTI-DISCIPLINARY APPROACH TO INTEGRATION

## PART II

**Jeanne Lacey. Angela Jacklin.**

**JEANNE LACEY** is a Senior Community Physiotherapist based at the Royal Alexandra Hospital, Brighton and has worked at Patcham House School since 1979.

**ANGELA JACKLIN** taught at Patcham House School from 1980-1987 and is now lecturer in Primary and Special Education at the University of Sussex.

Evaluation of our methods of integration at Patcham House Special School from 1983 onwards (APCP Newsletter Aug. 1992) revealed that we had neglected the importance of maintaining an integrated support network following transfer into mainstream school.

The evaluation also revealed that we needed to explore the implications of the cultural dichotomy between mainstream and special education.

These concerns were the focus of two small scale research projects 1987-88 (University of Sussex).

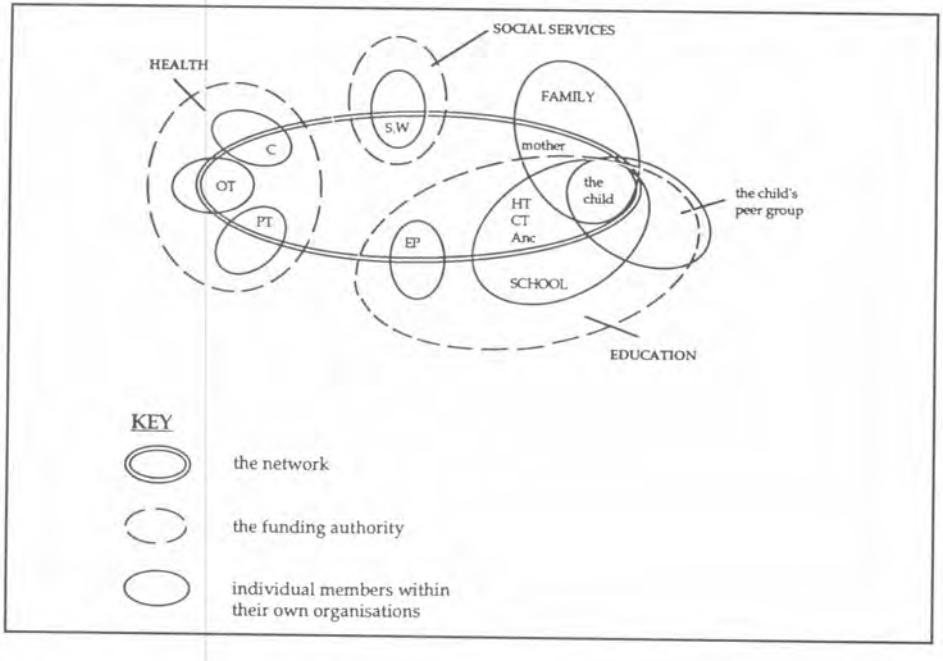
### 1. Multi-disciplinary Support Networks

The first project was concerned with the multi-disciplinary approach to special provision. It focused on and explored the network of support for children with relatively severe difficulties who had always been educated in mainstream schools. Two children with very different educational needs in two different mainstream schools were selected and the support they were given was explored in depth.

The relationships of the members of one of the networks were considered as follows (Figure 1). The child concerned had severe motor co-ordination difficulties.

Figure 1 An example of a support network for a child at mainstream school, with severe motor co-ordination difficulties.

| | | |
|---|---|---|
| From education | Anc | Ancillary |
| | CT | Class teacher |
| | EP | Educational psychologist |
| | HT | Headteacher |
| From health | C | Consultant |
| | OT | Occupational therapist |
| | PT | Physiotherapist |
| From social services | SW | Social worker |
| From family | The child | |
| | The mother | |




Differing support networks may involve differing and additional combinations of personnel.

The research showed that the multi-disciplinary support network developed within the special school could be replicated in mainstream schools. Several essential factors were necessary for maintaining the 'life' of the network. Its success depended on its ability to be sensitive to needs, and flexible and responsive enough to adapt and re-form as these needs changed. Other important factors were identified.

a) Individual members must feel part of a team. The team must have well defined goals within which individual tasks could be established and agreed.

b) Other people's perspectives and roles need to be appreciated. One way to achieve this is for professionals to work in other areas, for example, therapists working in schools. Another way is to replicate the multi-disciplinary 'base' of the special school at other settings (eg. The MacKeith Centre at the Royal Alexandra Children's Hospital) allowing professionals from different disciplines to meet.

c) Regular reinforcement and co-ordination of the network through both formal and informal meetings.

d) Support from the school, and especially the head, facilitates the effectiveness of the network's operation.

e) The school must be able to view children with special difficulties positively and to see that the skills and understanding that teachers develop when working with the child and the network can be directly beneficial to other children.

These insights gained from studying children already in mainstream schools helped us to understand the problems we had met when moving children into the mainstream and indicated how to set up and maintain a positive structure for giving them support.

## 2 The Transfer Process

The second project used an illuminative approach (Parlett and Hamilton, 1977). It set out to explore children's experiences in both mainstream and special education from the perspective of the child. The research methods were mainly interviews. Twenty pupils who had all attended both mainstream and special schools were chosen. Their feelings and views about their experiences at school were explored in an attempt to understand the problems they felt they faced.

In the initial analysis, three main concernes emerged. These were **(i)** friends, **(ii)** relationships with teachers and **(iii)** the organisation of the school. Having friends was revealed as being of the utmost importance, followed closely by, and inter-related with, good relationships with teachers.

The organisational and/or cultural features of schools that separated children from their friends or affected their relationships with a familiar teacher were substantial worries. The setting of the special school leads to close, friendly relationships with staff and many pupils assumed they would have similar relationships at mainstream. To find that many teachers did not even know who they were came as a shock and some pupils found it devastating.

One thirteen year old girl, Karen, talked about negative encounters with staff. These experiences and reprimands were for actions which she saw as reasonable behaviour on her part. She said she had quickly learnt that "You never talk to teachers, ever". She did not blame individual teachers as she realised that they were constrained by the way the school was organised.

Other children had difficulty responding to the different cultural settings, because they did not expect or understand the differences they encountered. One ten year old boy, David, described how he would respond (helpfully he thought) to 'coded' teacher questions eg. "Who's talking?" He did not realise that the question actually meant "Whoever is talking, be quiet". The result was usually a stiff 'ticking off'. In the special school, such a question would usually be answered.

The child's mainstream peer group picked up on many of these situations and sometimes

took advantage. Having friends was of the utmost importance and the children coped with these unwelcomed situations by seeking support. Karen gravitated to other pupils who also did not get on with teachers. She gradually gained acceptance by 'mucking about' like them, turning the negative interactions with staff to her advantage in order to gain friends. She was eventually suspended.

David never managed to resolve the situations in which he found himself, falling unwittingly into 'set-ups' by his peer group. His placement failed but he later successfully integrated into a different school. This time he went armed with a newly acquired cultural awareness.

The reactions of the peer group also had a bearing on the introduction of support staff and equipment into classes. Where these were seen to set pupils apart from the rest of the class, they were frequently rejected. However where they were seen as part of the social situation, as something to be shared, rejection was less likely. For example, one girl at secondary school explained how on the occasions when she needed to use her wheelchair all her friends "had goes" and came to admire her skill in doing 'wheelies'.

Further analysis revealed that the organisations and cultures of the mainstream and special schools were so distinctly different that they created a dichotomy, which made movement between the two a major readjustment. A child would often experience more than one transfer between schools and each transfer was a learning experiece for the child. To cope with the cultural expectations of a distinctly different school was very difficult and some children had to make substantial adaptations.

The implications of their perspectives went further. For example, from the perspective of the pupil, part time placement disturbed relationships and friends. Although it may be helpful in short term, prior to a move, in the long term for some pupils it may be as one pupil described,

> "It was silly going part-time, you can't get into it, it was a waste of time really, you've got to go or not go, you can't go to two different schools, it's just silly."

This helped to explain the failure of part-time placements which we had experienced at Patcham House School.

## 3 CONCLUSION

Our findings had implications for future attempts at mainstreaming pupils from special schools.

1. The special school needs to become less isolated, developing more links with mainstream schools and the wider community. This, combined with carefully structured procedures for preparing the child, facilities integration but constant evaluation is essential for monitoring its success.
2. Physical access is a baseline for integration. However, the physical difficulties of access to the curriculum which the child with disabilities faces in mainstream can, with goodwill and resources, be overcome.
3. Maintaining the multi-disciplinary support networks is vital to the process of integration. Any member of the multi-disciplinary team (for example, the physiotherapist or the teacher) can be the key worker or co-ordinator of the team. For a child with a physical disability this is frequently the physiotherapist. The pupil's placement must be monitored regularly and support given as appropriate. However, a multi-disciplinary base to give them support need not be sited in the mainstream school; it can be provided in a centre for outreach work.
4. From the child's perspective other factors were more important in influencing the success

of integration, especially those which disturbed pupil/pupil and teacher/pupil relationships. Most importantly the study heightened our awareness of the organisational and cultural adjustments children were required to make when they changed schools and highlighted the cultural divide between mainstream and special school which posed so many difficulties for our children. It is crucial that a physiotherapist, used to working in a hospital or special school, must be sensitive to these issues when supporting in mainstream. Integration must begin with 'moving out' from the isolation of the special school into the wider community.

**References.**


Eckersley, P., Clegg, M. and Robinson, P.R. (undated) Guidelines on Advice to Teachers, Appendix 3, in **The 1981 Education Act. Guidelines for Physiotherapists and other Paediatric Professionals**. (London, Chartered Society of Physiotherapy).

Parlett, M. and Hamilton, D. (1977) Evaluation as Illumination: A new approach to the study of innovatory programmes, in Hamilton, D., Jenkins, D., King, C., MacDonald, B. and Parlett, M. (Eds.) **Beyond the Numbers Game**. (London, Macmillan Education).

Jacklin, A. (1988) Multi disciplinary Approach to Special Educational Provision. Exploration of a Network and its Effects.

Jacklin, A. (1988) Differential Experiences of Schooling. Perspectives of Mainstream and Special Education.


## THE ARROW WALKER

**THE ARROW WALKER** is a lightweight and modular walker system developed by bioengineers at Princess Margaret Rose Orthopaedic Hospital in collaboration with physiotherapists. Devised for infants, children and adults, the Arrow walker is of the forward lean type and includes a removable saddle unit. The arrow shape affords good access through doorways and allows the user to approach work surfaces, hands free. The Arrow walker also includes directional locking castors which are useful in educating walking in individuals who have a tendancy to drift sideways. Ten cerebral palsy children have successfully used the Arrow walker for a year at Graysmill School in Edinburgh, reported in Physiotherapy; 1992, 78: 9, 679-680.

The Bioengineering Centre has a number of reconditioned Arrow walkers available for 2 week loan to allow physiotherapists the opportunity of evaluating it for their clients. Interested parties would have to meet the small freight charges involved which are typically less than £30.00 return in the UK.

*Further information:* **Dr. Robert Farley, The Bioengineering Centre, Princess Margaret Rose Orthopaedic Hospital, Fairmilehead, Edinburgh EH10 7ED. Telephone : 031 445 4123 x 295**

**ASSOCIATION OF PAEDIATRIC CHARTERED PHYSIOTHERAPISTS**

# *Annual Conference 1993*

## UNIVERSITY OF BATH

**Friday 2nd - Saturday 3rd April 1993**

# Stepping Out For Equality

*Application forms from Regional Reps. or send SAE to:*

**Mrs. J. Lott,**
**APCP Conference Booking**
**49, Pearce Avenue**
**Parkstone**
**Poole**
**Dorset**
**BH14 8EG**

# Proposed Pro

## FRIDAY 2nd APRIL

**9.00 - 10.00** **REGISTRATION & COFFEE**
in Foyer of University Hall

**10.00** **OPENING OF CONFERENCE**

**10.15** **AIMING AT INTEGRATION**
Dr. Chris Rolles,
Consultant Paediatrician,
Southampton General Hospital

**11.00** **A STRUCTURED MOTOR PROGRAMME**
Mr.Andrew Farren
Headteacher, Chamwell School, Gloucester

**12.00** **DISCUSSION**

**12.15** **EXHIBITION & LUNCH**

**2.00** **BALANCING THE FOOT**
Mr. Ian Winson, Consultant Orthopaedic Surgeon
Southmead Hospital, Bristol

**3.00** **TEA & EXHIBITION**

**3.30** **MULTI-LEVEL SURGERY IN AMBULANT CEREBRAL PALSY**
Mr. Peter Witherow, Consultant Orthopaedic Surgeon
Mrs. Jane Pyman, Superintendent Physiotherapist
Bristol Royal Hospital for Sick Children

**5.15** **CLOSE**

**5.15 - 7.00** **EXHIBITION**

**7.00** **RECEPTION** for all delegates and speakers in Senior Common Room

**7.30** **CONFERENCE DINNER**

# gramme 1993

## SATURDAY 3rd APRIL

| | |
|---|---|
| **8.30 - 9.00** | **REGISTRATION** |
| **9.00 - 9.45** | **APCP - AGM** (Members only, please bring cards) |
| **9.00 - 10.30** | **EXHIBITION & COFFEE** |
| **10.30** | **THE AVON PREMATURE INFANT PROJECT**<br>Dr. Neil Marlow, Consultant Senior Lecturer in Child Health, St. Michaels Hosptial, Bristol |
| **11.30** | **JUVENILE CHRONIC ARTHRITIS**<br>Dr. John P. Osborne, Consultant Paediatrician Royal United Hospital, Bath |
| **12.30** | **LUNCH & EXHIBITION** |
| **2.00** | **SITTING FOR EQUALITY**<br>Terry Pountney, Senior Physiotherapist Royal Alexandra Hospital for Children, Brighton |
| **3.00** | **OPPORTUNITIES & CHALLENGE IN SPORT - A LIFELINE FOR ALL**<br>Sarah Ashmead MCSP, SRP Dip. RGRT. & Sheila Talwar MAOT, SROT. St. Rose's School, Stroud.<br>Introduction by Ann Trotman PhD, MBE, Sports Development Officer for Disabled, Bristol City Council |
| **4.00** | **REVIEW & CLOSE OF CONFERENCE** |
| **4.15** | **TEA** |

## ABOUT THE CONFERENCE CENTRE

The University is situated on Claverton Down on an attractive campus overlooking the City of Bath. Comfortable study bedrooms are available close to the University Hall and there are good shopping facilities and a swimming pool on site.

## ABOUT BATH

Bath is a beautiful Georgian city with lots to see and do. Delegates arriving on Thursday evening might like to visit one of the many excellent restaurants, or do some exploring (a ghost walk is available for the intrepid!). Details of local accommodation will be sent for those who wish to stay in Bath on Saturday night and sight-see on Sunday.

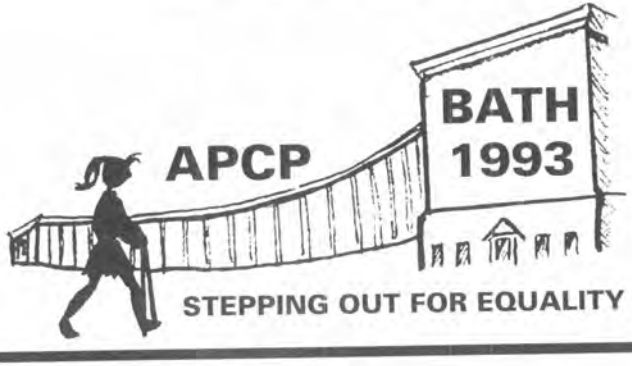
## HOW TO GET THERE

There is an hourly train service from London Paddington Station to Bath Spa and direct trains travel from Salisbury, Southampton and Cardiff. Taxis and buses are available from the Rail and Bus Stations to the University.

M4 and M5 motorways provide fast road access from London, the South West, the Midlands and the North, and the A4 passes through the City of Bath.

## CONFERENCE SWEATSHIRTS

A real must for 1993. These will be superior quality, in large and extra large sizes. The Conference Logo will be embroidered on and there will be a choice of colours. If ordered in good time sweatshirts will be ready for you to pick up at the Conference. Full details on order forms from Regional Reps, or SAE to Mrs. Gail Lilley MCSP, Conference Sweatshirts, 7, Winterfield Road, Paulton, Nr. Bristol, BS18 5RF.



# YOU TOO CAN LECTURE!

**Susan Rochat, Physiotherapeute Diplomee, Petit Lancy - Switzerland**

"Oh I could never lecture like J... she's so much brainier than me!"

It was this phrase overheard at the Norwich Conference which finally decided me to try and write this article.

My story starts three years ago. A British M.C.S.P. with a Bobath formation, I had been living in Geneva since 1975 with a Swiss husband and two Anglo-Swiss children. I was quite happily running my own part-time practice when "The" phone call arrived.

It was from a professor of a University about 150 kilometers from Geneva, she had been given my name by a friend of a friend ... I was apparently the "expert" they needed to give 8 hours of lectures on the problems of children with cerebral palsy, muscular dystrophy or partial blindness... Would I consider it? ... Could she meet me? ... When?

As I put the 'phone down my mind was in a turmoil. Yes I did know quite a lot about the subjects after 12 years of working with handicapped children but there was a lot of difference between a one hour talk on back-care and lifting (it was about all the experience of lecturing I have had) and 8 hours for University students and in french! Fortunately my husband was very encouraging, the children didn't doubt for a moment that I couldn't do it, so, as I quite enjoy new challenges I decided to accept. How was I to go about it?

I started by drawing up a list of what I thought essential for the students to know, description, brief pathology, normal and abnormal muscle tone, etc., etc. I put my list into what I considered to be a logical order and thus armed I fixed a meeting with the professor. She turned out to be young, dynamic and enthusiastic (profs weren't like that in my days I'm sure or am I just getting old? ... 40!) Yes the plan looked fine to her, the idea of short video films to help visualise the problems was good, could I include some practical advice she asked? Which days would suit me? The contract would follow so now there was no turning back.

Due to the time needed for travelling it had been decided that I would give two four hour lectures on separate dates. This was an additional difficulty, talking for 4 hours is quite a marathon. Would I have enough information? Would I dry up in the middle? Even worse, would the students grow bored. All these thoughts raced through my mind as I set forth to attack the problem.

My first instinct to draw up the list of priorities proved to be a good one. I was determined not to "read" the lecture. It is so painful to listen to a person who depends the whole time on his notes. I decided the system of titles and headings would be the one I would use. With the help of the initial plan of essentials I started reading books, papers, cuttings, old notes, anything vaguely connected with the subject. I also started making notes under the different headings until I had piles of papers covered with my untidy scrawl, but it didn't matter as I felt I had covered the topic and could answer almost any question the students would care to ask, at the worst I was fairly sure I'd know where to look for the answer. At the same time I had borrowed and viewed various videos and chosen relevant scenes to illustrate my talk. I found the different associations, children homes and parents that I contacted very willing to help. They agreed to lend films and were only too pleased that the problems of their "special" children were being recognised.

A week before the first lecture was due, after a sleepless night, I nearly rang to say that I couldn't go through with it but I have a very stubborn streak and decided I was not going to give up. Instead I sat down with my pile of notes and started writing the different headings with

the help of different coloured pens and highlighters. Suddenly the whole lecture fell together and finally my self-confidence came out of the red figures.

The students turned out to be very interested. They asked questions, listened without chatting and appreciated the bibliography I had compiled and photo-copied for them along with the names and addresses of the different associations which could prove useful to them for further information. The professor was delighted and asked me back the following year as well as introducing me to one of her colleagues who was giving "special needs" as a post-graduate course of teachers. She asked me to lecture on clumsy children which is a real break through for Switzerland as the problem is virtually unrecognised here.

The moral of my story is that you don't have to be especially "brainy" to lecture but you do have to be methodical and hard working in your preparation and most of all enthusiastic about your subject. Although a lot of hard work was involved, first time around, I got a lot of satisfaction despite the "nerves" as I faced my first group. Luckily these do decrease the more I lecture and now I really quite enjoy it!

Please let this encourage any of you who are hesitant about lecturing. Experienced physios have a lot to give. So do take the plunge.

*Sue Rochart*

## WORKING FOR THE RELIEF FUND FOR ROMANIA

**- Kathy Thomas and Janet Molyneux.**

*In addition to the work described in the following article Kathy and Janet also visited a children's home regularly, where the care of the children was adequate; an old people's home to organise group activities and exercise and did invaluable work in the community, where there was a vast need for physiotherapy input.*

## PAEDIATRIC HOSPITAL, SIGHISOARA, APRIL 1992

We are two Paediatric Physiotherapists employed by West Birmingham Health Authority. In April of this year, we joined a team of volunteers working for The Relief Fund for Romania, to spend a month based in a Paediatric Hospital in Sighisoara, Romania. We worked mainly with abandoned and gypsy children between the ages of one to four years.

On our arrival our initial impression of the children was that they were more responsive and better nourished than we had initially anticipated. However, on closer inspection, we found them to be living in crowded conditions, many of them disturbed and lacking in supervision and attention from the nursing staff. Laundry supplies were inadequate as was the nutritional value of their diet.

Our daily routine involved joining the nursing staff at the beginning of their morning shift to take the lead in bathing and changing the children. We were aware that if we were not present, the children would either be changed without washing or not changed at all. The clothing and nappies both inadequate and torn, often had to be tied together with string. Whilst waiting for breakfast we involved the children in constructive play. Over the month all their concentration spans and physical abilities improved vastly.

Breakfast frequently arrived around 9.45 a.m. and by this time the children were very hungry and fretful. Sometimes the children had a bottle of milk, sometimes bread soaked in

milk and occasionally bread soaked in hot tea. This was obviously nutritionally inadequate. We had to supplement their diet using baby food begged from other charity organisations as we were unable to purchase suitable food locally. We were aware that baby milk and food was being kept under lock and key in one of the hospital rooms. It was visable through a ground floor window. - Even when there was a supposed shortage of milk and food in the hospital this was not used. We were aware that aid had been stolen in the past.

We initiated a feeding programme. The children used bowls and spoons purchase by ourselves locally. At the end of the month many of the children could feed themselves with a spoon but because of lack of furniture and space we had to feed them on a rota basis. Many of the children had great difficulty chewing. We felt that rusks or toddler foods would have been invaluable to facilitate this.

At coffee time we often took Alvera out, (a seven year old gypsy girl who for unknown reasons had spent much of her life in the paediatric hospital) for a walk and to visit the cafe or local shops.

We were well aware of the social and psychological benefits of this but we were frustrated that we could not negotiate for other children to join us.

We were extremely distressed to find that the medical care we witnessed was often ineffectual, inadequate and we felt detrimental to the well being of the children. When presented with an obviously sick child, the medical staff used inappropriate sized dirty needles. They had a limited supply of syringes and paediatric medicines. On one occasion a child having an acute asthma attack was left untreated until we intervened. However there was very little we could do because of lack of appropriate drugs in the hospital.

**Recommendation**

(1) It is essential that productive and constructive play remains priority number one to enable all relief workers to continue to stimulate the childrens' learning ability.
This would be facilitated by regularly updating the supply of toys to the team. The possibility of a toy library should be seriously considered.

(2) Continue to work alongside nursing staff to ensure that bathing and changing continues.

(3) The Relief Fund needs to assess the possibility of providing additional similar style clothing to supplement hospital supplies.

(4) Assessment of laundry facilities with a view to future improvement.

(5) A supply of suitable childrens' cutlery, bowls and trainer cups is needed to continue the feeding programme.

(6) The use of bottles for children of 2 1/2 to 3 years is innappropriate. It is essential to supply suitable foodstuffs for a toddlers diet, particularly to encourage chewing.

(7) It is essential to continue taking Alvera out of the hospital daily and to negotiate for others well enough to do the same. A childrens play area could easily be developed.

(8) We felt it is essential that qualified medical staff are sent out to work alongside the staff in the Paediatric Hospital. The Relief Fund need to ensure that a minimum of two suitably qualified professionals are in each Relief Team.
We feel that the presence of a Senior Doctor in the hospital would be of enormous benefit in educating the hospital staff in the use of drugs and basic medical practice and procedures.

(9) We need to supervise the supply of Paediatric sized needles and syringes and appropriate medicines to the hospital.

(10) The Relief Fund needs to ensure an adequate hand over between medically trained staff. We delayed our own flight by 24 hours to have one working day together with the new team. It is essential that teams have the opportunity for adequate hand over.

**Conclusion**

On the whole, the month proved to be a very positive and productive one.

Although we were unable to change the living conditions in the hospital, each child had changed and progressed to a stage where they were ready for constructive play, self feeding and social interaction. We must stress how invaluable the work of the previous team had been prior to our arrival at the Paediatric Hospital, in preparing both children and staff to accept our input.

It is essential that this work is continued in order to build on these solid foundations.

---oooOooo---

## THE ORPHANAGE DISTROVICHI 2, SIGHISOARA

We continued to visit Distrovichi 2 on a twice weekly basis to monitor the movement of children to and from the Paediatric Hospital.

On the whole we felt these children were better nourished, dressed and cared for than those in the Paediatric Hospital. We were only allowed to see the baby room and playroom containing the older children. We were unsure of the whereabouts of the toddler age group. It is possible that these were all at the Paediatric Hospital at the time.

Although the older children had a play room and were free to move about, explore and play, the babies, some of whom were up to a year old, were left in their cots all day with little stimulation. As the weather improved we were allowed to take the older children out to play. The play area outside was hazardous due to litter and broken glass. The play equipment itself was also in a state of disrepair. We found the medical staff very friendly and helpful and willing for us to stimulate the children.

**Recommendation**

(1) The playroom needs a regular supply of constructive toys and supervised use of these to ensure the children learn to play with them. Many of these children are Physchologically disturbed and demonstrate very destructive behaviour.

(2) Regular input is needed in the baby room where the children are already developmentally delayed due to a lack of physical contact and stimulation. These children should be spending a proportion of each day in supervised play, (bearing in mind that 11 month old babies should be sitting, crawling and pulling to stand etc).

(3) The outside play-ground must be cleared of dangerous litter and play equipment must be repaired to prevent further deterioration.

(4) Aid workers need to formulate details on each child.

---oooOooo---

## AN APPRECIATION

### NOREEN HARE

The name Noreen Hare is synonymous with children and physiotherapy. Her very sincere interest in the field of paediatrics has given her a long and varied career. It has been a career which has served to benefit the children and improved the knowledge of all who work with them. Her inquiring mind and observation skills, have led to the development of a concept known as the Human Sandwich Factor. The recently formed Hare Association will continue to develop this thinking.

With a career that started at the Westminster Hospital in London, lead her to Montreal in Canada, then returning to spend many years at the Cheyne Centre in London, before moving north to Nottingham, Noreen is a well travelled person. Her ideas have created universal interest and this has led to many invitations to lecture, including tours to India from 1979 - 1982 in conjunction with the Spastic Society. She has served on the National Committee of the APCP, and as P.R.O. was responsible for the first "What is Paediatric Physiotherapy" leaflet. Noreen has always supported further education, with research and teaching. She has recognised the importance of passing on her skills and knowledge and is a validated tutor on the Post Registration Paediatric Physiotherapy course, now running at the Central University of England in Birmingham.

Her sincerity, humour and encouragement will be missed by all those fortunate enough to have worked with her. Most of all, the children everywhere, thank her.

**We all wish you, Noreen, a long and happy retirement.**

*Mary Clegg.*

A dinner-dance is to be held in celebration of Noreen Hare's contribution to paediatric physiotherapy. For details see Here and There.

## APPRECIATION - JENNY MCKINLAY

Jenny McKinlay has been Editor of our Newsletter for 4 years, and now relinquishes the role to Jeanne Lacey.

It was with great regret that we had to accept Jenny's resignation; she took on the role of Editor when the Newsletter had already been established as the excellent mouthpiece of our Association, and has worked immensely hard both to maintain standards and to leave her own mark.

Never one to sit back and accept a situation, Jenny's approach has been to challenge the Membership. She sought to present articles which would provoke a response, but to an extent the Membership let her down and seemed not to want to involve themselves in argument or discussion in print.

Jenny stays as a member of the National Committee, and few there have not been challenged to explain or justify a statement, usually rashly made but perceptively questioned by Jenny. She remains a highly valued member of that committee and her service to the Association is greatly appreciated.

*Jill Brownson*
*Chairman APCP*

## ANNUAL SUBSCRIPTIONS

## £15.50 for 1993

These should be renewed **BEFORE** 1st January 1993.

**ORDINARY MEMBERSHIP** is open to suitably qualified members of the Chartered Society of Physiotherapy.
**ASSOCIATE MEMBERSHIP** is open to suitably qualified professionals working in the field of Paediatrics.
**RETIRED MEMBERS** are only required to pay HALF the total annual subscription.
Membership runs from January to December.

*Cheques made payable to 'APCP' should be sent to:-*
*Membership Secretary, Mrs. Jeanne Lamond,*
*22 Whernside Rd., Cross Hill, Lancaster LA1 2TA.*

Members are reminded that we cannot refund money paid to APCP by Banker's Order, and are once again requested to cancel all such orders.

### ASSOCIATE MEMBERSHIP

Any new applications for Associate Membership of the APCP require to be proposed and seconded by full members of the Association.

# P.R.O. REPORTS

## 1) AGM March 1992

The CSP has been producing a number of monthly PRO news sheets which enable the membership to remain aware of events. There have also been a number of Press Releases on a wide variety of subjects.

A Dept. of Health on the subject of Cot Deaths was produced drawing attention to the background of this sensitive subject and making several recommendations, plus advice on the seeking of medical help in the event of the baby being unwell.

The new leaflet on describing the function of APCP - promised last year - is now ready after some difficulty in reaching a suitable format. This leaflet runs parallel to "Physiotherapy in Paediatrics". Our thanks go to Clare of MSF who did the graphic design and layout for us.

During the planning of Paediatric Physiotherapy Days, it was decided to design two new leaflets, one on Physiotherapy in Paediatrics and one for children. A working party was set up to organise these and children's contributions were collected. The PR Dept. at CSP then completed the layout and design. Our sincere thanks go to Lynn Duxbury and her team for the leaflets, posters, T-shirts and balloons used for this day. It is hoped these leaflets will be available for use in the future.

It has been a great pleasure to have with us at this Conference a Greek physiotherapist who not only wishes to become a member but would like to start a similar association in Greece.

I would like to remind members about the Children of Courage awards organised by Woman's Own near Christmas every year. Nominations for suitable children can be made by anyone by making contact with the Features Editor of Woman's Own.

There has been much anticipation and preparation for the new Children's Act which came into force in October 1991. This is an important piece of legislation designed to alter the approach of handling children and offering a new Court structure.

It has not as yet been possible to write definite guide-lines as fresh Policies, Procedures and Guide-lines are awaited from Social Services departments. However, we are now in a position to offer a first draft for consideration.

A number of new titles of handbooks are now in the pipeline thanks to Carol Foster.

*Caroline Dunn*
*March 1992*

## 2) Pro Report For November 1992

Since the AGM, this Association has been undergoing a number of changes of Officers, which will lead to a new style of leadership and emphasis. This is happening at a time when change throughout the Health Service seems to be happening at an ever increasing pace, so perhaps all this will remind all of us that none of us is immune to having these changes thrust upon us and that we must all learn to adapt to them and try to make them work to the advantage of our services.

This is the time of the year that we are asked again to think about "Children of Courage" Awards. These awards are given by Womans' Own Magazine to children who have either shown great courage in facing illness, or surgery or who have, with disregard to themselves, shown great courage and/or bravery in helping others. Paediatric Physiotherapists seem to be well placed to identify such children. If anyone wishes to put forward the name of such a child, please contact the Features Editor of "Womans' Own" Magazine directly, preferably within the next few weeks.

It was encouraging to find that at the last Regional Representatives Meeting, that there had been some recovery of enthusiasm for attending local courses; there are many being organised

around the country. The West Midlands were amazed to find 80 Members turn up to an evening Lecture on "An update of Anatomy and physiology", this is one in a series of three.

I am still encouraging our Overseas Membership to correspond with information about the work they are involved in, this is beginning to bring returns, but it is slow. Please continue to communicate any news which may be of general interest.

*Caroline Dunn, September 1992*

---oooOoooo---

## ABSTRACT

**Title** How satisfied are parents of pre-school children who have special needs with the services they have received?
A consumer survey.

**Authors** Paul Stallard - Dept. of child and Family Psychiatry
Simon Lenton - Dept. of Child Health, Royal United Hospital, Bath, England.

**Source** Child Care Health and Development, July/Aug 1992
Vol. 18, pp 197-205

Consumer satisfaction is an important health outcome measure and the feedback obtained from satisfaction surveys can be used to positively influence the planning and delivery of health care.

Such surveys are also an important way of assessing patterns of communication during consultation, thus affecting re-attendance, compliance with treatment and allowing the consumer to feel their concerns have been understood.

The purpose of this study was to obtain the views of parents of pre-school children with special needs to clarify their opinions of the services they had received and how, if necessary, matters could be improved.

A system of questionnaire/interviews was devised and a total of 12 volunteers were trained in interviewing and interpersonal skills. Each parent who volunteered was interviewed for one hour and given assistance with completing the questionnaire.

41 parents volunteered, in response to invitations sent to local Opportunity Playgroups. The average age of the children involved was 48.38 months, the diagnoses consisting of severe learning difficulties, cerebral palsy, deafness and other long term severe conditions.

Overall the results of the survey indicated the consumers felt reasonably satisfied with the level of services provided. The majority of questions received a 60% satisfaction level. 76% felt appointments were held at a convenient place and time and 83% felt they were conveniently spaced.

However 44% were dissatisfied with the amount of information they had received about available help, 61% had received no advice concerning fincancial benefits, 54% had not been advised about organising respite care, 61% had not felt able to discuss educational issues.

34% felt they had not received enough support in the early stages, 43% did not feel professionals had provided enough support for their families and 39% felt they had not been given a clear explanation about their child's difficulties. 20% felt they had received conflicting advice from professionals, 32% felt professionals did not understand their concerns.

With regards to their child's condition, parents are often the first to suspect potential problems. Between the period of suspicion and a definite diagnosis, it is essential for there to be close liaison and open discussion between the parents and professionals involved.

Patient dissatisfaction with medical consultations has been well documented, since many professionals, including doctors, do not receive adequate training in communication and listening skills.

The article ends by discussing the value and problems of consumer surveys, but concludes they are a means of providing consumer opinions of a service provided and give a useful yardstick against which future comparisons can be made.

*Gill Riley*

---oooOooo---

## COURSES

1

**INSTITUTE OF CHILD HEALTH**
(University of London)

**PHYSICAL DISABILITIES**
**25 - 29 January 1993 - Course fee: £300**

**The Seating of Children with Disability (Part of Physical Disabilities)**
29 January 1993 - Course fee: £60

**The Gross Locomotor Management of the Child with Congenital Hemiplegia**
12 February 1993 - Course fee: £60

**Ankle Foot Orthoses**
9 March 1993 - Course fee: £60

**For further information and registration forms please contact:**
Short Courses Office, Institute of Child Health,
30 Guilford Street, London WC1N 1EH
Tel: 071 829 8692 Fax: 071 831 0488

2

**CASTLE PRIORY COLLEGE**
Wallingford, Oxfordshire, OX10 0H
Tel: (0491)37551/26350

**The Sherborne Movement Method for Children with Special Needs.**
Date: 24 November 1992
Tutor: Cyndi Hill
Fee: £39.60 Course No. 28/230

**Perception - A Hidden Handicap?**
Date: 27-29 November 1992
Tutor: Pat Kennedy
Fee: £162.80 Course No. 28/232

**The Use of Multi-sensory Rooms**
Date: 2 December 1992
Tutor: Mark Gray
Fee: £39.60 Course No. 28/236

**Child Abuse and Special Needs**
Date: 11-13 December 1992
Tutor: David Pithers
Fee: £162.80 Course No. 28/250

**Children with Cerebral Palsy and Motor Impairment**
Exploring their special educational needs.
Modular programme 1992/93 in association with Canterbury Christ Church College
Details: SCOPE
Chalksole House
Alkham, Dover, Kent. CT15 7EE


## CERTIFICATE IN PAEDIATRIC PHYSIOTHERAPY

(Advanced) 1993/94

*Recruiting Now*

**For information please contact:-**

The Course Director,
c/o Pam Graham,
Registry Office,
Faculty of Health & Social Sciences,
Birmingham Polytechnic,
Perry Barr,
Birmingham
B42 2SU.

**Telephone: 021 331 5550**

*University of Central England in Birmingham*

# CONGRATULATIONS!!

## POST REGISTRATION COURSES SUCCESSES

CERTIFICATE IN PAEDIATRIC PHYSIOTHERAPY (ADVANCED)

AWARDED BY THE UNIVERSITY OF CENTRAL ENGLAND IN BIRMINGHAM (BIRMINGHAM POLYTECHNIC)

This course was validated by the University of Central England in Birmingham in April 1991.

The first running over 1 academic year was completed by 14 students in July 1992. The attendance on the course is on a part-time basis, with support for students from the university throughout the two semester.

The course is level 3 study, part of the Credit Accumulation and Transfer Scheme and The Chartered Society for Physiotherapy PACE study.

The ethos of the course is directed towards providing an educational context in which students can develop their role as advanced practitioners in Paediatric Physiotherapy.

All following 14 students were successful in obtaining their certificates:-

Jean Archer
Elizabeth Brame
Susan Chance
Katherine Drake
Denise Glover
Carole Hurran
Joanne Jenkins
Ian Jones
Janet Kelly
Joslyn Lee
Christina Mellor
Margaret Smyth
Zoe Walker
Dianne Woodcock

---oooOooo---

# HERE AND THERE

1. **NOREEN HARE,** Superintendent of Physiotherapy Services in Nottingham is taking early retirement in September 1992. In celebration of her contribution to the paediatric field, former colleagues and friends are invited to a dinner-dance to be held in Nottingham on Saturday 16th January 1993. Tickets will be limited.

For further details contact -
Jenny Gill or Jan Corderoy
Child Development Centre
City Hospital, Hucknall Road,
Nottingham NG5 1PB.

Anyone wishing to contribute to a retirement present please send cheque payable to Noreen Hare Retirement A/C c/o the above address.

2. **DID YOU KNOW?**

**i) Aids To Communication In Education - the ACE** centre is a national centre that:
- is involved in assessing children with communication difficulties,
- runs training courses for teachers and therapists,
- producecs publications,
- is involved in research and development,
- holds a resource library.

ACE Centre
Ormerod School
Headington, Oxford OX3 8DD

**ii) Every Year In The UK:**
- 1 million children are cared for in hospital - half under the age of 5 years,
- 3 million children are treated in accident and emergency departments,
- millions more receive care at home or in the community.

Action For Sick Children
Argyle House
29-31 Euston Road
London NW1 2SD. Tel 071 8332041

3. **A STUDY FROM ABERDEEN** comparing wheezing, hay fever, ezcema and asthma in 6,685 children aged 8-13 yrs over a period of 25 years has found that cases have trebled in the ten years 1979-89. Between two and a half and three million people are now affected. According to the National Asthma Campaign, asthma is the only treatable disease in the Western world that is increasing in incidence and severity.

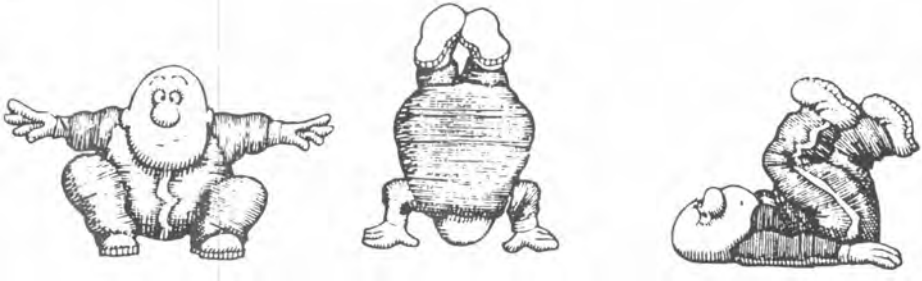
NB. A report from the Royal College of Physicians
"Allergy, Conventional and Alternative Concepts" has found that acupuncture, hypnosis and herbal medicine successfully treated allergies.

---oooOooo---

4. **THE RETT SYNDROME ASSOCIATION** has produced a brochure titled "What is Rett Syndrome?" To obtain a copy send an A4 sae to:
Helen Hurst, Administrative Officer,
6 Derby Terrace
Derby Road
Nottingham NG7 1ND

---oooOooo---

5.



In this new video **"WORKING WITH CHILDREN - THE ROLE OF THE PHYSIOTHERAPIST"** a range of services offered to children within the hospital, schools and the community are highlighted. Particular attention is paid to children with learning difficulties. The programme is aimed at parents of children who may require physiotherapy. For details contact:

Video Communication Services
Northampton Health Authority
Eden Lodge, St. Crispin Hospital
Berrywood Road, Duston, NPTN NN5 6UN.
Tel 0604 580944

---oooOooo---

6. **BOOKS FOR CHILDREN**
   i) "Going to the Doctor" and "Going to the Dentist". Pop up information books for children aged 4-10 years. Published by Childs Play price £4.95.
   ii) "My Visit to the Hospital" explains about having X-rays. Published by Wayland Publishers price £4.95.
   iii) "Why Charlie Brown Why?" tells the story of Janice who contracts and recovers from leukaemia and describes the effect of the illness on her and on her friends. Published by Ravettz Books price £4.50.

---oooOooo---

7. **TOYS FOR CHILDREN**

The Good Toy Guide. Copies available from newsagents in October at a price of £2.50. The recommendations of over 500 toys submitted to toy libraries by manufacturers this year will be published. The magazine will contain articles giving advice and information on such subjects as child development and appropriate toys; selection of toys to help child with speech/hearing problems; aggressive play and "violent" toys.

# REGIONAL REPORT

**South West**

**Carole Hurran, 23, Bayswater Avenue, Westbury Park, Bristol BS7 7NU**

The Conference Committee is deep in preparations for the 1993 Annual APCP Conference to be held at Bath University on 2nd and 3rd of April. We hope you like the proposed programme in the centre of this edition of the Newsletter. With it you should also receive a Conference application form and an order form for Sweatshirts.

We have tried very hard to keep prices reasonable despite rising costs and members have a significant discount on the Conference package. So rejoin APCP for 1993 NOW! - membership forms should also reach you with this Newsletter.

**South-East**

**Terri Fearn, Woodland Close, Peacehaven, E. Sussex BN10 7SF**

We have had two good study days so far this year - one on Conductive Education, the other on Muscular Dystrophy - this was organised jointly with NAPOT. Both were well attended.

We felt we should organise more study days jointly with NAPOT.

The theme for the study day on 14th November is Respiratory Care and is advertised in the September Physiotherapy Journal.

We have tried to run the courses at different venues around the region. If you would like one held in your area, please let us know. We would then ask your help in booking the venue, getting keys and advising on coffees and lunches.

Please remember that renewal subscriptions are due, and thank you all for your support.

**London**

**Rowenna Hughes - 87 Norbury Hill, London SW16 3RU**

The London branch are pleased at the proposal from the National Committee that their boundaries should be extended to include Bucks and Oxon.

We are looking forward to future meetings together. The recent study day held at Great Ormond Street was a great success. The committee changed the format of the day from structured lectures to a group of twenty physiotherapists working in groups to develop skills and techniques in various areas of paediatrics. The topics included neonates, asthma and cystic fibrosis. The feedback was excellent and we realise that more physiotherapists want to learn a skill and exchange ideas on their study days.

The Committee is now planning the programme for 1993 and hoping to hold a Hydrotherapy Course early in the New Year.

**East Anglia**

**Jackie Reynolds, Church Farm House, Ormsby St. Michael, NR29 3LN**

The Workshop on Vibroacoustics planned for September 12th was cancelled due to insufficient applications. This was disappointing as there had been no meetings since the Conference in March.

The Committee will meet soon to elect new officers and plan a programme to revitalise the region's activities.

Memberhsip numbers have improved after reminders were sent to lapsed members.

Support for meetings will hopefully improve.

**Trent**

**Jenny Gill, 42 Brittania Avenue, Arnold Rd., Nottingham NG6 0EB**

The day course planned for 24 October in Sheffield: "Evaluation and measurement of windswept deformity" has unfortunately had a very poor response. It may have to be cancelled if last minute interest does not materialize.

A study day on hand function is planned in Nottingham in early 1993 - probably February. Details will be sent out as soon as possible. Hopefully it will attract response from teachers and occupational therapists as well as physiotherapists.

It is hoped that the regional AGM in March will combine with a half day course - again, details to follow.

**West Midlands**

**Carol Foster, Physiotherapy Dept., The Childrens Hospital, Ladywood Middleway, Ladywood, Birmingham B16 8ET**

The first talk in the series Neuro-anatomy and Neuro-physiology - given at Morris House School of Physiotherapy by Mrs. Kate Woolman on Wednesday 16th September - drew an amazing audience of **81** Physios. The meeting proved most interesting, centering round neuro anatomy and development. The next evening is Wednesday 21st October - so be sure to be there early to ensure a seat, this evening will be devoted to Neuro-physiology and normal movement. Finally on 18th November - how we are able to affect change by handling and movement. It is hoped that a write up will be available for publication in the Newsletter.

Watch this space for 1993 lectures but reserve:

Wednesday 17th February 1993

| | | |
|---|---|---|
| Subject | - | Genetics |
| Speaker | - | Dr. Farndon |
| Venue | - | William Cant Room |
| | - | Children's Hospital |
| Cost | - | £2.00 |
| Time | - | 6.30 for 7.00 p.m. |

**Wales**

**Babara Bowen, Children's Assessment Centre, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid Glamorgan.**

On September 18th we held a Study Day -

Introduction To Sensory Integration run by S.I., U.K.

This was very well attended by a good mix of therapists, teachers and a parent and was of great interest to all.

Following the success of our **"Sharing Day"** in June, we are holding a similar session on **Wednesday**, November 18th.

This will be held at the Multidisciplinary Training Unit at Prince Charles Hospital, Merthyr. Buffet lunch (bookable 1 week in advance) available at £2.50. Presentations 1.30 - 4.30 p.m. Bring along your slides, videos, etc., of any unusual conditions or updated information on any conditions.

For further information, details of presentations, please contact myself or Mrs. Gaynor Bull at the Childrens Centre, Prince Charles Hospital, Merthyr.

Any ideas for next year's programme would be gratefully received.

Barbara Bowen, Superintendent Paediatric Physiotherapist

**North West** **Alex Winney, 14, Langley Road, Spital, Bebington, Wirral, Merseyside. L63 9HW**

As I write this piece for the Newsletter, we are receiving applications for the Study Day on "Visual Handicap" on Saturday October 10th, hopefully it will have gone well and will have been of help and interest to those that attended it. The Committees' thanks goes to those that organised the day.

Planning for next years courses is going ahead, definite details will follow with subsequent Newsletters or with seperate mailings.

Our thanks goes out to all of you who wrote to the committee with Study Day/ Course ideas; it does help us to decide what to put on and what will be of interest to you.

The '94 National Conference Committee and the Programme Sub-Committee have had several very successful meetings and we are ploughing ahead with organising it. Chester is to be the venue.

A little early, but every good wish for Christmas and the New Year from all on the North West Committee.

**North East** **Carrie Jackson, 4 Abbotsway, York, YO3 9LB**

Twenty-five members attended the Study Day on Sensory Integration held in York on September 12th. Our speaker was Joy High from the Sensory Integration Association of the U.K. who was assisted by Sarah Somers, an O.T. working in Goole, who has completed part I of the S.I.A. U.K.'s course. Our thanks go to both of them for a very full and interesting day and particularly to Sarah who gave her first S.I. lecture that day. We won't forget the experience of Joy's obstacle course viewed through the wrong end of a pair of binoculars, especially the coffee table to work-top section.

Our next Study Day is in the planning stage but should be just as much fun! Details will be enclosed in the newsletter. Apply now! Suggestions for Study Days are always welcome.

**Scotland** **Lyn Cambell, 19 Craigmount Avenue North, Edinburgh, EH12 8DH**

**N. Ireland** **Elizabeth Harty, 43 Ardress West Road, Tullyroan, Dungannon BT71 6NG**

Ruth Graham resigned as chairwoman and committee member last May, after several years of dedicated work to the APCP. We would like to thank her for her enthusiasm and hard work.

There are now 37 members, and because the committee felt that there are more physiotherapists working in paediatrics not members of the APCP or in isolation a questionaire was distributed throughout the province. This requests information on specialities being covered, ideas for subject matters for further study days and preferred venues.

A most successful 8 week Bobath Course was held during May and June in Fleming Fulton School, Belfast, and attended by 20 physiotherapists, 2 occupational and 2 speech therapists. This was acknowledged by all as being a tremendous learning experience and with the help of BABTT, it is hoped to maintain the impetus. Our sincere thanks to everyone involved, and it is hoped to repeat this course in a few years. It was very encouraging for our profession that the Government gave us major financial backing.

A Study Day on "Alternative Therapies" is planned for 10 October, in Craigavon Area hospital and Brownlow Leisure Centre. The occasion will be an opportunity for therapists to see this fine new Child Development Clinic, and glean ideas on lay out and equipment.

23rd November, Evening meeting on Respiratory Care in, The Ulster Hospital, Dundonald.

Further programme news for 1993 will be in the next Newsletter.