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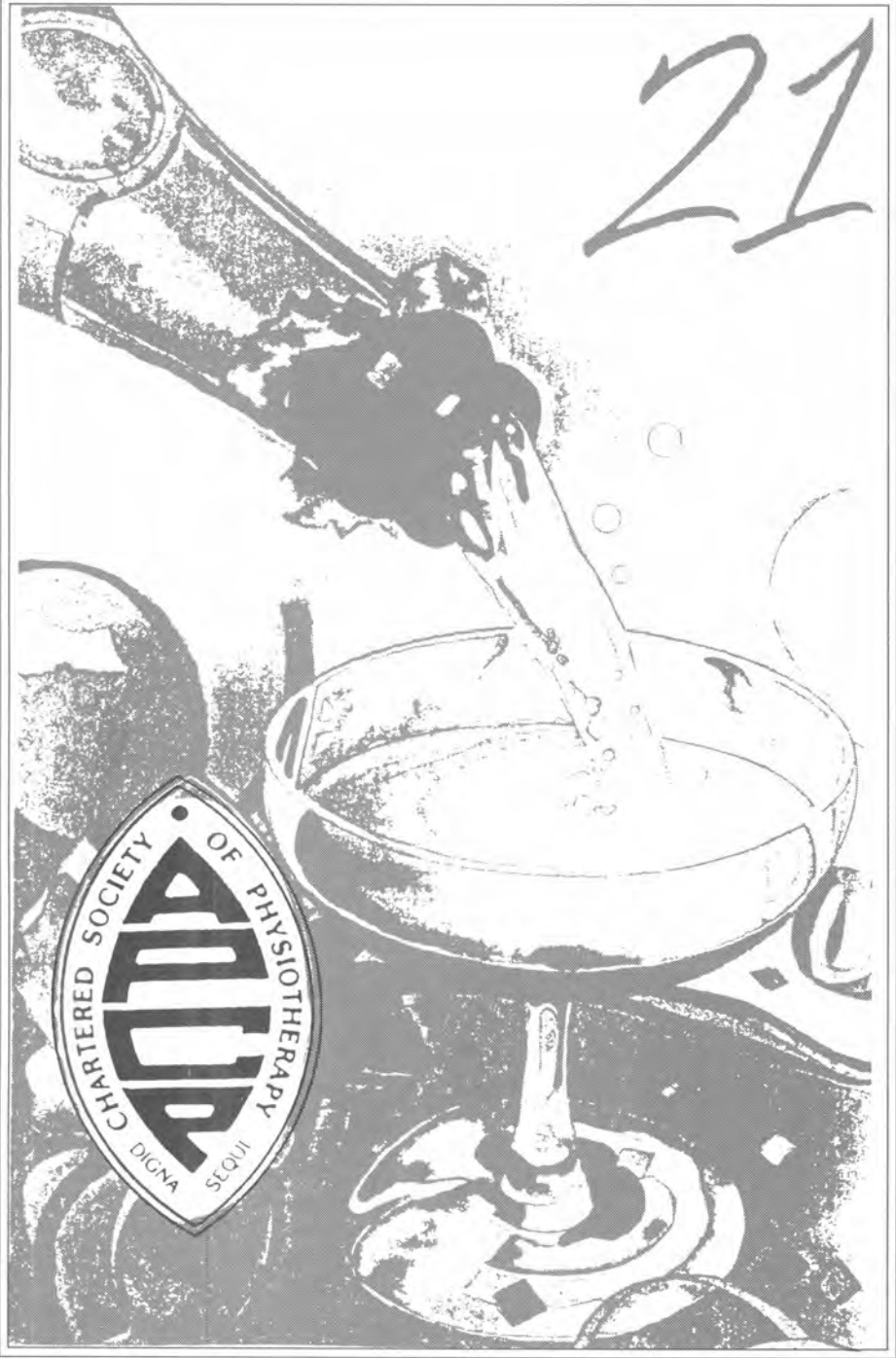
PAEDIATRIC

CHARTERED PHYSIOTHERAPISTS



NEWSLETTER

21



Association Of Paediatric Chartered Physiotherapists

Newsletter No.70

21st Birthday Issue

February 1994

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EDITORIAL

This is our 21st Birthday edition and bears our new title "Journal".

In February 1973 the first meeting of the Association was held in the Hospital for Sick Children, Great Ormond Street. A group of dedicated paediatric physiotherapists had worked energetically to organise that first national meeting and our thanks are due to them for laying down the firm foundations upon which we have been able to build.

They provided us with a constitution, which as Jean Biddle said in a previous editorial [Newsletter No.16], is a vital and necessary framework for a democratic organisation. One of their prime aims was to organise and provide post-registration education. We have all had the opportunity to benefit from their foresight, from those of us who attend local or national courses to those who have completed the post-registration Certificate in Paediatric Physiotherapy.

In that same editorial Jean Biddle gazed into her "crystal ball" and saw "A thriving A.P.C.P. of some 2,000 members, a diploma and a degree in paediatrics" and a time when "the paediatric physiotherapist will become one of the most valuable and respected members of the physiotherapy profession".

We are travelling well along that road but our membership has not yet reached 2,000 members. The strength of an association is a sum of its individual parts so let us all take some responsibility for trying to increase the membership. Alternatively send constructive criticisms or ideas as to how we can encourage more practising paediatric physiotherapists to join the A.P.C.P. In this time of equal opportunities men seem strangely reluctant to become active members of the Association!

As this is a rather special birthday we have asked for reminiscences from two of our most notable and respected retired Chairmen.

We have reprinted an article first published in Newsletter No.18 which gives an "historic" overview of how our professional skills have reflected and adapted to the advances in medical science.

A birthday is a time for nostalgia, taking stock and most importantly for looking ahead. The contents of this Journal therefore also reflect our present concerns such as research, audit and handling.

HAPPY 21ST BIRTHDAY A.P.C.P.

and a **HAPPY NEW YEAR TO ALL MEMBERS**

Jeanne Lacey
Editor

**COPY FOR THE MAY 1994 JOURNAL
MUST BE WITH THE EDITOR BY
MARCH 28th 1994**

The Editorial Board does not necessarily agree with
opinions expressed in articles and correspondence
and does not necessarily endorse courses advertised.

The Board reserves the right to edit material submitted.

LETTERS TO THE EDITOR

The Royal Belfast Hospital
for Sick Children
Belfast BT12 6BE Northern Ireland. telephone 240503
Physiotherapy Department

Dear Editor,

I have recently been referred a child with Noonan's syndrome. I would be grateful to receive information from any readers with experience in treating children with this syndrome.

Yours faithfully
CATHY BOYD

Physiotherapist
Child Development Clinic

University College and Middlesex School of Medicine
Department of Paediatrics
Sub-Department of Paediatric Handicap

Dear Editor,

I enclose a photocopy of the relevant section of a letter I have received from Dr. Rosemary Marks about her Department's needs out in New Zealand. Dr. Marks worked as the Senior Registrar in our service in the early 1980's and was extremely well thought of, both professionally and personally, by all of the other professionals on this multi-disciplinary team. As is evident, we still maintain links with her.

Although this country needs its paediatric physiotherapists, there are many who do like to combine the experience of travel with the opportunity to work in another country and someone may welcome knowing of this particular opportunity.

If anyone is interested in finding out more, will they contact Dr. Marks directly. I will of course be pleased to help where I can, although I do not have detailed knowledge of the work practice.

With thanks
Yours sincerely
MARGARET LAWRENCE

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New Zealand

From time to time in the past I have mentioned to you the ongoing problems that we have with shortage of experienced paediatric physiotherapists in Auckland. The degree of shortage tends to vary, but is currently fairly major. If you know of any experienced paediatric physiotherapists who might be interested in spending some time working in New Zealand, perhaps you could ask them to get in touch with me. We would welcome interest from people who are only interested in visiting on a temporary basis, although a commitment to a minimum period of six months would be necessary as it does take some time for overseas people to get to grips with the New Zealand system. The major area of need is in our District Child Development Services which provide home visiting and centre-based services mainly for pre-school children with physical or intellectual disability.

If you know of anyone who might be interested, please ask them to get in touch with me at the above address enclosing a brief CV, and I will pass the information on to the District Child Development Team Co-ordinators.

ON LOOKING BACK

Jean Biddle Past National Chairman 1976-1980

How well I remember the inaugural meeting of A.P.C.P. It took place in the lecture theatre of the Hospital for Sick Children, Great Ormond Street, in February 1973. The expansion in the number of physiotherapists working in paediatrics, particularly in Special schools, their thirst for greater knowledge in the management of their patients, the increase in the number of surviving children with spina bifida, the controversial treatment of cerebral palsy all led to a number of dedicated and enthusiastic physiotherapists meeting to pool their ideas and to form an association.

A committee was elected and the first Chairman was Moyna Gilbertson, the then Superintendant at G.O.S. In the months that followed we spent a great many hours drawing up the constitution and bringing in associate members - doctors, psychologists, teachers and welfare assistants - all concerned with the needs of our patients. Also setting up courses (day, evening and week-ends) which was the real starting point in the educational programme. The very first day course was held in May 1974 at Cardiff, "Spina Bifida - a review of allied problems," - a very big challenge at the time. From little acorns mighty oaks do grow - now there are courses on a vast range of subjects all over the country.

The emergence of researchers in the field of paediatric physiotherapy and the sharing of knowledge was very important - and, of course, still is - but I well remember the rather sparse sheet of roneoed paper which was our first Newsletter. Now we have a professionally produced 65-plus page magazine bursting with interesting and invaluable information.

Very little experience, if any, was given to the student physiotherapist on the treatment of children. So, in order to help the newly qualified and those new to our specialist field, we published several little booklets. These ranged from "The Clumsy Child" to "Sex for the Disabled".

The courses, conferences and the Newsletters all helped to bring the Association together. I was fortunate, and indeed honoured, to be the 2nd National Chairman from 1976-1980. This was an exciting time as we were still expanding. The education programme was gathering momentum, we were constantly being consulted by the C.S.P. the D.H.S.S. and many allied professions as well as numerous individuals.

The changing pattern of disabilities and the management of the children, particularly in the educational field with the integration into ordinary schools, has meant that the role of the paediatric physiotherapist is, perhaps, even more demanding now than when I retired.

I still receive the Newsletter and follow the progress of the A.P.C.P. with great interest and admiration.

In retrospect I realise how fortunate I have been in being involved in the establishment and early development of such a fine organisation.

May you continue to go from strength to strength.

Dec. 1993.

WHAT APCP HAS MEANT TO ME

Ann M.D. Grimley M.C.S.P., S.R.P. (retired) Past National Chairman A.P.C.P.

I was asked a little while ago to express what the Association of Paediatric Chartered Physiotherapists had meant to me. What a train of recollection that request set in motion... lines of thought and memories branching out in many directions. A.P.C.P., the association itself, its activities and its members have meant a great deal to me in my professional and personal development. For that I am grateful and thank all concerned.

Perhaps, to understand the importance of A.P.C.P. in my life, I should recap a little. Nearly eighteen years before the present Association was formed, as a newly qualified chartered physiotherapist I took up my first post in a busy General Hospital in Salford. Previous to that, my Paediatric training and experience had consisted of theory and a little practice with children with conditions such as flat feet, asthma, scoliosis bronchiectasis, poliomyelitis and fractures.

In that general hospital, the children's wards and wards for the elderly were assigned to the most junior physiotherapist. The Superintendent and senior staff told me that they were not of interest to them nor as demanding and satisfying as work on the adult orthopaedic, medical and neurosurgical wards. They thought that children and "old dears" were much the same as far as physiotherapy input went ie "chests and hips"! In general, one carried out the prescribed therapy modes requested by the consultant and did not question nor evaluate inputs let alone outcomes. Only doctors went to clinical meetings and case conferences!

An enlightened paediatrician generously tutored and took me with him on each ward visit and gently made me aware of the great clinical specialty this was for therapists as well as for doctors and nurses. There was virtually nothing other than Bobath or Cheyne Walk post graduate training available in the UK. I needed therefore to consider "sitting alongside Nellie" if I wanted to learn and become skilled in this field. My mentor kindly advised me to move to a Children's Hospital where I would learn and gain much more experience.

Later work in UK hospitals and USA schools and community services in the UK further broadened my horizons. Even though inservice training activities were undertaken, there was little or no personal development or career planning or management training or paediatric education offered in health districts and regions.

Thus it was from the start of my career in 1955 I learned that Paediatrics is a sharing clinical specialty. I was aware of my lack of knowledge and skills and that I needed some foundation training in normal development to understand the problems encountered in paediatric practice.

It took nearly another twenty years before A.P.C.P. members began to organise regular regional and national postgraduate study activities and to have direct influence and input into the basic physiotherapy training curriculum. From active involvement in the association, its ideals, experiences gained as a member of the education working group and in committee procedures I was able, at long last to fulfil my early dreams and the hopes of my mentor paediatrician. A.P.C.P. can be said to have been a major influence in my personal and professional life.

In 1973 a clarion call was heard from the Midlands folk, Ann Marks, Denise Woods and Mary Hazelwood who, in conjunction with Moyna Gilbertson invited UK therapists to meet in London to investigate possible formation of a specific interest group of the CSP. I marvelled at the foresight and courage of those valiant women and at their organisational skills.

At that meeting, a steering committee was called for and set up through nominations from amongst those present. All seemed to be going well until I heard my name going forward for

voting.. consternation... I could not at that time, give a spontaneous vote of thanks nor ask questions at a meeting without much rehearsal and great qualms! I was so surprised at the nomination. I had not the courage to refuse! It turned out to be a wonderful opportunity for my personal and professional development and a personal affirmation from peers.

That nomination has turned out to be a gift to me. What a lot of fun I have had - friendly yet hard working committee meetings. A.P.C.P. has brought me many dear friends and professional acquaintances; great work and personal satisfaction; broadened my horizons. I was encouraged into activities in which I would never have dreamed of becoming involved. Perhaps some would say it also brought out the bossiness in me. . forgive me if I ever did overstep that mark.. but, yes.. I became a crusader, had a mission, enjoyed myself even if I had to work hard to fulfil this call.

I learned of committee procedures and how to ensure tasks were completed from great chairmen such as Moyna Gilbertson and Jean Biddle. Thanks to Cynthia Mason and Sandra Holt I began to understand the importance of the role of the Hon Secretary of the Association and need for close working partnerships between Chair and Secretary. I began to understand there was a vital need for members and Hon Treasurers to maintain an even fiscal balance through fund raising and careful budgeting. I learned a great deal about bringing the A.P.C.P. to the attention of our clients, managers, profession and the public in general and the importance not only of the cultivation of media relations but finding and knowing the correct facts and presenting them in an uncomplicated and uncontroversial way in order to submit evidence to such bodies as the Chartered Society, Department of Health, British Medical Society or British Paediatric Association.

The hard work, many meetings and discussions ensuing from the Education Working group brought me into contact with some of the greatest professionals in Paediatrics in the UK.

Working with this group gave me courage to tackle not only organising the first ever National A.P.C.P. conference but also to identify and fulfil local and later, national training needs. Even building design has benefitted from A.P.C.P. influence! Members - identified needs had influenced the design of a new physiotherapy department in my hospital in Manchester. The fact that we as a group of physiotherapists in paediatric practice had no real focal point in the North West was accepted by my hospital managers and by the North Western Regional Health Authority and its forward thinking Education and Training Manager. Had A.P.C.P. then turned me into a saleswoman and forward planner? I must admit that self assertion was enhanced through this association.

This Region supported the innovatory national committee training weekends and meetings and underwrote many clinical education and training activities such as the twelve month series of evening classes and the (first UK outside London) Bobath Neurodevelopmental courses. This was followed by intensive course planning and mounting of the A.P.C.P. first post graduate certificated course. At last, I was enabled to further my paediatric education! Thank you Pam Eckersley and other course planning and tutor members.

Writing and editorial skills were developed and enhanced through work with the Publications and Newsletter committees..thanks Jeanne Lamond and to CSP Editor, Jill Whitehouse who once gave us an enlightened weekend workshop on Journal production.

I became involved with the publishers with the initial idea, the planning and possible contribution to the A.P.C.P. course source book "Elements of Paediatric Physiotherapy". This was a culmination and fulfilment of the A.P.C.P. education work in which I had been involved. I was delighted that its eventual publication coincided with my retirement. Thank you Pam for taking on the editorship so well... I have to admit to failure on that score..deadlines again! But

at least delegation skills, becoming aware and knowing myself and such shortcomings I owe also to A.P.C.P.!

To stand on my own on a platform or in a Lecture Hall still gives me stage-fright . . . however, emboldened and assured through those gradually acquired and often practised lecture and presentation skills I have managed to muddle through. Supported by colleagues and association members, I was voted onto the CSP council and gained more experience and I hope, insight into the management and development of our parent professional body. A.P.C.P. committee work had well prepared me for CSP Education and Journal committee work!

About ten years ago I was honoured to become chairman of A.P.C.P. How I did enjoy that office and was so well supported by loyal committee members. I value my Hon. Membership and feel proud to serve the Association on request. Throughout the years since that first meeting at Great Ormond Street I feel I have been blessed with so much friendship, comradeship and professional support. I have been challenged, stretched, demanded of, exhausted by but triumphed in the achievements of the Association. The personal contacts made through association activities have brought me much joy and companionship. I have been enabled to forget my innate shyness and have even been known to preside at a medieval banquet and to dance (or prance) in public and round the tables after an annual dinner!

I sincerely thank A.P.C.P. and its members who have meant so much to me and are valued by me as friends personally and professionally.

Feb. 1994.

The following article was first published 13 years ago in the February Newsletter No.18. Miss C.E. Browning is an Honorary Member of the Association in recognition of her valuable work with the original Post Reg. Committee, London Region.

CHANGES IN ORTHOPAEDICS OVER THE YEARS

Miss C.E. Browning, ONC., MCSP., Dip.T.P.

When I was asked to write an article for the paediatric newsletter by the P.R.O., I had great difficulty in deciding upon a subject. This title was suggested by the secretary of the paediatric association, and I am still uncertain whether she is paying me a compliment with regard to my many years of experience or whether she feels that the proper title should be "The Ramblings of a Geriatric"?

On thinking over the changes that I have seen in the orthopaedic field during my working life, I have come to realise how many vast improvements have occurred in this branch of medicine.

When I began my training as an orthopaedic nurse there was a preponderance of patients suffering from tuberculosis affecting bones and joints. The only available treatment was prolonged immobilisation in extensive splints in bed for many months or years, as this was before the discovery of anti-tubercular drugs. When the disease at last became quiescent, the affected joint was usually ankylosed due to the amount of destruction that had occurred. Although the patient would eventually go home, it was understood that the infection could flare up again at any time. If a sinus developed between an abscess cavity and the skin surface, secondary infection of the wound was almost inevitable and many patients had very long standing discharging wounds. Surgery involving the actual infected tissue was practically never attempted because this would usually result in widespread dissemination of the tubercle bacilli throughout the body. Some unfortunate patients developed tubercular meningitis, which was almost invariably fatal, and as many of our patients were young this was a most distressing complication.

Osteomyelitis was common, either from a blood borne infection or even as the result of a gun shot wound, sustained in World War I. Wide spread surgical excision of infected bone was performed, but in the absence of antibiotics it was often impossible to eradicate all infection, and many patients had frequent spells in hospital with recurrent infection and with chronically discharging wounds. The work of professor Trueta and others during the Spanish Civil War introduced the use of the closed plaster of paris technique, the Winnett-Orr treatment. A plaster cylinder was applied to the affected limb after the diseased tissue had been excised, leaving a large open area. The cylinder was retained for several weeks before being changed. Although the open wound was clean and showed signs of healing when the plaster was changed, the plaster itself became more and more smelly as the weeks progressed. As many patients went home in these plasters, one could only hope that they would have a bedroom to themselves, and that the family became acclimatised to the increasing smell.

I also remember the experimental use of maggots to clean up an infected wound. This was tried out on patients in a young mens ward, which was just as well as the sight and even the thought of lively maggots crawling about and eating ones tissues was rather too much for most patients to tolerate.

The introduction of some of the first antibiotics, such as prontosil, M & B 693, worked miracles in the treatment of some of these patients.

Anterior Poliomyelitis was common, as no form of immunisation was available. The hospital possessed several iron lungs which had been donated so generously to many hospitals by William Morris, the motor manufacturer. Weaning the patient from the respirator as the paralysis subsided was one of the most difficult problems.

Patients were admitted with paraplegia from the spinal cord injuries sustained in road traffic and mining accidents. As the nursing staff had a lot of experience with regard to the prevention of pressure sores in long stay patients with tuberculosis, nursed on frames, it was possible to prevent pressure sores developing in the paraplegic patients, but urinary infection in the absence of antibiotics was a very serious problem. Many of these patients became ambulant with the aid of crutches and calipers, but the degree of mobility and independence was far short of that achieved nowadays, since the work of Professor Ludwig Guttman.

Reconstructive joint surgery was not available, so we seldom saw patients with osteoarthritis. Gross deformity resulting from rheumatoid arthritis could usually be corrected to the extent of giving the patient a more normal life.

Although I have seen many other changes, those that I have described have impressed me most and have made me realise all the advances in medical science that have occurred within my life time, and which have made so much difference to the health and well being of the human race.

A STUDY OF THE EFFECTIVENESS OF TRAINING FOR POOL HELPERS, IN THE TEACHING AND MONITORING OF WATER SKILLS FOR DISABLED SWIMMERS

**Kim Peacock M.C.S.P., Sen.I Physiotherapist, Sanderson Centre,
Newcastle Upon Tyne**

In October 1992, I enrolled on a 6 months Action Research Project at the University of Northumbria. This was for a Clinical Educators course and was worth 30 points towards a Masters Degree. I have been a Paediatric physiotherapist for 12 years and qualified for 24 years so it was with some trepidation that I embarked upon the course. The course consisted of 9 university based days over the ensuing 6 months.

Acknowledgements

Grateful thanks go to the staff, pupils and parents of Pendower Hall Special School.

Introduction

This study investigates the change in attitude and ability of pool helpers in a disabled swimming class, following implementation of a teaching package and assessment scheme.

Movement in water allows people with disabilities freedom from the constraints that they endure on dry land. Water provides a medium for a wealth of experience (Bren Pointer 1990) in physical and motor skills. This is backed up by Reid Campion (1986) who feels that children with disabilities should not be denied the 'delight' of movement in water. For this to be possible and for disabled swimmers to be safe and confident to progress to independence in water they need skilled tuition.

"Whatever the circumstances training is essential, otherwise neither the swimmer nor the instructors will make any progress. It may be tempting to muddle through and pick up things as you go along but this is not good enough". (Association of Swimming Therapy 1992 -

To investigate what quality of assistance was being provided, the research focussed on a small weekly Hydrotherapy class held at Pendower Hall Special School. The class consisted of eight children aged 5-7 years (mean age 6.25), with varying disabilities. The Halliwick Swimming Method (Profile Section C.1) as promoted by the Association of Swimming Therapy (AST) was used. This method requires one to one helper: swimmer rather than flotation aids in the early stages.

The class is run by a Halliwick trained Senior Physiotherapist. Extra support is made up of one class teacher, 2 physiotherapy assistants (one of whom is Halliwick trained) and 4 parents. Help of this kind was found to be normal in special schools Thomas (1987), Dyer (1989), and Wolfendale (1989), stressed the importance of parental involvement across the whole curriculum, swimming included.

The pool helpers, although not necessarily trained, fulfil a very valuable role in supporting and encouraging their disabled swimmers. However, from observation it was felt that they took a passive role and they were merely acting upon instructions without understanding the theory and teaching behind the games and activities involved in the Halliwick method. They

tended to be oversupportive and initiated their swimmers movements. Thereby not allowing the pupils to develop their own body control or to progress to achieving independent skills. Any progress made by the children was not recorded. As a result of the introduction of the National Curriculum, records now need to be kept for childrens achievements.

Evidence suggests that a more structured approach to training these extra helpers would increase their confidence and awareness (Thomas 1987). This would hopefully lead to helpers taking a more active role in the teaching of water confidence and skills.

It was decided that a program of training for pool helpers would be instigated in addition to the use of an assessment scheme for swimmers to enable progress to be recorded.

It was anticipated that this approach will change helpers attitude from passive to active 'thinkers' enabling them to be more aware of teaching points and stages in progress that can be gained through correct handling and encouragement.

Method

A qualitative Action Research Study was undertaken. Three strategies were used for gathering information over a three month period. These were in the form of pre and post teaching questionnaires, video recordings and the use of an assessment scheme. This triangulated approach was to add to the validity and reliability of the project (Cormack 1991).

Initial Questionnaire

The eight pool helpers were recorded during a structured interview conducted by the researcher. The purpose of the interview was to obtain their views on the pool class and their level of understanding of the aims and teaching progressions before implementation of the teaching package. The tapes were transcribed and a content analysis was carried out on the findings. A Teaching Package was formulated from the information gathered.

'Dry Land' Teaching Session

This took the form of 3/4 hour 'dryland' teaching session to explain:

- 1) The teaching points of the Halliwick Ten Point Program
- 2) The National Curriculum Requirements (NC)
- 3) The Swim with Independent Measurement Assessment Scheme (S.W.I.M.)

Handouts were provided on all three topics.

Assessment Scheme

The S.W.I.M. Assessment Scheme was chosen because existing swimming tests (BSAD, ASA and AST Badge Tests, and others were thought to be too advanced for the severely disabled children in this class. The S.W.I.M. Assessment Scheme is being developed by Joe Mason, an Occupational Therapist, for his B.Sc. Hons Degree in Health studies. The original scheme was not in a practical form to be used in a pool environment. It has been further developed with the assistance of the researcher to correspond with the Halliwick System.

Pool Demonstration

Following the dry land teaching session a half hour pool demonstration, given by the

researcher, of correct handling procedures for disabled swimmers was observed by the helpers.

First Assessment

The following week during the pool class the helpers were involved in filling in the assessment booklet, after each skill was performed by their swimmer. During this first assessment a video film was taken to record handling skills and the achievement level of the swimmers.

Ongoing Teaching

During the next two months of pool classes helpers were instructed to give minimal necessary physical support to their swimmer to allow the swimmer to control own body balance, within safety limits. Although all the elements of the assessment scheme were tested four major elements were selected for more concentrated practice. These were:

Pool skill A	-	Water Entry
Pool skill C	-	Water Breathing Development
Pool skill E	-	Vertical Rotation Development
Pool skill J	-	Exit Development

These were felt to be most appropriate to the disabled swimmers learning levels. These are the first skills taught in the Halliwick System to ensure that swimmers can be safe in the water.

The practice sessions were in the form of normal games of a Halliwick session (AST p 70-88) with emphasis on the helper to encourage their swimmer to do as much for themselves as possible.

Second Assessment

After two months a second assessment of the swimmers abilities was recorded by the helpers. Helpers were asked to encourage their swimmers to be involved with their own recordings. If they were capable the swimmer coloured in the pyramid of achievement and placed the stickers in the appropriate box. This second assessment, during the pool class, was video recorded to allow the researcher to observe any changes in helpers handling skills. It also gave a permanent visual record of the swimmers progress. Permission for filming was obtained.

Final Questionnaire

A final questionnaire was administered after the second assessment. This was to discover whether helpers had felt more knowledgeable about the Halliwick System and whether they were more aware of progressions involved in attaining swimming skills.

Results

Of the eight helpers initially on the project seven completed the two questionnaires. One questionnaire had to be discarded as the physiotherapy helper left the school during the project. Two helpers were the parents of one child, the father acted as pool helper, the mother was on the side watching and assessing. They therefore assessed the same child independently. The senior physiotherapist did not always have the same child and has applied her comments to the class in general.

From the initial questionnaire - The Halliwick System was liked by the helpers, their reasons are shown in table I. 75% of helpers recognised that their swimmers were improving but 35% were unsure whether they had contributed to this improvement before training. More Halliwick information was wanted by 75% of the helpers.

Table 1 - Reasons Given For Liking The Halliwick System.

Reasons	Numbers	Percentage
Disabilities needing 1:1 help	2	25
Suitable for many disabilities	3	38
Swimmers safer and more confident	6	75
Swimmers could hear instructions from individual helpers and get easy explanations	1	13
Helpers could see more individual achievement of children without artificial aids	1	13
Overboisterous children could be better controlled	1	13
Parent appreciated being able to spend time helping child	1	13
Flotation aids not suitable for the types of disabilities in class	2	25

The following results are derived from the follow-on questionnaire.

Dry Land Teaching - see Table II.

Helpers felt that the information given was relevant and increased understanding of the Halliwick System as did the 10 Point Program Handout.

Table II - Dry Land Teaching Session (n=7)

How much did it help you to aid understanding of the Halliwick Swimming System?	A great deal	2	29%
	An adequate amount	5	71%
Were instructions for helping swimmer easy to understand?	Understood all	2	29%
	Understood some of it	5	71%
Was information relevant	Relevant	4	57%
	Very relevant	3	43%

The sections of the Halliwick Program that the helpers felt were the most applicable to their swimmers are shown in table III. All but one helper, who was unsure, were able to apply the N.C. guidelines and understood what was required of their swimmer.

Table III - Halliwick Ten Point Program Handout (n=7)

Did handout help you understand Teaching Points in the Halliwick System?	Understood all of it	6	86%
	Understood some of it	1	14%
Teaching Points helpers were able to apply their own teaching:	Number of times Mentioned:		
Mental Adjustment	4		
Breath Control	5		
Disengagement	6		
Vertical Rot.	4		
Lateral Rot.	3		
Combined Rot	1		
Balance	1		
Turbulent Gliding	1		
Simple Progression	3		
Basic Movement	3		

Pool Training - see Table IV.

Pool training has increased helper confidence in teaching water skills and is supported in the second part of the video tape. 86% of helpers felt they could apply the 10 point program to their swimmer.

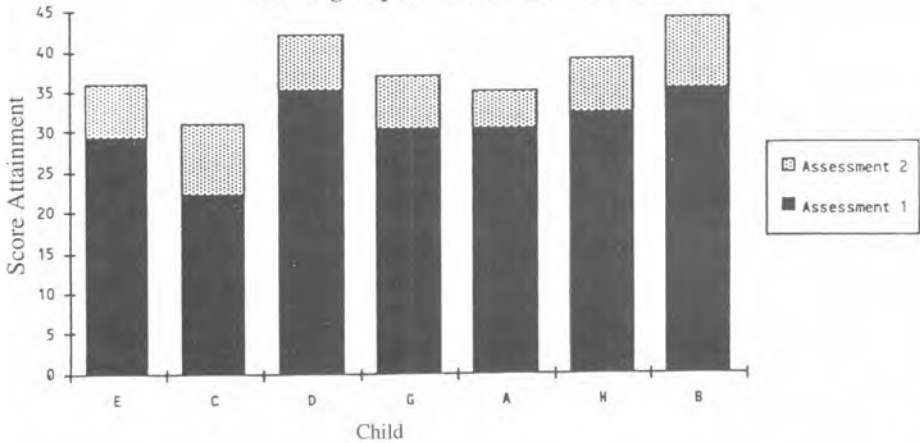
Table IV - Pool Training (n=7)

Were instructions easy to understand?	always	2	29%
	usually	5	71%
Did you understand how to apply Halliwick 10 pt program in pool session?	always	6	86%
	sometimes	1	14%
How confident do you now feel in teaching water skills?	very confident	3	43%
	confident	4	57%
How relevant were pool activities to your swimmer?	always	4	57%
	usually	3	43%

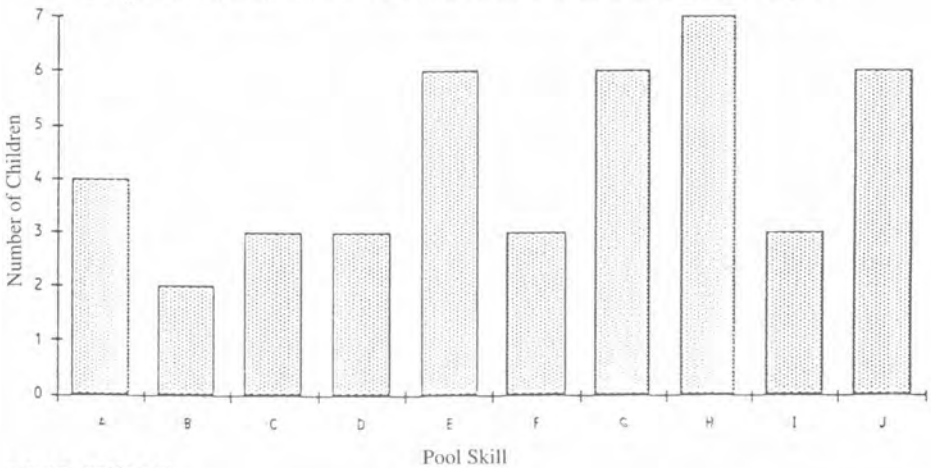
Childrens Progress

All children had progressed on the score sheets 5 - 9 points (mean 7.3) see Graph 2. Vertical rotation, combined rotation, water stroke development and water exit were the skills in which most progress was seen. See Graph 3.

Graph 2
Total Scores For 1st and 2nd Assessments
Showing Improvement in all Swimmers



Graph 3
Graph to Show in which Pool Skills most Children had made Progress



POOL SKILLS

A - Water Entry.

D - Water Balance

G - Combined Rotation.

J- Water Exit

B - Water Adjustment.

E - Vertical Rotation.

H - Water Stroke Dev.

C - Water Breathing.

F - Lateral Rotation

I - Water Tolerance.

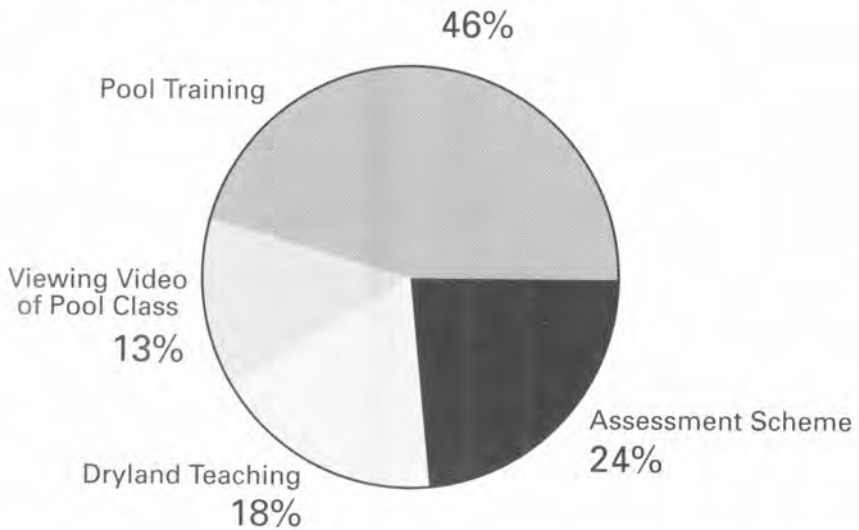
Some form of training for pool helpers was felt to be helpful by 6 out of 7 assistants.

Training in handling and support techniques was thought to be the most useful. Viewing a teaching video of pool work was also felt by the majority to be a useful teaching aid.

General /Overall Feelings of Helpers

There was a very positive attitude to the pool classes since training. Despite early feelings of lack of confidence and the time consuming aspect of filling in the A.S., the helpers all felt happy about it. Five mentioned being more aware of progress and they recognised that more was being taught "instead of just playing games". Confidence of helpers and swimmers had increased. Pie Chart III shows that 6 out of 7 helpers found that the practical training during the classes was the most helpful form of teaching. Use of the assessment scheme was the second choice.

Pie Chart I - Most Helpful Forms of Teaching Given



Video Recording

The video recording of the first assessment pool class showed typical Halliwick activities. However, pool helpers were seen to be lifting swimmers into the pool and lifting them into a vertical position from lying on their backs. Swimmers were doing very little initiation of their own movements. The helpers were also shown filling in the assessment booklet for the first time.

The second video recording concentrated on those skills that had been selected for extra practice (see Method). It showed improvement in helpers handling skills and progress in swimmers achievements. The two videos have been edited with the help of the researcher to produce a 13 minute narrated film called "Water Confidence: The Key To Progress".

Discussion

The numbers in this study are small and analysis and conclusions difficult to make. There was no control group and collection of data was unscientific. Miles and Huberman (1984, p16)

point out that there are few guidelines for analysing qualitative data and that the researcher is open to "self delusion, unreliable and invalid conclusions". However Stone (1991) quotes "It is important to appreciate that qualitative approaches which aim at understanding are not lacking in rigour".

Despite varying backgrounds, the pool helpers had a common core of interest, that of improving water confidence and body balance of their disabled swimmers. A structured approach to training was provided to make it a more rewarding experience for helper and child. (Edwards and Redfern 1989, p149-152).

However this project should be considered as a pilot study due to its short duration (3 months). If swimmers' progress is to be shown as a reflection of helpers improved awareness and confidence, the study would need to be of longer duration. Progress of disabled swimmers can be very slow.

Helpers were exposed to two forms of learning:

- 1) Teacher centred in the form of a lecture and demonstration.
- 2) Student centred when assisting their swimmer to achieve pool skills and then record progress.

Evidence gathered by triangulation (questionnaire, assessment scheme and video recording) has identified the most appropriate learning strategies for these helpers. The chosen methods of data collection have revealed a positive attitude of pool helpers to the teaching methods implemented. The majority found practical pool teaching and experience to be the chosen methods of learning - thus reinforcing student centred learning, supported by Kolb et al (1974) in the 'learning cycle' and 'experiential learning' (learning through experience) as mentioned by Hyman (1992, p88) and Higgs (1993).

The questionnaires produced 100% return as numbers were very small and respondents were regular pool attenders. Bias is present in the project due to the researcher being both questioner and teacher. An attempt to overcome this was made by making the second questionnaire anonymous rather than a structured interview as in the first questionnaire. The problem of the 'halo effect' as mentioned by Oppenheim (1992, p231-232) of respondents answering questions without reading them, was recognised. Ranking of some questions had reversed scales. This unfortunately led to two respondents answering them incorrectly.

The results from the first taped interview showed the helpers to be enthusiastic and happy to help, but without a great deal of understanding about the Halliwick method. This is not surprising as it is not practical to expect all helpers to be Halliwick trained. The comments after the second questionnaire reflect their feelings. Progress and achievements of swimmers were mentioned seven times. It is interesting to note that using a Visual Analogue Scale (V.A.S.), that parents involved in the scheme felt that their swimmers had improved by a mean of 4.7cms (76%) out of a total 6.2cms (Scatter Graph 1). They (helper) felt that they had contributed to this improvement by a mean of 5.6cms (72%) out of a total of 7.8cms. Whereas the Teacher, Physiotherapist and Physiotherapy assistant felt improvement was a mean of 3.1cms (50%) out of 6.2cms and their contribution, of a mean of 2.9cms (37%) out of 7.8cms. This discrepancy may be accounted for by the following factors:

- a) Parents may be more perceptive to their own children.
- b) Parents may be more ambitious for their children and mark high.
- c) Parents found the experience more rewarding.

- d) Parents felt more involved in their own child and therefore felt that they had contributed more.
- e) Staff helpers were more used to recognising progress as part of their job. Especially the physiotherapist who marked low in these scores.

The researcher was aware that the A.S. was very subjective especially as parents were involved. To exclude subjective bias of individuals views, the assessment should be performed for all swimmers by one external examiner.

Confidence seems to be the key for both helpers and swimmers to progress through a learning cycle. As helpers become more confident in allowing their swimmer to do more for themselves, the swimmer in turn had the confidence to progress in gaining water skills, as seen in Graph 2. Confidence was improved by having more knowledge and a more directed approach to handling and support techniques. Initially some helpers were anxious "I didn't feel very confident at the beginning but it has been great to see progressions the children have made". Asked if they felt confident to teach water skills one helper says "I feel more confident now than at the beginning" and another says "I am now more confident in the pool with my daughter".

Helpers mention an increase in swimmers' confidence as a way of judging improvements, in the initial questionnaire and again in the follow on questionnaire. One helper says "she wouldn't let go at the beginning and was anxious about everything she did" the same helper about the same child later comments "(child) is more confident in the water but I feel she can progress even further". Helpers were now starting to recognise progress and one helper comments "I did not realise at the beginning what achievement could be made".

It was felt important that the helpers were directly involved in filling in the A.S. for their swimmer. This reinforced the learning process as they were required to recognise and record progress rather than the group leader or a poolside observer. The S.W.I.M. Assessment Scheme provided a means of recording swimmers achievements. Instead of reliance on unstructured teacher observations (HMI 1991) we now have a written and visual record (via video recording) of the swimmers' ability. Steve Brook (1989) argues for assessment "to gain information to enable teachers to teach more effectively so that a child can learn more efficiently".

The A.S. is not proved to be reliable or valid as it forms part of an ongoing project for a B.Sc.Hons degree (Mason 1993). Halliwick classes have always incorporated the assessment skills, using games and fun activities and helpers now recognise progress in the class due to the use of the A.S. One parent states, "I feel as if we are achieving something instead of just playing games", and another says "it showed how much can be learnt through play". The use of the A.S. has made helpers more aware of what the Halliwick classes try to achieve.

Although childrens' progress is not the issue of this study it does reflect the level of confidence that the helpers have been able to instil into their swimmers. A finding supported by Emma Smith (1988). This case study of a non swimmer found that the child only gained skills when confident. All the children improved in some elements. The most progress was seen in vertical rotation (skill E), combined rotation (skill G) water stroke development (skill H) and water exit (skill J). All swimmers increased their scores in these skills. Vertical rotation (skill E) is a skill that can be easily subdivided into simple stages and was incorporated into many of the activities practised by the children. Although skills G & H were not ones initially practiced, the swimmers gained sufficient confidence to attempt them at the 2nd assessment. Skill C - Breath control showed little change. Only 3 out of 7 swimmers improved on the A.S. despite practice. Most were at the stage of being able to blow with lips in the water

(see Graph 3). It is realised that not until children are fully confident at this level will they immerse their noses. This takes much practice and confidence.

As there was no control group the researcher is not sure how much progress the children would have made without educating the helpers. However these children and helpers had been attending hydrotherapy sessions for at least a year. The first assessment was taken as the standard reached in this time without training of helpers or assessment of swimmers. The children may also have progressed due to involvement in the assessment scheme themselves (Fox and Biddle 1988).

It was hoped that the children would gain motivation by being involved in their own assessment as advocated by Brook (1989) and by HMI (1991). Both felt that involvement gives feed back to pupils and increases motivation. In a pilot study of the A.S. done by the researcher with older children, the A.S. had been seen to be a great incentive to try harder. This was explained by a greater understanding due to age and less severe disabilities. There was also a competitive element involved.

However in the research project 6 out of 7 helpers felt that these swimmers were only able to understand 'some' of the A.S. and 3 out of 7 were unsure if they (swimmers) would have tried harder as a result.

A word of warning about assessment needs to be heeded from HMSO (1992) Records of attainment should be based on assessments made during the assessment period and not a 'one off' final assessment. For this reason, it is felt that although needing to keep record keeping to a minimum, a longer period of time needs to be spent observing these children as progress can be very slow.

It has been shown that, with some slight adjustments, the assessment scheme will give suitable records of pupils progress for the National Curriculum for Swimming. The researcher feels that this type of scheme, which breaks skills into subskills of achievement, could be adapted for other physical activities i.e. Trampolining, Hockey Skills for special needs children.

Although the Halliwick classes proceeded as normal during the project (apart from the 2 assessments) helpers awareness of what was being taught was greatly enhanced. They all recognised skills that their swimmer was achieving. Three helpers mentioned that they felt a lot more was being taught in the class. One helper states "The project has helped the children not just to move around in the water, but at the same time taught them skills on the way to swimming".

The presence of a camera team may have caused helpers to act differently, (Polgar & Thomas 1991, p122). The researcher had previously videod the class and she had become familiar with the group, the camera team were strangers. This did not appear as a problem on viewing the film as all helpers were very dedicated to their swimmers needs and seemed unaware of the camera.

The film of the pool class has revealed a great improvement in the helpers handling abilities of the children. It shows that given the correct support and encouragement swimmers gain sufficient confidence to initiate independent movement. The improvement in helpers and swimmers confidence was observed by the researcher and T.V. Director during editing of the film. Actions were much more co-ordinated and there was a real 'sense of purpose' about the class. The video recording is not only providing evidence of what took place in the sessions but through the editing facility is able to provide a model of progress and potential of this approach. Helpers felt that a teaching video to show to future pool helpers, would be a useful teaching aid. It is hoped that this video together with a revised assessment scheme can be

developed for this purpose. Students, volunteers and new staff would then gain prior knowledge of the requirements of a pool helper before helping with a pool class. Interest has been shown in using the unedited video film as a resource to develop An Interactive Video Disc. (I.V.D.) for student training (Pinnington 1991 p10).

Conclusion

Pool classes for disabled swimmers rely heavily on untrained voluntary help. As qualified practitioners we need to be aware of the helpers needs and the contribution they can make if properly trained. Pool helpers are closely involved with their swimmer and it is they who build up trust and confidence in their swimmer. This close bond makes them the ideal person to teach and assess water skills.

The study has highlighted that practical participation and teaching in the pool is the preferred method of learning. Helpers have gained confidence and awareness of swimmers' progress. Training in the use of the S.W.I.M. Assessment Scheme has not only provided records of pupil achievement for the National Curriculum but was also a useful tool to facilitate student directed learning.

The video recordings of the two pool sessions has been made into a short film suitable for showing to prospective pool helpers. It could possibly be used to encourage parents of new children (to the school) to volunteer their help in the pool. It is hoped that together with the revised assessment scheme it will form a useful teaching package for staff, students and volunteers.

It is hoped that the video together with the S.W.I.M. assessment scheme can be developed to provide a teaching package for new pool helper before assisting in a hydrotherapy class.

Further Information on the Halliwick Method can be obtained from:-

Association of Swimming Therapy
Ted Cowen (Hon Secretary)
4, Oak Street Close, Yapton
West Sussex, BN18 0JA.

Further reading:- Swimming for People with Disabilities
Association of Swimming Therapy.
Pub A & C Black London 15BNO713634413.
Available from P. McMillan, 24, Arnos Road, London, N11 1AP.

Further Information on S.W.I.M. Assessment scheme & video from:-

Kim Peacock, MCSP
Unityne Health
Newcastle Physiotherapy Department
Sanderson Centre, North Avenue
Gosforth, Newcastle-upon-Tyne,
NE3 4EL.

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AUDIT: A THREAT OR A PROMISE?

Sue Barnard M.C.S.P., Audit Officer, Wessex Region

Audit is the NHS buzz word of the nineties. But what is it? A management conspiracy to eat away even more of our clinical time with endless paperwork? Or a method of self regulation and monitoring designed to assure ourselves, purchasers and consumers of our dedication to a quality, efficient and effective service?

It hardly matters on which side of the fence we sit regarding audit because it is soon to become an integral part of our clinical lives.

In the 1960s, Donabedian led the way in medical audit and quality assurance with papers looking at the evaluation of the quality of medical care. The World Health Organisation in 1985 in their document, "Targets for Health for All" stated that by 1990 all member states should have built effective mechanisms for ensuring quality of patient care within their health care system. As a member state, Britain was obliged to work towards this target and by 1989 the White Paper "Working for Patients" stated that health care professionals should audit their own performance not only to measure and record the quantity of their work but the quality also.

Herein lies the quandary. It is relatively simple to measure quantity - we just count numbers of staff, patients, hours we work etc. But in these days of limited resources and ever increasing demand we have to justify our very existence by assuring purchasers that they are getting the very best quality of service and the most effective patient care delivered in the most (cost) efficient way.

The key words are

Quality Effectiveness Efficiency

These can be defined as:

Quality, degree of excellence

Effectiveness, having power to produce effects, operative, serviceable

Efficiency, capable, competent, producing effect, proficient

Audit therefore, is nothing more daunting than a tool, the results of which assures others that the service we offer is excellent, producing effects through skilled, proficient intervention and self management.

Definitions of Audit

There are many definitions of audit, some designed more to confuse and mystify than clarify. The most concise is an unattributed definition which states:

"Audit is the study of actual practice versus the concept of good practice."

A definition devised by and pertaining to Therapy Audit is:

"A methodical review or investigation of resources and activities both clinically and managerially, a means of quality promotion whereby a group of peers within one discipline decides criteria of good performance and then audits their records to find the level of competence"

(College of OT QUAWP 1989)

The problem with this definition is that it just refers to auditing notes in a retrospective way. It is equally possible to collect information as you go along in a prospective study. But the principles are the same.

Note that this definition refers to "peer review". The Department of Health is very keen that the professionals doing the work actually set their own standards and audit themselves. Although this seems like extra work, we would not appreciate having standards thrust upon us by people who have very little idea of the ways in which we work. Similarly, when we set standards we must consult and include all other agencies involved in order to get full consensus.

Setting Standards

If we are to audit our service we must have standards in order to have something against which to measure our actual performance. Standards are also important in contract building for they set out exactly what our service offers and what the purchaser and consumer can expect.

The Normand Report published in 1991 called for the development of standards and clinical audit amongst some of the professions supplementary to medicine. The Chartered Society of Physiotherapy was already addressing this in their Quality Assurance Working Party and through Specific Interest Groups, and in 1993 published their updated Standards Folder.

So what is a standard? The definition from the European Newsletter on Quality Assurance is:

"The precise count or quantity that specifies an adequate, acceptable or optional level of quantity".

The Collins English Dictionary defines a standard as:

"accepted example against which others are judged; a measure to which others must conform"

In other words, a standard comprises getting together to decide what are accepted examples of practice, in terms of quantity and quality of service, who is responsible and what are the expected outcomes.

Outcome Measures

As an audit compares actual performance to concepts of good performance (our standards) we need to identify some indicators that relate to the standard and are measurable. These are called outcome measures.

Outcome measures are results measured at a certain moment that can be compared with previous or subsequent results or a set standard, in order to note change.

Outcome measures are linked to standards. For example, a standard for physiotherapy assessment of pre-school children with developmental delay, may state that these children "will have a review assessment every six months". The outcome measure used to check this standard would be "the number of children assessed". A check of how many children were assessed (actual practice) compared with the total number of children on the books that should have been assessed (concept of good practice) would tell us how close we were to our standard.

A physiotherapy intervention outcome measure is an audit tool that measures the alteration in the health or functional status of a patient that is due to physiotherapy intervention. An example of this would be quality of gait in a diplegic child, where on initial assessment he walks 5 metres on his toes and after a course of physiotherapy is able to walk the same distance

with heels down. You have had a positive effect on the functional status of this child and because it is formally noted as an outcome measure would be shown as a positive effect of physiotherapy intervention in an audit.

The Audit and Quality Cycle (based on Hunter 1993)

Audit, standards, outcomes and quality all fit together into the audit and quality cycle.



“Objectives” used in this way mean the all encompassing role of the service. An example of an objective for a paediatric physiotherapy service might be:

“The Paediatric Physiotherapy Service will provide physiotherapy for children with physiotherapy needs from birth to 19 years of age within the hospital, community, mainstream and special schools, nurseries and playgroups within the geographic area of this Trust.”

You may want to continue with a mission statement which identifies what exactly you intend providing eg: pre-school developmental assessment, liaison with health visitors and school health, special baby care unit 24 hour cover, talipes clinic, links with RDA, Asthma Society Groups etc etc.

“Standards” are set at Trust level and need to be set for every aspect of the service eg: numbers of staff - including how and where they are allocated, contingency plans for annual and sick leave, resources, training, links with other agencies, policies of intervention in different conditions etc.

“Departmental Protocols” relate to the standards but identify how these will vary according to the departments within a Trust.

For example a standard for physiotherapy cover for children of school age with physical disabilities may state:

“All physically disabled children will be assessed and receive appropriate physio intervention”.

The departmental protocol for children in special schools will adopt the standard but relate it to this area eg:

“Children with physical disabilities within *special schools* will be assessed or reviewed every term. The physio will visit twice a week to treat the children and check that the agreed therapy plan is being carried out.”

For children in mainstream schools the protocol may read:

"Children with physical disabilities within *mainstream schools* will be assessed or reviewed every term. The physio will visit twice a term to check that the agreed therapy plan is being carried out. Parents will be invited to this visit. 'After-school' arrangements will be made where the physio feels that further intervention is required."

Actual practice is audited against the set standards using the outcome measures.

From the results of the audit physios must look carefully to see if standards are being reached. If not, why not? There is no point in undertaking an audit unless we are prepared to be surprised by the results (maybe unpleasantly surprised) and act on them. It may be painful to realise that a service we thought was running efficiently and effectively is in fact a shambles. We must be prepared to change if our audit shows the need.

But it's not all bad news. We can use audit to our advantage. A recent audit showed that senior clinicians were spending 40% of their time on non clinical administration - things like writing letters to doctors, phoning transport etc. The results of the audit were shown to management who - together with the sacrifice of a few unused senior II hours - found funding for some extra clerical and secretarial time and dictaphones for physios to record letters and reports. The result has been an improvement in the efficiency of the service and the resulting increase in job satisfaction amongst the physios has improved both effectiveness and quality of care. However, there had to be give and take on both sides including some flexibility with skillmix.

It may be appropriate to revise out standards or departmental protocols and even, rarely, our objectives in the light of our audit. We may need to amend or clarify the wording, change standards that were set enthusiastically too high or up grade standards where we surprise ourselves with our efficiency.

The idea is then to put those recommendations into action and reaudit to see how much closer we come to our standards the next time around.

Terminology in Audit

We have already looked at some audit terminology. It seems to be changing all the time and is often confusing.

Medical Audit in most cases means any audit done by doctors relating to medical care eg: the number of patients up to date with their vaccinations.

Clinical Audit refers to audits involving anyone else within a multidisciplinary team or an aspect of medical administration eg: numbers and times of phone calls to a GP surgery.

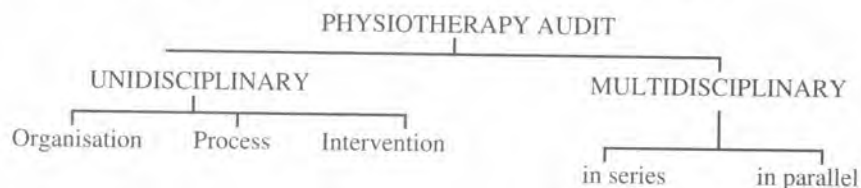
Nursing and Therapy Audit refers to audits undertaken by nurses or therapists.

Multidisciplinary Audit follows the care or service received by a patient being treated by several agencies eg: skill mix within a stroke unit. This term is often used interchangeably with clinical audit and relates more to the team than to an episode of care.

In physiotherapy it may be better to divide audit into:

Unidisciplinary - pertaining just to physiotherapy services and

Multidisciplinary - pertaining to our role in the multidisciplinary team.



Organisation Audit pertains to anything relating to the organisation or management of the service. It includes staff levels, skill mix, facilities, resources, management structure, pay and conditions, travel, staff deployment by experience and geography etc.

Process Audit pertains to anything relating to the way the patient gets into, through and out of the system and includes referrals, waiting lists, DNA figures, reports to consultants, client satisfaction etc.

Intervention Audit pertains to the interface between physio and patient/carer ie: the "hands on" bit of physio! eg: goal setting, core physio outcomes, specific conditions or modalities of treatment etc.

Multidisciplinary "in series" Audit pertains to the interface between where physiotherapy stops and another agency starts or vice versa. An example would be to audit the interface where the physiotherapist leaves the patient to wait for their transport for the journey home.

Multidisciplinary "in parallel" Audit pertains to the relationships between physios and other agencies relevant to the management of the patient as s/he passes along an episode of care eg: links between the physios and teacher, welfare assistant, OT, speech therapist etc in the treatment of a schoolchild with physical disabilities.

In Conclusion

From April 1994 money for audit will be going directly to Health Commissions and Purchasers and hence to Trusts. Audit is expected to become a part of our clinical work. It is therefore worth spending some time setting standards, deciding what outcomes to use and devising ways of recording them clearly in our day to day records. Then an audit assistant can be employed on audit monies to do the number crunching, leaving physios to do what they do best - treating the patients! But remember, until we have decided all our standards and outcome measures, audit will be time consuming. It is worth it if we can make audit work for us and not just do it to pay lip service to a management directive.

To get the best out of audit remember the following points:

1. Do investigate areas that are problems and need improvement.
2. Do get the co-operation of all involved.
3. Do write clinical records in a way that they can be audited by a non physio audit assistant.
4. Do make audit work for you by using it to identify possible solutions and collecting valid data that can be used in management/budget negotiations where appropriate.

5. Do aim to use audit to maximise quality, efficiency and effectiveness of service.
6. Do remember that audit is confidential. You don't have to show the results to anyone except those who were involved. You must, however, be prepared to act on them.
7. Don't waste time auditing things you know are OK.
8. Don't waste time auditing things you don't have the ability to change!

The Bottom Line - A Quick Guide to Audit!

- Think of a problem area in the service, or one where some quality, efficiency or effectiveness is lacking.
- Get everyone involved in this area together and set a standard.
- Agree what outcome measures would show changes between actual practice and concept of good practice (the standard).
- Write these down as a form.
- Decide whether you can get this information from existing records in a retrospective audit or whether you will have to gather data concurrently.
- Decide your time scale of data collection and appoint someone to oversee the project and someone to crunch the numbers.
- Conduct the audit.
- Analyse the results.
- Get together to see how close you have come to your set standard.
- If you have achieved your standard - Congratulations, but maybe you can set a higher one for next time.
- If not, decide why not. What needs to be changed in order to reach the standard?
- Implement the changes.
- Reaudit to check that things are improving.
- Set up a rolling annual plan of audit of different things in the Department to keep yourselves on your toes and impress the Purchasers. If you are already involved in an audit of your choice you are less likely to have one imposed upon you.

Good Luck!

Sue Barnard MSc. MCSP

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- no. 24 References for Outcome Measures

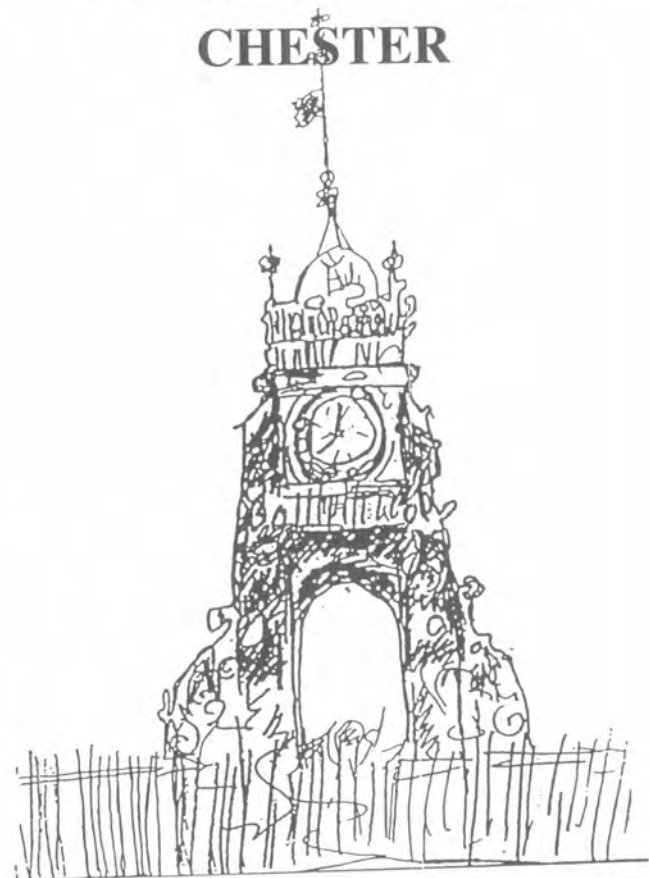
Literature search of Medical Audit Information Service, King's Fund Centre available from CSP

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HAVE YOU APPLIED YET?

**CONFERENCE 1994
CHESTER**



THURSDAY - SATURDAY

7th - 9th April

**COMING OF AGE
21 Years of A.P.C.P.**

MANUAL HANDLING - GETTING THE ACT TOGETHER

**Carole Hurran BA, Grad.DP, MCSP, Superintendent Physiotherapist
S. Bristol School**

The Manual Handling Operations Regulations came into force on the 1st January 1993 and were published by the Health and Safety Executive (HMSO). Many of us are at different stages in formulating policies, assessing risks, obtaining the necessary equipment and dealing with training needs, though in a perfect world all these aspects should have been in place at least a year ago. The number of current job adverts in Physiotherapy for 'Manual Handling Advisors' and 'Back Care Co-ordinators' indicates growing activity in the Health Service to meet the legal requirements. The same cannot be said for all other institutions.

Physiotherapists working in schools and nurseries may find a baffling lack of interest in promoting safer manual handling by some Local Education Authorities. This may be partly due to the devolving of responsibilities and budgets to individual schools, though many special schools will not take on full LMSS until April 1994. At present the physiotherapist may be the only person in a special school trained in manual handling or with access to the advice of a 'competent' person trained by the Health Authority. While it is very important for physiotherapists to give education staff helpful encouragement and advice in taking responsibility regarding manual handling, it must be a shared commitment which will inevitably have time, management and budget implications.

The experience of paediatric physiotherapists based at Claremont School working in the Southmead Health Service area may be worth sharing with others in a similar situation. The appointment last summer of a Manual Handling Advisor, Gordon Adams, at Southmead, enabled two of our team to be trained as 'competent persons'. Work went forward at the hospital physiotherapy department to design patient risk assessment forms enabling active transfer needs to be documented as part of the manual handling assessment so that patients are encouraged to help with the recommended procedure rather than to be hoisted at all costs. While these forms are suitable for paediatric inpatients the activities listed do not cover a wide enough range for our special schools and in any case each school would need to work out its own system.

The Headteacher at Claremont, Bob Coburn, had recently moved from New Fosseway School in South Bristol, where they had been fortunate in having a qualified manual handling trainer on their physiotherapy staff, who with the Community Paediatric Superintendent Sue Taylor, set up a system and form for all educational staff to use there in early 1993.

Our first priority was to invite Gordon Adams to talk to the whole staff at Claremont for a half day's inset on Manual Handling. This was very successful in helping people to understand the regulations, the importance of setting up a good system of assessment and training, and accepting some changes to current practice where necessary. Although no lifting techniques were demonstrated at this session staff were noticed to become more careful when handling the children afterwards and in particular more willing to ask colleagues for help if needed. Physiotherapists continued to give advice and help on suitable approaches to individual problems of handling within the class teams with Health and Safety lists displayed in each classroom on lifting and handling needs.

HOME INSTRUCTIONS

Wheelchair to Floor - Two-Person Lift

Lifting

The wheelchair is prepared and two people are in position to lift the child (as described in FL-2).



They lift the child upward as they stand erect.



The person who is holding the child's legs moves one hand down to the child's calf.



Both persons step sideways to clear the wheelchair, then lower slowly until the child is safely resting on the floor.

Special Instructions

FL-3

The specific technique for each child should be determined by a physical therapist after thorough evaluation.

Our competent person, Lyn Hemmings, was freed from some physiotherapy contact time to co-ordinate standard practices and level of risk and all departments were asked to compile lists of activities involving manual handling within the school. 36 different activities were identified ranging from transferring from stool to floor and back, potting, calipers - lying to standing, and 'pushing buggies while carrying stools!' A small working party was set up to refine these activities and produce a child manual handling assessment form including 16 different tasks for which the child may require assistance.

The standard practices were agreed and information will be made available to staff on these by practical workshops and a policy book containing 'Do's and Dont's' and line drawings of all the recommended methods of transferring and lifting children for the 16 different activities so far identified. It is envisaged that this will be added to as other tasks involving equipment and the environment indoors and out are looked at : swimming, riding and school trips including loading up the minibus will all need risk assessment and recommended procedures.

The use of video, books and photographs will all help to build up staff knowledge and it is also hoped to offer parent workshops in the future. Each special school has different needs, and our SLD all age schools will certainly be looking at hoists if they haven't already got one. One local special care unit Lyn works at has calculated 92 separate activities involving lifting during one day shared by only 2 or 3 staff. This excellent unit ensures frequent toilet training and change of position for the children who range from 3 to 18 years of age.

In addition to the Guide to The Handling of Patients published by the National Back Pain Association and the Royal College of Nursing, 3rd edition, we have found several other useful publications. Transferring and Lifting Children and Adolescents is an American publication available from Winslow Press, Telford Rd, Bicester, Oxon OX6 0TS. £28.50 + VAT, Product Code 04 - 1125. Pages are intended to be photocopied and there are clear instructions and attractive line drawings of many useful transfers. Care is needed in selection as some lifts would not be recommended for larger children, unfortunately including the illustration on the cover. Invacare (Carters) have produced a small booklet on Handling and Lifting giving an overview of current legislative requirements and safe working practice. Tel. 091-259 6660. The Association of Swimming Therapy have produced guidelines for manual handling tasks at the swimming pool and implications of the 1992 manual handling regulations, price £2.50.

I have been sent a copy of a lifting and handling assessment form for an individual child and for a school outing by Heather George who is based at the Rose Road Centre, Southampton. She works in a PMLD school where lifting policies are 'absolutely necessary'. An assessment form with individual lifting instructions is placed in each child's classroom file by the physiotherapist. They have had to insist that nearly all the children are hoisted off the floor even though they may be lifted from chair to plinth by two people. The school outing form is filled in by the teacher so that the staff concerned are aware of the risks.

Please share problems and experiences with us - you may like to write a short article on how you have dealt with manual handling problems or tell us of any useful videos and publications you have found; this feature could run and run

* * * * *

THE SPASTICS SOCIETY MULTIDISCIPLINARY ASSESSMENT SERVICE

By: Sally Wright MCSP and Isabel Chilton MCSP
(Consultant Physiotherapists to the Advisory Assessment Service).

Background to the Multidisciplinary Assessment

In 1994 The Spastics Society will relaunch itself with a new name (not yet decided upon) and a new mission for people with cerebral palsy and associated disabilities. As part of that relaunch the Advisory Assessment Service has been clarifying the activities that it will be engaged in the 1990's.

The Advisory Assessment Service aims to provide 4 key services:-

1. Providing advice on quality assessments and how these can be obtained from local statutory bodies.
2. A training service on assessment.
3. An individual assessment service - where the client is seen by a single professional.
4. A multidisciplinary assessment service.

The focus of this article is on the multidisciplinary assessment service - and in particular on our assessment of children. The multidisciplinary assessment service is a long established service based at Fitzroy Square in London. The multidisciplinary assessment of children takes place on a Monday and Wednesday throughout the year. Accommodation is available at Fitzroy Square and many families spend the night before or after at the centre.

The usual pattern is for two children to be seen on each day though occasionally we spend the whole day assessing one child. The assessment takes a very full day - starting at 9:15 in the morning and ending at approximately 6:00.

During the day the child will be assessed by an educational psychologist, a speech and language therapist, an occupational therapist, a paediatric consultant and a physiotherapist. The day ends with two panel meetings for the families with all the professionals.

Each professional sees the client for approximately an hour - usually this is on their own, though opportunities for joint assessment work exist. Some of the members of this team work full-time for The Spastics Society while some work on a sessional consultancy basis. Currently the physiotherapists work on a sessional consultancy basis.

Children for multidisciplinary assessment come from all over England and Wales. Referrals are usually through The Spastics Society Regional Social Workers though families can contact us direct. The benefit of referrals coming from regional field staff is that this gives the family a point of contact with their own community. Before coming for an assessment the relevant local professionals are contacted and asked for copies of their latest reports.

Our multidisciplinary assessment report is sent directly to the family. The report is theirs to distribute to local professionals as they choose. We do stress to the parents that it is their right and responsibility to distribute the reports. The waiting list for multidisciplinary assessments is approximately 6 months.

The Role of the Physiotherapist

The primary role of the physiotherapist is to address the specific concerns and issues raised by the parents, carers and/or children.

In order to achieve this we have to first:-

- Identify overall reasons for assessment.
- Clarify specific physiotherapy issues.

Having established the above the assessment then moves through the following stages:-

- Observe and interact with the child and family/carers.
- Discuss findings with other panel members and family.
- Provide a written report.

Identify overall reason for referral.

The reason for referral is gleaned from client's completed questionnaire. Additional information is obtained on the day from both client, the Spastics Society Social Worker (who may accompany the family) and other members of the multidisciplinary team. Due to the length of our waiting list current reason for referral may have changed from the original and thus needs to be re-established.

Some examples of overall reasons for referral are listed below:-

- confusion about advice and information already received.
- concerns about diagnosis.
- anxiety about major changes in the child's life, e.g. change of school.
- opportunity to discuss child's abilities and disabilities.
- independent opinion about child's future.
- advice on management.
- independent opinion about Special Educational Needs.
- advice about educational provision and placement.

Often it may be necessary to spend some time clarifying overall reasons for referral with the family to allow us to tailor our assessment to meet the family's needs.

Clarify specific physiotherapy issues.

Specific issues may be identified within the overall reasons for referral but may also arise during the actual day. Again it may be necessary to spend some time clarifying these with families.

Examples of specific physiotherapy issues include:-

- advice about which therapy program is best for their child.
- advice about therapy program.
- advice about orthopaedic management.

- advice about equipment such as standing frame and seating.
- advice about mobility aids including walking aids.
- explanation on the meaning of terminology.
- clarification how cerebral palsy affects the child's physical abilities.

Observation and Interaction with the child and family/carers.

We have one hour in which to develop a positive relationship with the child and family/carers, gain a general impression of the child's abilities and disabilities and address any specific issues within the general context of the child's abilities. A hard task!

The areas covered over the assessment period vary according to the needs of the client. Sometimes assessment is a general overview, sometimes it is very specific.

Parents are nearly always present in the room or otherwise looking through a two-way mirror.

In order to get the best from the child under artificial assessment conditions we aim to create an atmosphere that is non-threatening to the child and family. To achieve this we have to be quick to perceive the situation and be flexible in our approach. Sometimes this means all our clinical information will be gained from observation of the child at play, sometimes we may choose to work through a parent or carer. Obviously extra information can be gained from "hands on" but we only move to this stage when the child is accepting of such interaction. We want the child and family to find assessment a positive experience.

Discuss findings with other panel members, child and family/carers.

We try to present our views in a manner that will help clarify issues and order priorities and encourage participation of child and family/carers. We do sometimes find ourselves giving out a lot of information which can obviously be difficult for parents to assimilate. It is therefore helpful if two people involved with the child attends the assessment. This ensures better retention of information and means they can discuss the issues afterwards. If the Spastics Society Social Worker has accompanied the family she/he will also be present at this discussion. As a general comment we try to focus on key issues of concern. Discussion generally takes about half an hour.

Written report.

The written report aims to summarise points discussed on the day as well as provide written information tailored to the particular needs of the family. Examples:-

- additional support for physiotherapy provision.
- independent opinion of physiotherapy needs to be included in parental contribution for Statement of Special Educational Needs
- summary of discussion issues.

The report is written for the parents and it is the parent's responsibility to distribute the report to whoever they wish. We actively encourage parents to send copy of report to all professionals involved locally with child. We would like to stress that in making our written recommendations we are not influenced by Local Health Authority guidelines or availability of local provision.

We always end our feedback with asking the family whether they have any other questions.

Personal Opinion about the Service

The greatest asset of the service is that:-

- a) it is independent and
- b) it is multi-professional.

Being independent means that we are not governed by Local Authority guidelines or policy. Recently in some therapists eyes The Spastics Society has become closely identified with Conductive Education. It is important to point out that the multidisciplinary assessment service concerns itself with the individual needs of the child and does not adhere to any one therapy/education approach. By being multidisciplinary we have the opportunity to share different perspectives concerning the child and family.

Usually both the parents attend the assessment and so it is an excellent opportunity for both parents to hear about their child first hand. The parents are usually highly appreciative of the time spent with their child and the chance for mutual discussion. They frequently report that they have never had such an opportunity before.

Our assessment does of course have its limitations. Our opinions are based on reading available reports and what we find and hear on the day. The child is not in an environment familiar to them and we may not see them at their best. The family have often travelled a long way to attend the centre and may not have slept well the night before in an unfamiliar building. The day is a busy one with five professionals to see on one day and a lot of information to take on board. So from the families point of view it can be a fairly stressful day and is always a tiring one.

From our point of view it is also tiring. At the end of the day we are expected to produce a report about the child that is accurate and informative.

Although we always request a report from the local physiotherapist we do not communicate directly with them. Direct communication would be useful as a lot of background which may be relevant to us can be obtained from informal direct communication. We have recently began a trial of communicating directly with the local physiotherapist both before and after our assessment (with the parents permission).

Having worked in the service for some years we find a number of recurring issues commonly raised by families. These include the following:-

- provision of splints
- frequency of physiotherapy treatment
- lack of physiotherapy treatment for school age children in the holidays
- lack of home visits for school age children
- inadequate training of parents/carers to manage child's physical program
- reports from parents about lack of contact with their child's physiotherapist once the child is in school.
- maybe most importantly and worrying from all our points of view, increasing concern that local assessment of needs is decided on by local resources not the needs of the child.

We think it is vital that an independent assessment service, such as The Spastics Society, works closely with local therapists and compliments and supports their work.

We hope you find this article of interest and would value your comments on points raised.

The Clyne Schools Challenge

**Julie Harvey M.C.S.P. Superintendent Physiotherapist
District Services Unit W. Glamorgan.**

In the last 2 years in West Glamorgan the Education and Health Authority came together with a local activity centre, Clyne Farm, to organise the Clyne Schools Challenge. The aim was to give special needs youngsters from throughout West Glamorgan the chance to represent their school alongside their friends and mainstream pupils.

The course was planned by the Clyne Activity Centre staff with some guidance given by health and educational professionals.

The challenge was aimed to stretch every child participating to his or her fullest potential both academically and physically.

For many youngsters it was the first time that they had competed against others let alone represent their school, for others it was the first time they had worked with and supported youngsters with special needs.

Activities were planned as daily events for one week in 1992 and one week in 1993. Each day consisted of

1. Ice breaker activities.
2. Problem solving activities including archery, horse riding, word search, treasure hunts etc.
3. Clyne valley assault course.

Over 400 children have taken part in the Challenge including children with cerebral palsy, muscular dystrophy, spina bifida, Down's syndrome, dyspraxia, asthma. All worked to their fullest potential and ended the day physically tired but with improved self esteem, more confidence and an awareness of caring for their environment and living together.

For my part I have never seen so many children trying so hard to work together, stretching and strengthening muscles, balancing, thinking and concentrating and so on in such a happy environment, and ending the day with a real sense of achievement.

All of the staff who participated were pleased with what they could see taking place. In fact by the end of each day many were extremely surprised at what some of the children could achieve.

For all who have participated so far it has turned out to be an extremely rewarding project which will not be forgotten.



SURVEY OF TREATMENT/MANAGEMENT MEASURES OF THE AMBULANT CEREBRAL PALSY CHILD

Fiona Hainsworth M.C.S.P. Mary Harrison M.C.S.P.

From 250 delegates at the APCP Bath Conference 1993 we received 53 replies [= 21% return] to the questionnaires we handed out.

The comments below are taken in exact form as stated in the delegates' replies.

(1) Do You Use Outcome Measures?

92% of the replies said yes

4% said no

4% said don't know

Of the listed outcome measures

61% used POMR

82% used video

24% used Physiological Cost Index

45% used goniometry

0% used sphygmomanometry

2% used the Bartel Index

22% used gait analysis lab

(as people use more than one outcome measure, % won't add up to 100)

Other outcome measures used were

Photos

In-house check list of motor skills

Myometer

Korner type

Uniform Assessment

Feedback from child, parent, teacher, etc.

FIP

Goal setting functional assessments

Objective setting

Observation

(2) Do You Routinely Use AFO's?

81% said yes

19% said no

If 'yes', what is your criteria for putting children in AFO's?

Listed in order of most common replies -

1. T.A. tightening
2. Hypotonia and knee hyperextension
3. Ankle instability
4. Habitual toe walking
5. Pronated foot

6. Paralysis - reduced tone in foot)
Still mobile correctable foot)
To achieve heel strike)
7. - Child with spastic diplegia for standing balance (short term)
 - Progressive footwear deformity
 - Improve functional abilities
 - For balance in standing and walking
 - Prevent contractures
 - Correct foot alignment for early weight bearing and transfer of weight
 - Post T.A. lengthening
 - Post growth to maintain heel strike
 - Athetoid for foot stability
 - Post serial plastering
 - Foot must go to 90° first
 - Pre-surgery
 - Overstretched T.A.'s
 - To reduce energy expenditure
 - Reduce extensor thrust on ground strike

(3) Do You Use HAFO's? (Hinged)

49% said yes

51% said no

If 'yes', what is your criteria for putting children into HAFO's?

Listed in order of most common criteria -

1. To allow a more normal gait pattern
2. Need to have active dorsiflexion
3. Want to control foot and ankle but also allow mobility at ankle
4. - Dorsiflexion must be beyond 90°
 - When we want to allow some passive dorsiflexion to enable function, e.g. squatting, getting up off the floor
 - Children who can't achieve a good pattern in fixed AFO's
5. - Must be able to stand with heels down
 - To maintain active/passive dorsiflexion
 - Children with no deviation of foot on movement
 - To enable more active controlled movement
 - To restrict plantiflexion but maintain muscle power
 - When there is hypotonia where inactivity of calf muscles would lead to muscle wasting
 - For more able spastic diplegia as short term intervention

(Several people commented on the difficulty of finding wide enough footwear to accommodate hinged AFO's)

(4) **Do You Have a Time Limit on the Use of Orthoses?**

27% said yes

73% said no

'Yes' comments were -

Some said 3 month review, others said 6 weeks assessment

Other comments were -

- Time dictated by the duration of the problem
- "I feel some time-out essential for the child - daily; therefore often use in combination with other footwear, e.g. Pedro boots, biomechanical inserts"
- Regular checks to see if they work
- Ongoing assessment to ensure minimal use. Don't feel they should be used longer than necessary

'No' comments (practically all 'no' comments were as follows -)

- No but review with orthotist regularly and not automatically replaced
- No without reviewing suitability when grown out of them
- There is no fixed time limit, each case is considered individually

1 person commented that some children reject AFO's at 9-11 years for a spell and then ask for them again to improve gait in teenage years

5) **Do You Use Serial Plastering?**

79% said yes

21% said no

If 'yes', when do you use it?

Most common reason was for T.A. tightening followed by -

- To discourage persistent toe walking
- Pre AFO issue
- To achieve passive full range of movement or to assess child for orthotic suitability
- Assessment prior to T.A. lengthening
- Use if AFO failing to correct gait and can't be tolerated
- Gives a useful stretch every 6-12 months, e.g. around growth spurts
- To stretch out knees with crouched diplegias
- To stabilise the foot or the ankle in order to work for pelvic/hip and/or knee stability
- Sometimes only need serial plastering and not AFO's
- To re-educate gait
- To improve foot posture
- As assessment tool for short term treatment intervention tending to move more towards night splints, long term instead of AFO's
- I felt serial plastering not usually necessary if AFO's used correctly

Any Other Comments

- AFO's only as good as the orthotist who makes them
- I feel strongly that AFO's should be physio/orthotist prescription, and that acceptance depends strongly on whether there is immediate rejection of a poor fitting AFO or wrong prescription with poor functional result and rectified by recasting
- Quality of AFO's varies tremendously and often the problem is limited access to orthotists not employed solely by one firm
- Problems of pressure areas, fine tuning of AFO's and delivery time
- Decisions as to the use and management must involve child and family in order to get full co-operation and use
- Would like more access to gait analysis
- With more severe spastic equinus, AFO's often seem to correct position/improve gait, but in reducing child's walking speed it appears to put up PCI. If so, we tend to use them for part of the day only
- Dislike splints generally, due to weakness and muscle wasting they may cause
- AFO's used too routinely and long term implications of using them
 - a) not fully understood
 - b) not always considered
- I don't agree with their use on non ambulant children who are unlikely to achieve functional walking. I see them more as a short term intervention tool or aid to treatment

Our Comments

We were very disappointed with the response - only 21% of Conference delegates returned their forms, despite being reminded to do so each day at the Conference.

Due to the poor return we cannot therefore come to any firm conclusions.

We found it interesting that from the small percentage of people who replied, it appears that serial plastering seems to be making a come-back in popularity as a treatment technique, and would agree strongly with the comments made that AFO's are only as good as the orthotist who casts and rectifies!

If there are any readers of the Journal who were not at the Conference but would like to comment on the questionnaire, we would love to hear from them.

MARY HARRISON

Superintendent Paediatric Physiotherapist
Regional Child Development Centre,
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FIONA HAINSWORTH

Senior I Physiotherapist,
Regional Child Development Centre,
St. James's University Hospital, Leeds

ABSTRACTS

EFFECTS OF INHIBITORY CASTS AND ORTHOSES ON BONY ALIGNMENT OF FOOT AND ANKLE DURING WEIGHTBEARING IN CHILDREN WITH SPASTICITY.

Nanci R. Ricks Robert E. Eilert

Developmental Medicine and Child Neurology. 1993. 35.11-16

One theory about the improvement in gait seen in children with CP who use inhibitory casts holds that they are a result of better posture of the foot. To examine this theory, the authors used x-rays to document the position of the foot both before and during inhibitory casting to see whether there were measurable changes in foot posture that could be ascribed to the casts.

The bony alignment of the ankle and foot was compared during weight-bearing with the children in and out of inhibitory casts (N=12), static ankle-foot orthoses (N=7) and articulated ankle-foot orthoses (N=8).

The only ankle change which was significant was calcaneal inclination in the articulated AFOs versus out of the orthoses. There was no significant difference in any of the other angles in any of the groups.

The Following Pre-Conference Abstracts are of papers given at the International Conference to celebrate the life and work of Dr. Ciaran Barry, held on 23rd - 25th September 1993 at The Central Remedial Clinic Dublin.

The Abstracts were sent by Margaret Cameron.

AETIOLOGY OF CEREBRAL PALSY

**Bengt Hagberg, Department of Paediatrics,
East Hospital, S-416 85 Gothenburg, Sweden**

Cerebral palsy (CP) is not a disease but a complex symptom. Biologically the term is an artificial concept, nevertheless useful as an umbrella term in society. - Our studies on 'The changing panorama of CP in Sweden' covering the birth years 1954-86 and comprising of almost 1200 CP cases, give information on the various groups of origins met. When analyzing data fullterms have to be separated from preterms, the latter when possible separated in gestational age groups. Biologically, brains of different maturity represent 'separate species'. The sites and type of lesions differ depending on the stage of development at the time of cerebral insult.

The two major risk factors for CP are: to be born too soon and/or too small; and to have been exposed to disrupted brain perfusion/oxygenation in fetal life, during delivery or neonatally. Our studies indicate that the final timing of CP impairments in children born preterm are perinatal (mainly postpartal) in the vast majority. Recent international studies using serial postpartal ultrasound investigations and MRI tally well with this statement. The majority of such impaired preterms end up in the CP categories diplegia or tetraplegia. CP in children born at term, in contrast, is mainly attributed to prenatal or unknown - i.e. likely

prenatal factors. Perinatal adverse factors, particularly birth asphyxia, have for long been re-emphasized. Our data indicate that only about 20% of CP children born at term have a perinatal origin. The clinical subgroup with particular perinatal relevance is the dyskinetic (less than 10% of all). Genetically determined CP is mainly found within the group of simple ataxia.

The different clinical subcategories of cerebral palsy will be shortly reviewed as to patterns of origin, for every subgroup separated into fullterm and preterm born.

NEW ASPECTS OF SPASTIC CONGENITAL HEMIPARESIS

Richard Michaelis

Department of Paediatrics, Division of Child Neurology
Eberhard-Karl's University Tübingen, Germany

Towards the end of the last century, at the beginning of this century, the aetiology of congenital spastic hemiparesis was believed to be caused mainly by perinatal traumatic complications. Yet, even then some authors emphasised that prenatal and natal occlusion of cerebral arteries, especially those of the arteria cerebri media were found in autopsies of children, suffering from congenital spastic hemiparesis. In spastic hemiparesis the affected arm is still described in most of the related textbook as to be more severely affected than the leg. If no seizures occur the prognosis of an individual child is thought to be favourable in respect of motor, cognitive and speech development, regardless of the size, and surprisingly enough, of the extension of the central lesion.

During the last twenty years, a change in aetiology of congenital spastic hemiparesis was reported by some authors, who independently and with different approaches, found in many hemiparetic children a completely normal prenatal, perinatal and postnatal history. They argued, that prenatal, yet not well understood, complications must have caused central lesions, generating spastic hemiparesis.

In addition, studies of hemiparetic children revealed a greater variability in neurological aspects. The upper limb was not found to be always the most severely affected one. Arm-dominated hemiparesis was existent in about 50% of hemiparetic children in different populations, leg-dominated in about 30% and leg and arm were equally affected in about 20%. About one third of hemiparetic children were born preterm, two thirds were born at term. MRI studies in particular offered new aspects of the type and location of central lesions. Four types are known: Cortical and subcortical lesions, dysmorphic findings, periventricular lesions, and in a few children no lesions were found at all. The type of lesion may refer to the time of gestation the lesion occurred, most often obviously during the last trimester.

It is of particular neurobiological interest to notice, that in children with spastic diplegia, a widely varying neurological phenomenology is found, in contrast to the rather uniform type and position of periventricular lesions, seen on the MRI, whereas in children with spastic hemiparesis the neurological findings are found to be quite similar and invariable in relation to the manifold and very different types of the central lesions.

PERINATAL PROBLEMS IN PERSPECTIVE

Professor T. Matthews

In this talk the problems of cerebral palsy are addressed as seen from the perspective of a neonatal paediatrician. It will include a comment on the changing mortality rates in very low birth weight infants with a fixed prevalence rate of cerebral palsy leading to an increased percentage of children with cerebral palsy who are very low birth weight. Recently advances in neonatal care including the advent and use of brain ultrasound imaging and the predictable effects of various appearances such as grade 3 or 4 intraventricular/periventricular haemorrhages and periventricular ischaemic areas and periventricular leucomalacia will be addressed. In addition, the effect of antenatal use of corticosteroids in lowering the very low birth weight mortality by 40% and the post natal use of surfactant in infants with severe respiratory distress syndrome lowering the mortality rate by 40% will be commented on. The neonatologist's dilemma with improved survival rates as a direct result of the current situation leads to the question of what should be done with infants less than 750 grams at birth. This group now have a 40% survival rate with full intensive care, and preliminary results suggest that this can be achieved without increasing the frequency of handicap.

The origins of asphyxial in full term infants will also be addressed and in particular the poor ability of signs of fetal distress such as heart rate abnormalities or passage of meconium in predicting or preventing fetal asphyxia in labor. Definition of asphyxia in term infants will be discussed and in particular the importance of hypoxic-ischaemic encephalopathy with seizures as a marker for asphyxial damage although some babies with a diagnosis of hypoxic-ischaemic encephalopathy turn out to have either a metabolic disorder or some other diagnosis. The improved understanding of the pathogenesis of brain damage will be discussed.

CONDITIONS THAT MIMIC CEREBRAL PALSY

Dr. M. D. King

Cerebral Palsy has been defined as "an umbrella term covering a group of non-progressive but often changing motor impairment syndromes secondary to lesions or anomalies of the brain arising in the early stages of its development". (Mutch 1992). Except for a small group of children with post-natally acquired cerebral palsy the majority of pre-natal or peri-natal in origin and present before the age of 1 year. The key features of cerebral palsy are

- (a) the non progressive nature of the brain lesion whether it be due to damage (as in anoxia, infection, vascular disorders, metabolic disease or trauma) or due to a developmental disorder (as in chromosomal, genetic, malformation and neurocutaneous syndrome);
- (b) predominant motor impairment. It may be argued that children with several mental handicap and hypotonic cerebral palsy or with syndromes such as Rett Syndrome and Angelmann syndromes should be excluded.

Studies on the aetiology of cerebral palsy are fraught with difficulties. Prolonged follow-up is essential to detect benign and progressive conditions. Disorders which may predispose to asphyxial encephalopathies such as neuromuscular disorders may not be evident early on in life. Confirmation of pre-natal infection may be difficult if the appropriate tests are not performed in the newborn period. Cerebral palsy in low birth weight survivors may have very different explanations. Pre-natal encephalopathies (Barth 1990) may be very slowly progressive over the first decade. Finally metabolic disorders may be difficult to diagnose as they can mimic asphyxial encephalopathy in the neonatal period, they may cause static malformations and they are not always associated with acute encephalopathy post nately.

Conditions that may mimic cerebral palsy include those that present early in life with prominent motor signs and are exquisitely slowly progressive. These include:

- Lesions of the spinal cord and craniocervical junction
- Metabolic disorders
- DNA repair defects
- Pelizaeus - Merzbacher Disease
- Dopa - sensitive Dystonia

The clinical clues of these conditions will be outlined but in general atypical progress, absence of a satisfactory explanation and any evidence of other system involvement (eye movement, retinopathy, deafness, sphincters etc.) should prompt consideration of an alternative explanation. Additional pointers to metabolic disorders include

- (a) family history of similar disorder with or without consanguinity
- (b) cerebral palsy recognised during or after an illness in the first two years
- (c) a fluctuating course exacerbated by viral illness with vomiting.

The relevant imaging and laboratory screening tests will be outlined. The biggest yield will be in children with predominant ataxia (- diplegia) dyskinesia and hypotonia.

SELECTIVE DORSAL RHIZOTOMY: EXPECTED AND REALIZED OUTCOMES

Professor Alfred Healy, University of Iowa, Iowa City, USA

Selective posterior rhizotomy (SPR) has been utilized for over a century as one of a variety of therapeutic approaches to the treatment of spasticity associated with cerebral palsy in patients of all ages. However, only recently has SPR been utilized for the treatment of younger children with relatively mild forms of cerebral palsy spastic diplegia. For carefully selected patients from this cohort, current reports indicate modest positive outcomes relating to reduction of spasticity, increase in mobility and other functional abilities, and on occasion, an increase in the overall quality of life for the child.

Such positive outcomes are achieved at the cost of requiring the child to receive general anaesthesia; undergo an invasive spinal destructive process; endure modest degrees of postoperative discomfort; participate in a 6-12 month intensive rehabilitative muscle strengthening and re-education program; and dedicate significant educational and personal time to achieve, what is at best, a modest positive outcome.

This presentation is intended to provide participants with information regarding the nature of cerebral palsy spasticity; the rationale for SPR's effect on spasticity, the historical evolution of the surgical use of SPR; current protocols regarding patient selection; and overview of the operative procedure; a summary of immediate and long term post-operative complications; an outline of the post-operative rehabilitation process; a review of expected outcomes; and perspectives on the resources, including personnel, that are required to provide contemporary SPR services.

FOOT DEFORMITY IN CEREBRAL PALSY

Michael M. Stephens, The Children's Hospital, Temple Street

Foot deformity constitutes just part of lower limb dysfunction in the child with Cerebral Palsy and therefore must not be treated in isolation. It requires a multi-disciplinary approach with ones clinical partners and often decisions on treatment are made after multiple visits using gait analysis and EMG studies to complement clinical decisions. This paper explores specific concepts in relation to the foot because deformity in this area is not just to do with spastic muscles, but also it leads to abnormal ground reaction forces. Before any treatment programme is considered one has to decide if the deformity is fixed or flexible. If it is fixed bone surgery is often required, if it is flexible soft tissue procedures may be needed. The deformity likewise may be dynamic or static which likewise affects any treatment programme. The muscle function has to be fully assessed and EMG studies are useful for this. The muscle has to be assessed if it is phasic, spastic when it acts excessively or if it is dyphasic when it is out of phase with the normal gait cycle. Some muscles are non functional and they act as a tether.

Treatment must be based around such an assessment and can vary from physiotherapy modes to orthotic management to surgery. Usually treatment progresses to surgery when such conservative methods have failed. Some deformities become rigid earlier. The varus foot tends to become more rigid from the age of 5 while the valgus deformity may not become rigid until 15 years of age. Therefore the timing of such treatment often has to be more aggressive earlier in the varus deformity. Treatment must be based around normal biomechanical concepts. Stability particularly in the foot is depended on ligaments and muscles because the joints of the foot are skeletally inherently unstable. Therefore specifically in Cerebral Palsy these structures are required for normal motion and ground reaction forces. On heel strike the foot acts as a shock absorber because the foot is flexible with the heel in valgus. In this position the instant axis rotations of the calcaneo cuboid and talar navicular joint are parallel allowing flexibility within the midfoot. The contraction of the tibialis posterior muscle later in the gait cycle brings the heel into varus changing the orientation of the instant axis of rotations of the

two joints so that the foot becomes rigid converting the foot from a shock absorbing organ to a rigid propulsive organ. Therefore excessive varus leaves a rigid foot early in the gait cycle and later there will be excessive ground reaction forces on the lateral side of the foot. In contrast to this the valgus deformity which is persistent at the late portion of the gait cycle leads to midfoot instability and forefoot abduction and pronation.

Equinus deformity is probably the commonest deformity either in isolation or in combination with other deformities. Treatment depends on factors already discussed above. In this deformity the gait pattern of the whole leg must be observed because excessive lengthening of the heel cord in the presence of flexed knees will probably make the gait worse and increase crouching. In contrast to this, equinus associated with extension deformities of the knees is often the best indication for an isolated elongation of the achilles tendon. Varus deformity is one of the most challenging areas in Cerebral Palsy. Accurate assessment is mandatory to prevent under or over correction and since it becomes more rigid in an earlier age active treatment.

BOTULINUM TOXIN IN THE MANAGEMENT OF CEREBRAL PALSY A COMBINED CLINICAL AND EXPERIMENTAL STUDY

A. P. Cosgrove, H. Kerr Graham, Royal Belfast Hospital for Sick Children

In children with Cerebral Palsy there is frequently a failure of longitudinal muscle growth which if untreated leads to contractures and deformities. This failure of muscle growth has been demonstrated in animal models, such as the Hereditary Spastic Mouse.

Botulinum Toxin A when injected into skeletal muscle, results in a prolonged but reversible paresis. This effect has been used for a number of years in conditions in which there is over activity of specific muscle groups. We have evaluated the role of Botulinum Toxin A in the management of spasticity, in a combined animal and clinical study.

The Hereditary Spastic Mouse carries an autosomal recessive gene for a type of spasticity which is remarkably similar to spastic Cerebral Palsy. In a prospective randomised trial, six day old mice received a calf injection of N. Saline or Botulinum Toxin A. The animals were sacrificed at maturity and the length of the gastrocnemius was measured directly and expressed as a fraction of tibial length. In the spastic mice injected with Saline, there was a 13% failure of longitudinal muscle growth. However in spastic mice injected with Botulinum Toxin A, a muscle growth was normal and contractures were prevented.

We received ethical approval for a preliminary clinical trial of Botulinum Toxin in children with spastic Cerebral Palsy. The entry criteria were children with dynamic contractures of lower limb muscle groups which were interfering with function. Prior to injection all children were assessed by static examination with recordings of joint range of motion. All ambulant children had gait analysis before and after injection of toxin.

Thirty three children have been treated with a minimum follow up of 18 months. A consistent reduction in muscle tone was noted in all injected muscle groups. In the majority

of children this was accompanied by improvements in function. Gait analysis revealed objective improvement in sagittal plane kinematics. Equinus deformity, as evidenced by "toe walking", responded well to injection of the gastrocnemius and soleus muscles. Children who had difficulty in "long sitting" or walked with a "crouch gait" because of tight hamstring muscles, responded well to hamstring injection.

The effects of Botulinum Toxin injection on muscle tone lasted about four months. However in some children the clinical benefits were much longer in duration, possibly because of a favourable shift in the agonist/antagonist balance.

On the basis of this combined animal and clinical study we conclude that Botulinum Toxin A may have a useful role in the management of children with spastic Cerebral Palsy. In the short term muscle tone is reduced and function is improved. In the longer term contractures may be reduced.

Further Pre-Conference abstracts will be published in the May Journal.

REPORT

Outcome Measures

Michèle Lee, Public Relations Officer

A group of London Superintendent Physiotherapists formed a committee in June 1993 in order to look at the possibility of setting Outcome Measures for Paediatrics. It was decided at this meeting that the group should divide into sub groups in order to consider various areas of treatment and formulate Outcome Measures for each area - Respiratory, Orthopaedics, Neuromuscular, Neurodevelopment and Dyspraxia. The group also decided to enquire as to what measures, if any, were being carried out by other Physiotherapists around the country and a letter was therefore printed in the A.P.C.P. Journal asking for information from other members. Response for this was small but those who did reply had really only started to consider the subject.

Since that meeting there has been a great deal of hard work by all members of the committee and progression is well under way. Outcome measures have been formulated by some of the groups and are now being tried and evaluated. Other areas are near completion. The Committee hope to evaluate all the outcome measures over the next 18 months and it is hoped that these will then be published in a booklet by A.P.C.P. for all the members.

COURSES

Tadworth Court Children's Hospital

STUDY DAY

Wednesday, 27 April, 1994

*"Rehabilitating Children following
acquired brain damage"*

AN INTERDISCIPLINARY APPROACH

This Study Day will cover the philosophy, structure and process of rehabilitating children at Tadworth Court. Our approach is interdisciplinary, therefore, we welcome any individual whose clientele may sometimes include children with acquired brain damage.

The cost is £35.00.

For further details please contact Mrs. Ivy Gosling, Tadworth Court
Children's Hospital, Tadworth, Surrey KT20 5RU,
telephone 0737 357171, Ext 2162.

INTERDISCIPLINARY TEAM MANAGEMENT OF CHILDREN WITH MULTIPLE DISABILITIES

7th - 11th March 1994.

THE NEWCOMEN CENTRE, GUY'S HOSPITAL

Cost: £195.00

This course is aimed at physiotherapists, occupational, speech and language therapists. Also colleagues who are returning to or beginning to specialise in community paediatrics.

The emphasis is on working within a multidisciplinary team to provide efficient and effective therapy input to children and their families.

For further information, please contact

The Course Secretary

Newcomen Centre, Guy's Hospital, St Thomas Street, London SE1 9RT

Tel No.: 071 955 4072

PAEDIATRIC AUDIT

Saturday March 5th 1994

at SALISBURY DISTRICT HOSPITAL POST GRADUATE CENTRE.

The day will be led by Sue Barnard MCSP, Audit Physiotherapist for the Wessex Region and will be in the form of workshops looking at the purpose, structure and process in designing paediatric audit.

The South West Region AGM will be held during the day.

Cost including lunch, will be £18 for APCP members, £25 for others.

Applications to Carole Hurrin, 23 Bayswater Avenue, Bristol BS6 7NU.

Please make cheques payable to APCP South West Region and send with a stamped addressed envelope.

BASIC PAEDIATRIC PHYSIOTHERAPY COURSE BRISTOL

April 21st, 22nd and 23rd 1994.

3 day course intended for physiotherapists new to paediatrics and will include a day each on Neurology, Respiratory and Orthopaedic conditions.

This course is being run as a joint venture between Avon College of Health and Southmead Health Service NHS Trust.

Cost will be £100 for the 3 days or £36 per day.

Details from Fiona Eckford, Physiotherapy Dept. Southmead Hospital, Bristol BS10 5NB or Kathy Badlan, Avon College of Health, Frenchay, Bristol.

THE SPASTICS SOCIETY FOR PEOPLE WITH CEREBRAL PALSY

Castle Priory, Thames Street, Wallingford, Oxfordshire OX10 0HE
Telephone: Wallingford (0491) 837551 * 826350 Facsimile: (0491) 826359

WORKING WITH CHILDREN

64/11/94

£60 (plus £10.50 VAT)

15 March 1994

SHERBOURNE MOVEMENT FOR CHILDREN WITH SPECIAL NEEDS

Level 1 - Part 1

Sherbourne Movement - What has it to offer?

- Do you work with children who have learning disabilities - in education, therapy, or any other environment?
- Do the children in your group lack self-awareness and self-confidence?
- Do they have problems with body awareness and use of space?
- Are they able to make good positive relationships?
- Are you able to find ways of enabling the less able children to take a leading role?

Sherbourne movement can contribute positively to all these aspects; it can help to develop a positive self image and self esteem and improve communication skills through a heightened awareness of movement quality.

Course commences at 9.45 a.m. and concludes 4.00 p.m.

Course Tutor: **Cyndi Hill**

90/138/94

£60 (plus £10.50 VAT)

26 April 1994

MANAGING VIOLENCE AT WORK

Do you manage or supervise staff who may have to cope with violence or aggression at work? Do you know what the law says? What IS and IS NOT good practice?

If you want a framework for developing effective proactive management of violence at work, then this course will help you. It is aimed mainly at residential staff but will be of relevance to all care workers and teachers.

Aims

- will expand your knowledge and understanding of the law
- will relate regulations and guidance to good practice
- will explore frameworks for developing safe working
- will promote effective team working for support and learning

Method

The course will involve all delegates in the learning process. We will work in small groups and together identify and explore issues. Current research will be used to illuminate our own experience together with handouts on the major points. At the end of the day you will be asked to form action plans based on identified gains.

Content

- the framework, law, regulations and policy
- the managers' responsibilities
- monitoring and recording
- support and learning

Course commences at 9.30 a.m. and concludes 4.30 p.m.

Course Tutor: **John Jenkins**

MANAGEMENT

60/11/94

£180 (plus £31.50 VAT)

14-15 MARCH 1994

FINANCIAL MANAGEMENT FOR NON-FINANCIAL MANAGERS

Do you need to be on top of the financial issues of your organisation? Are you confident that you can question and challenge Finance Officers on how to manage the finances of your organisation? Would you like your confidence built up?

This course is aimed particularly at those managers who have significant budget responsibilities for the first time.

Objectives

At the end of the course, delegates will be able to:

- answer the question "What is Financial Management"?
- have an overview of the financial management processes
- identify key steps in budget construction and management
- gain confidence for necessary involvement in the financial management process

Content

- background, introduction and expectations
- why financial management for non-financial managers?
- what is happening to our funds?
- getting the information for financial planning
- costing our activities
- constructing a budget
- managing a budget
- controlling the budget
- income generation
- financial management and team work
- personal action plans
- evaluation

Course commences 9.30 a.m. on
14 March and concludes at 4.30 p.m. on 15 March.

Course Tutor: **Hilary Barnard MBA**

74/149/94

£60 (plus £10.50 VAT)

22 MARCH 1994

CREATING A POSITIVE IMAGE

Lacking in confidence? Need to present a positive image for a job interview or to give a presentation?

Then this course is for you. It will cover:

- effective verbal communication
- effective body language
- how dress and accessories can help or hinder
- presentation skills - how to get your message across

Course commences at 10.00 a.m. and concludes 4.30 p.m.

Course Tutor: **Jacqui Adams**

78/17/94

£225 (plus £39.38 VAT)

25-27 MARCH 1994

TEAM BUILDING

Would you like to:

- develop better teamwork within your staff group
- improve selection and recruitment of new staff
- build self-confidence and encourage personal development in staff

This TEAM BUILDING workshop, aimed at senior and middle managers in the personal social services and health care professions, will help you explore the key characteristics of high-performing teams, what prevents teams from functioning and look at how people work together with the help of the TEAM MANAGEMENT WHEEL.

The programme is highly participative with groupwork exercises, discussions and tasks in teams that will encourage everyone to join in and learn together.

The course commences at 5.30 p.m. on 25 March
and concludes with lunch on 27 March

Course Tutor: **Trevor Stevens BA BSc Med**

VACANCIES

SENIOR I COMMUNITY PAEDIATRIC PHYSIOTHERAPIST

DISTRICT SERVICES UNIT WEST GLAMORGAN

We are looking for a team spirited physiotherapist with good organisational and communication skills who enjoys all areas of paediatric care to be one of a team of physiotherapists in a young and enthusiastic paediatric physiotherapy department.

The post is community based and the therapist will be expected to visit homes, schools, both integrated and special, nursery schools and clinics in the east side of the county.

For further information please contact:

**Mrs. Julie Harvey, Superintendant Paediatric Physiotherapist
St. Thomas Clinic, Balaclava St., St. Thomas, Swansea, W. Glam.**

Tel: (0792) 648675

Do You Wish To Advertise A Course?

Please send any available information on courses for inclusion in further editions to

JACKIE REYNOLDS,
LARK COTTAGE, CRATFIELD,
NR. HALESWORTH IP19 0BN.

This should be in two weeks before the deadline.

N.B. The Journal is published quarterly.

HERE AND THERE

THE DAVID HART WALKER - UP AND RUNNING

Carole Hurran BA, Grad. D.P. M.C.S.P.

Andrew Collins of Genesis Orthotics tells us of recent progress in gaining acceptance of the David Hart Walker by the NHS. In early December a meeting was held with the Medical Devices Directive and agreement was reached to establish a clinical trial based at the centre in Birmingham where the walkers are supplied and fitted. This will involve evaluation of the walker with old and new patients using the expertise of the Genesis Orthotics staff to assess and adapt the device to individual needs. The first visit by the MDD will be on 26th January and will comprise initial value judgements on the efficacy of the equipment before more detailed studies.

The Spastics Society sponsored a trial of the walker in Liverpool earlier this year and according to Andrew the results indicated that a large range of patients could benefit. The Spastics Society are now rumoured to be developing their own device.

Over 100 children have now been supplied with the device by the Birmingham David Hart Clinic and a further 14 children have been rejected, usually for problems with dislocating hips. There is a £2 million product liability insurance on the device but until passed by the MDD including complying with the relevant British Standard it cannot be prescribed through the NHS. Some consultants have already prescribed the device despite this but the children are held on the waiting list at present. All the devices so far supplied have been funded by charitable trusts in hospitals or by private donations. The cost is £1,600 and all modifications and alterations are done at the Centre.

A new device has also been developed for diplegics which is mainly designed to prevent scissoring and could be used in certain cases as a progression from the original walker. It could be supplied direct to physiotherapists for use as an assessment tool as well as an appliance. This will be in production very soon.

The Centre welcomes visits from interested physiotherapists:

The Birmingham David Hart Clinic

Genesis Orthotics, 1 Holt Court South, Off Jennens Road, Aston Science Park
Birmingham B7 4EG

Tel: 021 - 3595717 Fax: 021 - 3596087

CHRONIC HYPERVENTILATION SYNDROME

Patients with Chronic Hyperventilation Syndrome are being referred to physiotherapy departments more and more frequently.

However, as this condition is not yet covered by the core physiotherapy undergraduate curriculum many therapists do not feel confident that they are able to offer effective treatment.

With this in mind a group has recently been set up to further knowledge, pass on expertise and for discussion and education.

It is our aim to produce an information pack containing not only a list of experienced therapists available around the country for advice and guidance but also a recommended literature list and guidelines on recognising the symptoms of the condition and treatment.

We are sure that there will be a lot of interest in activities of the group and are keen to hear from anyone experienced in treating Hyperventilation who would like to join and also from people who are keen to learn more about CHS and wish to acquire a pack.

Please contact me at the address below, with details of your experience (or lack of it!) enclosing an s.a.e. for further information.

Anne Pitman, M.C.S.P.,
Chairman, Physiotherapy for Hyperventilation,
Princess Grace Hospital, 42-52 Nottingham Place, London, W1N 3FD

ACCEPTABLE SPINAL JACKET FOR THE YOUNG CHILD

Young multiply handicapped children are often prone to scoliosis, but both they and their parents find the conventional spinal jackets difficult to accept. With the help of an Occupational Therapist specializing in splinting, and a Physiotherapist experienced with Jobst garments, we have devised a softer but efficient jacket that can be washed and easily replaced as the child grows.

The child was measured for a Jobst vest with front velcro fastening, and a nappy strap. During the marketing, pockets were attached to each side of the jacket. On receipt of a satisfactory fitting garment, the child was placed in a good position, and therma plastic panels, having been specifically moulded to correct the scoliosis were slipped into the pockets. Thus, the child was held in a good comfortable position.

The jacket is comfortable to wear and the panels easily removed for washing and remoulding. Once the parent has been shown how to measure for the vest, as the child grows they can be measured at home, thus causing less problems for the family. By the time the therma plastic is unable to maintain the corrected position, both parents and child are more able to accept the conventional spinal jacket.

For Further Information Contact
Jean Ward M.C.S.P., S.R.P. - Paediatric.
Childrens Physiotherapy, Central Clinic, Colchester, Essex

RESPIRATORY SLIDES

The Association of Chartered Physiotherapists in Respiratory Care (ACPRC) has collected a library of some 260 slides depicting all aspects of work of the physiotherapist in the respiratory field. The categories are anatomy, paediatric ITU, medical, community, adult ITU, surgery, equipment, general paediatrics, assessment, x-rays and miscellaneous cartoons.

At present, this valuable resource is available free to all full members of the ACPRC. However, the ACPRC would like to extend the facility to all Chartered Physiotherapists at the small charge of 50p per slide plus a returnable deposit of £1 per slide in case of loss or damage.

For a catalogue and further information send an A4 SAE to Mrs. Veronica Bastow,
Physiotherapy Dept. The Queen Elizabeth Hospital, King's Lynn, Norfolk PE30 4ED.

FIELDFARE TRUST

The Fieldfare Trust organises activities and events for people with disabilities and disadvantages to enjoy the countryside. They normally involve mixed groups of people with and without disabilities aimed at raising awareness of the needs of people with disabilities and increasing countryside opportunities for everyone.



Skipworth Common, Selby, North Yorkshire (*above*) is one of the "Easy Going" trails blazed by the Fieldfare Trust. Others include Stockhill Forest, seven miles from Cheddar, and Burton Agnes Hall, half-way between Driffild and Bridlington. For more information on trails, contact the Fieldfare Trust, tel: (0742) 701668.

Roger Thomas/Fieldfare Trust



"EASY GOING" in Stockhill enables everyone to enjoy the natural beauty of the Mendips

[Photographs and text reproduced by kind permission of 'Disability Now' and Fieldfare Trust.]

Fieldfare is active across the whole spectrum of countryside recreation for people with disabilities and carefully works WITH not FOR people with disabilities to ensure that everyone's voice is heard.

THE COMPUTER KIDS' LIBRARY

is ideal for children with special needs who use a B.B.C. Computer. The library contains programmes suitable for children from 3 - 8 years. A varied and wide range of programmes are available at low cost.

Contact:- Telephone : 081 - 866 3322

THE GOOD TOY GUIDE

is available from National Association of Toy & Leisure Libraries, 68 Churchway, London NW1 1LT at £1.25 + 50 p&p.

Some toys are particularly suitable for children with special needs, and these aspects will be emphasised by an appraiser with appropriate experience. Key symbols within the guide highlight toys for children with visual or hearing impairment.

Contact: Julie Apfel or Mandy Clifford, 10 a.m. - 5 p.m. on 071 387 9592.

The following Review was published in the I.C.A.C. Newsletter.

BRIDGING THE GAP

by Ruth Marchant and Marcus Page (NSPCC - 1993)

The title of this publication refers to the gap of knowledge between practitioners who have skills in working in child protection and those who have skills in the working with severely disabled children.

It argues for the enskilling of both groups and goes through a number of practical issues in the investigation of child abuse with children using alternative communication. Careful consideration is given to the role of the accompanying adult as allowed in the Home Office/ Department of Health Memorandum of good practice.

Price £5.95 from NSPCC.

CORRECTION

The video entitled **Motor Components To Normal Movement In The First Year** mentioned in the last Newsletter is £25 (not £10 which did seem rather a bargain!) and is available from the Teaching Support & Media Services, Southampton University.

REFERENCE LIST

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REGIONAL REPS. REPORTS

South West: Mrs. Carole Hurran, 23, Bayswater Ave., Westbury Park, Bristol. BS6 7NV.

Our AGM and Study Day will be on Saturday March 5th 1994 at Salisbury District Hospital's new Post Graduate Centre. The topic for the day will be Paediatric Audit and the cost including lunch will be £18 for members, £25 for others. Applications to me please, enclosing an SAE.

Please send me nominations for Regional Representative before the day if possible. I have very much enjoyed my 4 years serving on the National Committee but feel it is time for someone new to have the opportunity now.

South East: Sheila Minet, Old Knowle, Frant, East Sussex TN3 9EJ.

Our study day on Juvenile Chronic Arthritis, which was held in conjunction with NAPOT, had a good attendance and everybody seemed to enjoy it. On **February 26th, David Sutton and Ros Boyd** are our speakers at a study day about conservative approach to CP including splinting and postural management. This will be in Tunbridge Wells and will be combined with our AGM, so we sincerely hope as many members as possible will come. The next date for your diaries is **May 14th** when we shall be holding a Dyspraxia Day.

London: Rowenna Hughes, 87, Norbury Hill, SW16 3RU.

We are all looking forward to 1994, hoping the Study Days will be as well attended as 1993.

Future Planned Lectures

Saturday, March 12th at Great Ormond Street

'GEMS' - Guide to Early Movement Skills - Portage Development

Speakers: Chris Bungay - Superintendent Physiotherapist

Molly White - Lecturer in early education.

There will be a Regional Meeting on January 12th to discuss future study days and lecture evenings for 1994. A lecture is being organised for early Summer by Mr. Bullock, Consultant Neurosurgeon on 'Dorsal Rhizotomy'. We are always grateful for any suggestions on topics for future study days or lectures.

Our sale of sweatshirts continues to be a success. The committee would like to take this opportunity to wish you all a Happy New Year.

Hoping to see many of you at Chester for the Conference in the Spring.

Trent: Jenny Gill, 42 Britannia Avenue, Arnold Road, Nottingham. NE6 0EB.

A Sharing Day will be held on Wednesday, 2nd February 1994, 2 to 4 p.m. at the Child Development Centre, Nottingham.

There will be a series of short presentations by local therapists about interesting case studies of children with neuromuscular conditions.

A nominal charge of £2 per person will include tea and coffee during the afternoon.

If you would like to attend, please contact myself or Margaret Cameron at Nottingham CDC on 0602 691169 ext. 45367.

The AGM for the region will be held at Nottingham CDC on Wednesday 9th March. Hopefully the AGM will be part of a half day session on Orthopaedics & Orthotics. Details to follow.

A number of posts on the local committee will become vacant in early 1994. Anyone interested in playing a more active part in local APCP matters please contact me at the number above. Time commitment is minimal but your contribution would help to strengthen the Trent Region Committee.

West Midlands. Carol Foster, Physiotherapy Department, The Children's Hospital, Ladywood Middleway, Birmingham, B16 8ET.

The three evenings given on splinting concluded on the 25th November and were well attended with good presentations from all three speakers - and were voted very successful.

The committees' main efforts have been to support the Bobath course in 1994 - which is being run at Lea Castle Hospital, Kidderminster. Funds for participants, we hope, will be assisted by donations from business and industry - letters will be circulated. There is also a planned programme of Media coverage.

The Annual General Meeting will be held at Bray's school in mid March.

Wales: Barbara Bowen, Childrens Assessment Centre, East Glamorgan Hospital, Church Village, Nr. Pontypridd, Mid Glamorgan. CF38 1AB.

We enjoyed an excellent Christmas night out at Llanerch Vineyard. The noise level rose proportionately with the wine!

Thank you for the 2 replies to the Questionnaire, I'm sure I'll receive all the others soon - New Year's resolution! Let's make this a dynamic year with plenty of new ideas.

Happy New Year.

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

A short report. Firstly, I hope you all had a really good Christmas and New Year.

Secondly, you will have received an application form for this years' AGM in Warrington on Saturday March 5th 1994. Please complete it as soon as possible and send it back to Sue Leech.

This year we are able to fund ten bursaries of £50 each. For further information about them, please contact Eileen Walters at:-

The Community Health Clinic,

Blackhall Road,

Kendal,

Cumbria.

Tel.no: 0593 727564

I shall look forward to seeing many of you at the AGM and the National Conference this year. All very best wishes.

North East: Liz Hardy, 45 Kestrel Close, Norton, Stockton-on-Tees, Cleveland.

TS20 1SF.

A study day on 'Neuro-sciences' was held on 27th November and proved to be a great success. A respectable turnout (swelled by members of ACPIN) were fascinated by the presentation given by Dr. Nigel Laws. His handouts - and patient replies to our questions - ensured that we were not blinded, but enlightened, by science! Many thanks to Carrie Jackson for her hard work in organising the day.

The next date for your diary is Saturday February 12th 1994. Alan Bass, Supt. Physio will discuss "Physiotherapy Management of Head Injuries in Children and Young Adults" at Leeds. This will include a practical demonstration. Since the AGM will also take place during the day, please do try to attend. Nominations for new regional committee members to me, please.

Scotland: Lyn Campbell, 19 Craigmount Avenue North, Edinburgh EH12 8DH

The next study day will be held in conjunction with the AGM on Saturday 5 March 1994. The venue has not as yet been finalised but the topic for the day will be Sensory Integration and details will be advertised in Therapy Weekly.

N. Ireland: Elizabeth Harty, 42 Tullyroan Road, Dungannon. BT71 6N9

The well attended evening meetings have proved worthwhile not only for the excellent lectures but also have provided an opportunity for our members and frequently multidisciplinary associates to meet and share information and problems and thus help to lessen the sense of isolation felt by many - please keep coming! All are welcome!

Planned Events:-

17th Jan

- Evening Meeting. Mr. Adair, Orthopaedic Consultant. Lecture on spinal deformities and their management. Followed by Miss Jackie Reynolds - Co-ordinator for the C.P. Register Panel, who will explain the proposed physiotherapy research to be carried out with selected children in N.I.

11th Feb

- Study Day on Seating Management, organised by Action Design at Musgrave Park Hospital, Belfast. A forward learning pack will be sent to all who have enlisted, later in January. The Committee has gone to a lot of effort to contact every possible professional involved in seating management for this unique event.

14th March

- Evening meeting on Behavioural Modification by Dr. Pat Donnelly in Fleming Fulton School. Followed by A.G.M.

April

- Study Day on Counselling Skills by Dr. Jarlett Benson, Psychiatrist at Royal Victoria Hospital - to be confirmed.

May

- Joint Study Day with O.T.'s on clumsy children. Details to be confirmed.

A Happy New Year To All A.P.C.P. Members.

A.P.C.P. MATTERS

1. ANNUAL GENERAL MEETING 1994.

The 21st Annual General Meeting
of the
Association of Paediatric Chartered Physiotherapists
will be held on
SATURDAY 9th APRIL 1994
at
CHESTER COLLEGE
beginning at 9 a.m.

All paid up members of the Association are invited to attend.
Voting will be restricted to full members of the Association and
a current membership card will be required.

Minutes of the last AGM are available from the Secretary
on receipt of a SAE.

Nominations are invited for 3 committee vacancies.
Nominations should be sent to the Secretary by the
end of February together with a proposer and seconder
who should be fully paid up members of the Association.

Michele Lee, PRO, and Jill Brownson, Chairman,
reach the end of their terms of office.

REPRESENTATIVES CONFERENCE

at

CONGRESS 1994

Motions are required for Representatives Conference.

All members are invited to submit motions
for consideration.

Motions to be forwarded to
Hon. Secretary, Mrs. Fiona Corkhill.

A.P.C.P. will forward motions to C.S.P. for consideration.

Representatives of A.P.C.P. will present the motions at the
Representatives Conference

All motions selected by C.S.P. are
published in Physiotherapy.

Members who feel strongly about any motion published
are encouraged to contact the A.P.C.P. Representatives
to speak on their behalf.

REMINDER

Association of Paediatric Chartered Physiotherapists



Membership Application/Renewal 1994

- 1) Ordinary Membership is open to annual subscribing members of the Chartered Society of Physiotherapy.
- 2) Associate Membership is open to professional people with an interest in paediatrics, subject to the approval of the National Committee.
- 3) **Annual subscription for 1994 is £16.00**, and runs from 1st January to 31st December. All cheques should be made payable to 'APCP'.
- 4) Retired members are only required to pay half the total annual subscription.
- 5) Subscriptions for overseas members are £2.00 less than the current full subscription.

I wish to *Apply for/renew my membership of the Association of Paediatric Chartered Physiotherapists.

*Delete which is not applicable. **PLEASE USE CAPITALS ON THIS FORM.**

Title:

Initials: Surname:

CSP No. APCP No.

Profession: Grade:

Address for correspondence:

.....

..... Post Code:

Tel. No:

Place of Work

..... Post Code:

Tel. No:

