NCSS
National Council of Social Service

Best Practice Guidelines In Physiotherapy For Early Intervention Programmes

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Preface

The practice of therapy has evolved, developed and matured over the years. The last decade saw significant growth and expansion of therapy services in social service sectors. With the growth and expansion in clinical therapy practice, it is of paramount importance that sound practice principles and protocols are in place.

Professionalism has taken a deeper root in the way we practice as we mature as a profession and the clients we serve become more knowledgeable. A basic tenet of professionalism of therapy practice is dependent on the standards of the service provided. It is therefore important for all practitioners to strive for excellence in the standards of service delivery.

Best Practice Guidelines for Physiotherapy services requires that the therapists not only act in accordance with the knowledge, principles, and philosophies of their own profession, but also with a larger set of beliefs in mind. These beliefs and philosophies have grown out of collective experiences across disciplines. These collective experiences have evolved through much endeavour to manage and support the client with special needs. The aim is to enable them to overcome the various challenges to their capabilities and well being.

These Best Practice Guidelines for therapy services will provide the therapists not only with the practice protocols but also serve as an evaluation tool.

Strategy and Specialisation Department
Service Development Division
National Council of Social Service

Contents

Best Practice

Best Practice is the process of seeking out and studying the best internal practices that produce quality performance.
In therapy practice it is a professional decision and action based on knowledge and evidence that reflects the most current and innovative ideas available for therapy service.

Objectives of Best Practice Guidelines (BPG)

- Improve client care.
- To provide a scientific and systematic procedure for delivery of therapy care.
- A resource for therapy practitioners, administrators, social service and health care policy makers and other professionals.
- To describe the practice and delivery of therapy services using the disablement model within the context of the special schools objectives.
- To establish the preferred practice pattern of therapy service within early intervention.
- To delineate preferred practice patterns and help therapists / therapy services to:
  - Improve quality of care.
  - Enhance positive therapy outcomes.
  - Ensure efficient service provision.
  - Develop specialisation and speciality service.

- To establish benchmarks/ quality indicators in therapy practice in the social service sector.

- To document the provision and outcome of therapy service in the social service sector.

- To serve as a basis for evaluation and accreditation of therapy services in the social service sector.

Disablement Model

The model of disablement refers to the impact of acute and chronic condition on the functioning of the body system, human performance, and of the usual, expected and personal desired roles in society. This model is used to delineate the consequences of disease and injury at the level of the person and the society.

A number of models have emerged and all the models attempt to explain the inter-relationship of diseases, impairments, functional limitation, disability, handicap and the effect of the interaction of the individual with the environment.

Some of the commonly discussed models are:

Nagi Model

Active Pathology	Impairment	Functional Limitation	Disability
Interruption of normal process, and effort of organism to regain normal state	Anatomical, physiological, mental, or emotional abnormalities and loss	Limitation of performance at the level of the organism or person	Limitation of performance of socially defined roles and tasks within a socio-cultural and physical environment

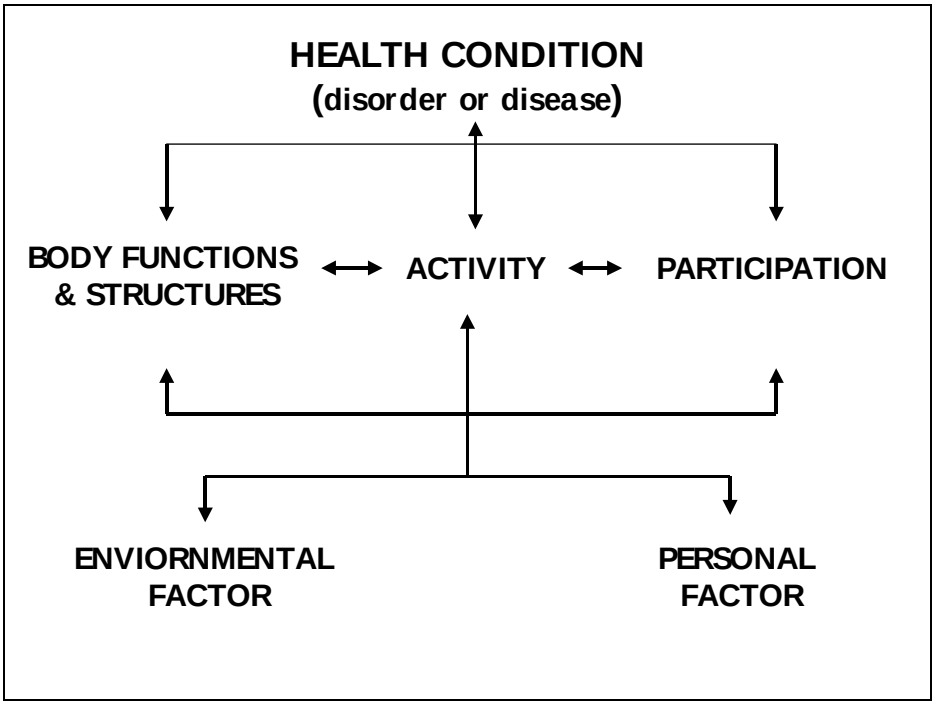
WHO - International Classification of Impairment, Disability, and Handicapped (ICIDH) 1980

Disease	Impairment	Disability	Handicapped
Intrinsic pathology or disease	Loss or abnormality of psychological, physiological or anatomical structures or function at organ level	Restriction or lack of ability to perform an activity in normal manner	Disadvantage due to impairment or disability that limits or prevents fulfilment of a normal role – depending on age, sex, sociological factors – for the person

WHO - International Classification of Functioning, Disability and Health (ICIDH - 2)

ICIDH – 2 as a classification does not model the "process" of functioning and disability. However it is used to describe the process by providing the means to map the different constructs and domains.

It provides a multi – perspective approach to the classification of functioning and disability as an interactive and evolutionary process.



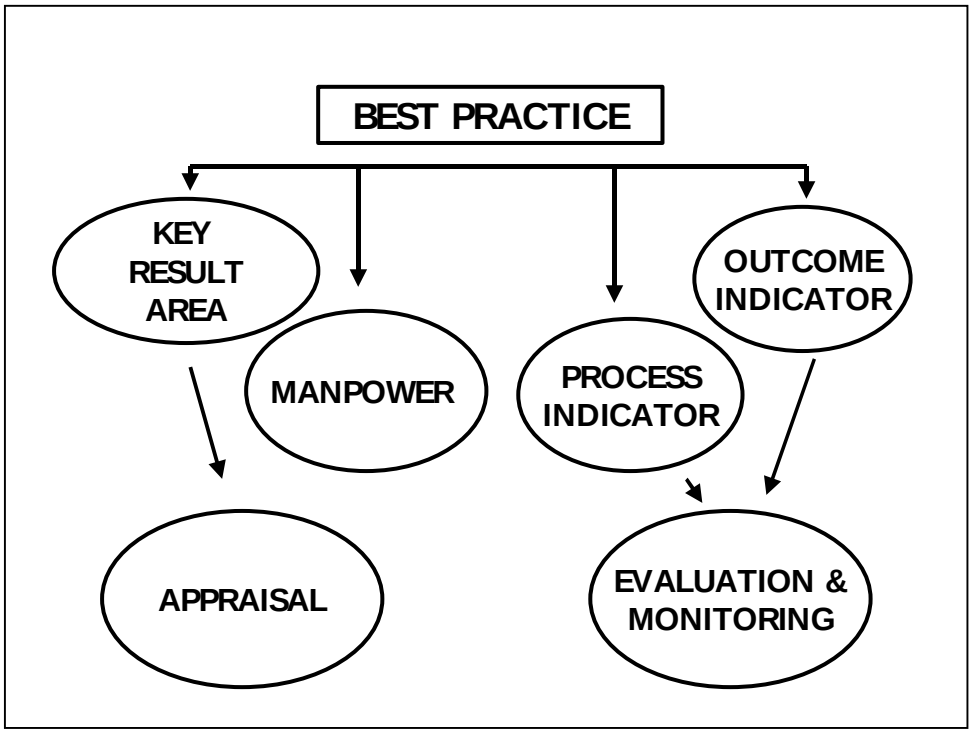
Understanding of interactions between the constructs and domains of ICIDH-2

An individual functioning in a specific domain is an interaction or complex relationship between health condition and the contextual factor (i.e. environment and personal factor). There is a dynamic interaction among these entities and intervention is one of the entities, which have the potential to modify one or more of the entities.

Future Development of Best Practice Guidelines

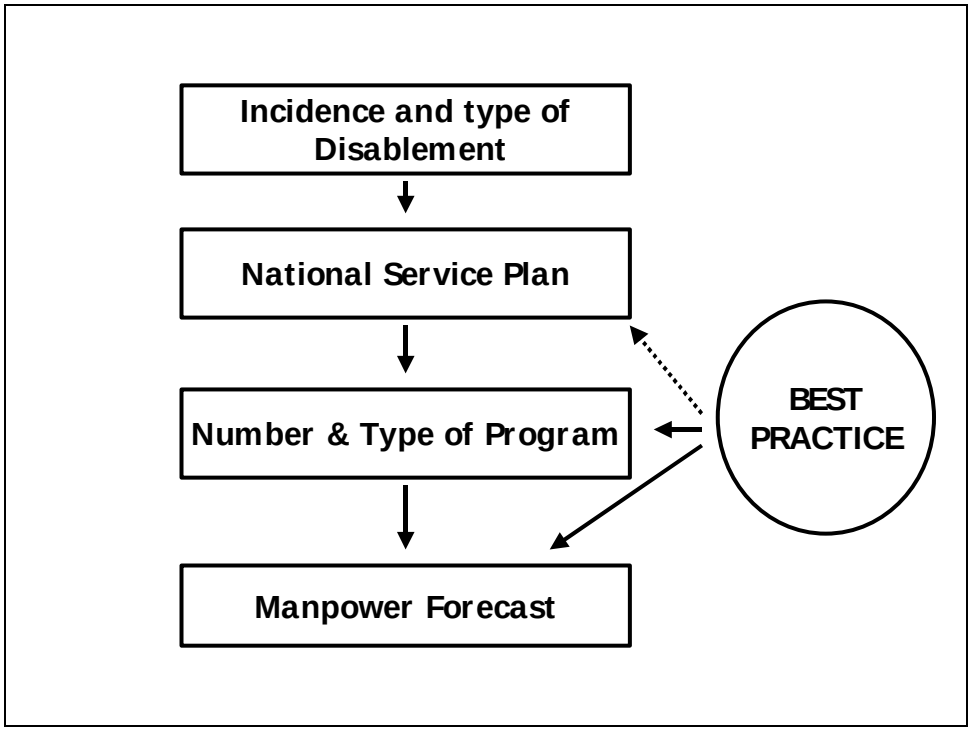
Best Practice Guidelines (BPG) are evolving guidelines and will be constantly updated and modified to be relevant with the development of scientific literature, outcome research, new intervention strategies and practice settings.

Therapy best practice guidelines will be integrated with the programme evaluation system (PES). It will form the basis for evaluating individual therapists and departmental performance through structured reporting systems.



Schematic diagram to depict how BPG can form the basis of programme evaluation, manpower planning and performance appraisal.

BPG will also assist in future sectoral manpower planning by delineating appropriate programme-specific manpower norms and practice patterns.



Schematic diagram to depict role of BPG in manpower forecast

Programme Standards

1. Early Intervention Programme Objectives

- To provide an early intervention programme and rehabilitative services for children six years and below, who have either developmental delay, intellectual, physical or multiple disabilities.

- To provide a structured programme for children with autism, autistic tendencies or associated severe behaviour or communication problems.

- To encourage parental involvement in the training programme and educational activities of their child.

- To promote public education and awareness of the special needs of children with physical, intellectual, developmental, multiple disability, and autism.

- To encourage and support the formation of Parents Support Groups to help new parents of disabled children.

- To provide opportunities for staff training with the aim to establish a pool of local suitably qualified teachers and professionals

2. Objectives for Physiotherapy Department

- Provide therapy intervention to facilitate, develop, improve and maintain sensory-motor, and daily living skills among students with multiple disabilities enrolled in the early intervention programme.

- Optimise functional ability by deformity and contracture management with the use of therapeutic techniques and appropriate assistive and adaptive technology.

- Practice evidence-based therapy.

- Provide comprehensive caregiver programmes.

- Facilitate collaboration with teachers and other professionals to maximise child's development.

- Develop the child's ability to participate in school and family activities and functions, so that the child will be able to take their full place within the community.

3. Objectives for Physiotherapy Programmes

- Identify impairments, plan and execute appropriate physiotherapy programme for the children enrolled in special education school.

- Facilitate the child's development and functions through structured therapy care plan.

- To educate parents, teachers and caregivers on child's physical conditions and to actively engage them in the overall management of the child.

- To educate and demonstrate home programmes to parents and caregivers, to reinforce therapy goals at home settings.

- To advise on functional activities and home modifications to maximise child's potential at home environment.

- Build rapport with parents/caregivers and integrate their expectations into client's therapy goals.

- Facilitate parental counselling.

4. Physiotherapy Objectives for Early Intervention Programme

- To provide motor training to infants and young children with developmental disabilities.

- To enhance balance, postural control and facilitate movement and locomotion.

- To enhance spatial orientation during interaction with environment.

- To enhance co-ordination, timing and sequencing and motor planning.

- To enhance upper limb function and fine motor activity.

- To reduce dependency, and enhance independence in activities of daily living.

5. Physiotherapy objectives for Structured Teaching for Exceptional Pupils (STEP)

- To improve balance, coordination, postural control and motor planning in children enrolled in the STEP programme.

6. School intake criteria for EIPIC

- Children with intellectual disability below 6 years old.
- Children with autism between 1.5 to 4 years of age.

7. Intake criteria for physiotherapy EIPIC programme

- Children enrolled in the school with intellectual disability below 6 years who will benefit from physiotherapy intervention.

- Children enrolled in the school with multiple disabilities below 6 years of age who will benefit from physiotherapy intervention.

- Children enrolled in the school with autism between 1.5 to 5 years of age who will benefit from physiotherapy intervention.

8. Distribution of work in relation to departments objectives

- Direct Therapy Intervention: 80% of working hours.

- Continuing Education and Training: 5% of total working hours.

- Meetings Departmental and Organisational: 5% of total working hours.

- Planning and Departmental Administrative work: 10 % of total working hours.

9. Indicators for physiotherapy department

- Department staff will spend 80% of man-hours in direct intervention.

- Therapy Department delivers at least 90% of scheduled therapy sessions.

- Therapy Department achieves 75% of targeted therapy outcomes at every six-monthly review of individual care plans/ IEPs.

- Department will achieve 100% of project[1] (Key Result Area (KRA) for therapists).

- Department achieves 80% satisfaction from service recipient (children/ caregiver).

- Department staff will spend at least 5% of man-hours in continuing therapy education and in-service training per year.

- Department has 100% compliance to safety guidelines at any given time.

[1] 85% of identified projects should be in physiotherapy practice (Care Path/ Research/ Technique or Programme development) or department related.

Therapy Service Delivery and Intervention

Physiotherapy management assimilates assessment (client evaluation / examination) therapy diagnosis, prognosis and intervention to maximise therapeutic/functional outcomes

1. Assessment

Quality of physiotherapy care involves problem solving process whereby therapist makes effective decision on intervention based on symptoms, signs, and limitation of function when assessing/evaluating and re-assessing the child with special needs.

- All clients receiving services at therapy department, class and natural setting must be screened/assessed before commencement of service.

- All clients referred to therapy department will be screened/ assessed within two weeks.

- All assessment and screening will follow a standardised format.

- Departments / therapists are encouraged to use therapy documentation software for standardisation of assessments / reassessments and daily reports.

- All documentation (assessment / reassessment / daily reports) should be completed within the same day of the event/ intervention.

- It is mandatory that assessment/reassessment/ daily report be dated and signed by the therapist.

- Therapists should make every effort to include parents/caregivers, teachers and other concerned therapists, while evaluating the child.

- All assessments/reassessments and daily reports should be accompanied by recommendations, goals and intermediate and long-term outcomes for therapy interventions.

- All clients should be assessed/reassessed every six months.

- Therapists should effectively communicate their assessment/evaluation findings, goals and anticipated outcomes with parents/caregivers, teachers and other concerned therapists and referral agencies.

2. Care Plan

- Therapists are encouraged to use the therapy care-plan as a guide.

- Individualised care-plan should be developed after full client assessment and in consultation with the client, family/caregiver and other professionals.

- Care-plan outcome should be properly discussed and documented.

- All care-plans should be reviewed every two years.

- Therapists are encouraged to expand the care-plan whenever required.

- Development of a specialised care plan following re-constructive surgery is strongly recommended.

- All individualised care plans should incorporate caregiver training.

- Therapist shall communicate the findings of his/her examination, evaluation, diagnosis and prognosis with other professionals and caregivers.

- Therapists shall inform and collaborate with the client/caregiver to establish treatment goals and care- plan.

CARE-PLAN FOR CHILDREN WITH CEREBRAL PALSY AND DEVELOPMENTAL DISABILITY

Impairment	Intervention	Anticipated Goals & Expected outcome
Delayed Motor skills	Developmental activity training - Prone development - Supine development - Rolling - Sitting - Kneeling - Standing Movement pattern training - Balance Training in Sitting - Standing - Coordination activity Perceptual awareness Neuromuscular education and re-education - Creeping - Crawling - Reciprocal movements - Kneeling - Standing/ assisted standing Motor training - Joint compression - Weight Bearing - Weight Shift and Control - Bio-feed back	- Motor function (motor control and motor learning) is improved - Postural control is improved - Quality and quantity of movement between and across body segments are improved - Range of motion is improved - Relaxation is increased

Impairment	Intervention	Anticipated Goals & Expected outcome
Impaired Sensory Integration Impaired movement pattern in functional activity and play Impaired Locomotion	Body Mechanics and Postural stabilization - Postural control training & awareness training - Postural stabilization activities Balance Coordination and Agility training - Motor function (control and motor learning) training - Neuromuscular training - Perceptual training - Posture awareness training - Sensory training or retraining - Task specific performance training Flexibility Exercise - Muscle lengthening - Range of motion - Stretching - Muscle strength Gait and Locomotion training - Developmental activity training - Gait training - Assisted locomotion training	- Sensory awareness and processing are increased - Balance is improved - Gait, locomotion and balance are improved - Joint integrity and mobility are improved - Motor function (motor control and motor learning is improved - Muscle performance (strength, power and endurance) is increased - Postural control is improved - Quality and quantity of movement between and across body segments are improved - Relaxation is increased - Sensory awareness is increased - Sensory modulation is established - Motor planning is improved - Participating in games and simple sports has achieved

Impairment	Intervention	Anticipated Goals & Expected outcome
	Breathing strategies - Active cycle of breathing - Forced expiratory technique Positioning - Positioning to alter work of breathing - Positioning to maximise ventilation and perfusion - Pulmonary postural drainage Electro-therapeutic modalities - Bio- feed back - NMES - EMS Compression Therapy - Compression bandaging - Compression garment - Taping casting Gravity assisted compression device - Standing frame - Tilt table	- Improved ventilation and airway clearance - Improved motor control and motor learning - Improved functional activity - Improved sensory awareness and motor learning/training - Improved osteogenesis

Impairment	Intervention	Anticipated Goals & Expected outcome
Impaired Activities of daily living (ADL)	ADL training - Bed mobility - Transfers - Toileting IADL Training - Mobility - Home maintenance - Structured play for infants and children - Home/school environment Functional Training Programme - Simulated environment and tasks - Task adaptation - Travel training Adaptive device - Environmental controls (home/ school modifications) Assistive device - Canes - Crutches - Walkers - Static and dynamic splints - Wheelchair Orthotic device - Brace - Cast - Shoe insert - Splints	- Balance improved - Quality and range of purposeful movement improved - Gait and locomotion improved - Improved independence in mobility and daily living activities - Enhanced Social participation - Optimal joint alignment / stability in movements - Loading is achieved - Ability to perform physical action, tasks improves. - Promote self-esteem and emotional well-being

Impairment	Intervention	Anticipated Goals & Expected outcome
	Protective device - Brace - Cushion - Helmets Supportive device - Compression garment - Corsets Injury prevention and education - Injury prevention and education during self-care and home management - Injury prevention / re-education with use of devices and equipments - Safety awareness training	- Optimal joint alignment / stability in movements - Loading is achieved - Ability to perform physical action, tasks improves. - Level of supervision required decreases - Ability to assume resume required self-care in home / school.

CARE-PLAN FOR CHILDREN WITH DOWN SYNDROME AND INTELLECTUAL DISABILITY

Impairment	Intervention	Anticipated Goals & Expected outcome
Delayed Motor skills	Developmental activity training - Prone development - Supine development - Rolling - Sitting - Reciprocation - Kneeling - Standing/ assisted standing Motor training - Joint compression - Weight Bearing - Weight. Shift and control - Bio-feed back Movement pattern training - Balance Training in Sitting - Kneeling - Kneel standing - Standing - Coordination activity training - Perceptual awareness training	- Motor function (motor control and motor learning) is improved - Movements / components of movement are better coordinated - Quality and quantity of movement between and across body segments are improved

Impairment	Intervention	Anticipated Goals & Expected outcome
Awkwardness of movement during play and functional activities Impaired Sensory Integration Impaired Locomotion	Body Mechanics and Postural stabilization - Postural control training & awareness training - Postural stabilization activities - Sensory stimulation - Sensory Protocol Balance Coordination and agility training - Motor function (control and motor learning) training - Proximal joint control training - Neuromuscular education - Perceptual training - Posture awareness training - Bilateral Activities - Sensory training or retraining - Task specific performance training Flexibility Exercise - Muscle Tone - Muscle length - Range of motion - Muscle strength	- Postural control is improved - Postural stability is improved - Sensory awareness and processing are increased - Joint integrity and mobility are improved - Weight-bearing status is increased - Balance is improved - Gait, locomotion and balance are improved - Motor function is improved - Muscle performance (tone, strength, power and endurance) is increased - Improved active control of peripheral joint - Improve / maintain Muscle length - Sensory modulation has achieved - Motor planning is improved - Promote self-esteem, socialisation and emotional well-being

Impairment	Intervention	Anticipated Goals & Expected outcome
	Gait and Locomotion training - Stair Walking - Tandem Walking - Walking activities in Tread mill - Functional gait Training Breathing strategies - Active cycle of breathing - Forced expiratory technique Positioning - Positioning to alter work of breathing - Positioning to maximise ventilation and perfusion Injury prevention and education - Injury prevention and education during self care home /school / play Orthotic device - Spinal - Shoe insert - Splints Protective device - Helmets	- Functional Independent locomotion - Ability to perform physical action, tasks improves - Airway clearance improved - Improved cough - Improved ventilation - Exercise tolerance increased - Level of supervision required decreased. - Ability to assume resume required self-care in home - Improve joint Stability and function - Contain postural and structural deformity - Encourage purposeful functional movements

Impairment	Intervention	Anticipated Goals & Expected outcome
	Functional Training Programme - Simulated environments and tasks - Task adaptation - Travel training	- Independent in mobility and self care in different environment - Independent travelling on public transport - Increased participating in games and simple sports - Promote self-esteem, socialization and emotional well-being

CARE PLAN FOR AUTISTIC SPECTRUM DISORDERS (ASD) CHILDREN WITH SENSORIMOTOR PROBLEMS

Impairment	Intervention	Anticipated Goals & Expected outcome
Delayed Motor skills	Development activity training - Prone and Supine lying - Rolling - Crawling - Jumping - Reciprocation - Climbing Motor Training - Joint compression - Weight Bearing - Weight Shifting and control - Bio-feed back Movement Pattern Training - Balancing training on a small base - Climbing up and down on a unusual/uneven shape of ground/equipment - Coordination activity training - Perceptual awareness training	- Motor function (motor control and motor learning) is improved - Coordinated movement is increased - Quality and quantity of movement between and across body segments are improved - Difficult Balancing activity has achieved - Timing and Sequencing gross motor activity has improved - Motor planning in simple functions is increased
Poor Postural Control	Normalise Low Muscle Tone and Strength - resisted exercise and activity	- Muscle tone, strength are improved - endurance is increased

	and activity - vestibular activity with proprioceptive input - proprioceptive activities Balance control - challenge equilibrium during functional activities	- postural control has gained in various positions - grade/speed control of movement has improved (slow and fast) - higher level balancing is improved - normal pattern of movements achieved - Postural Security is improved
Poor Motor Planning and Organization skills	Body awareness and Spatial Orientation - start with passively moving through the task - providing self directed proprioceptive and other sensory inputs functional activities Initiation to purposeful Tasks and Ideational skill - providing a variety of activities repeatedly for interactions - using simple adaptive reaction and later moves to more complex behaviour types of tasks	- Improved perception of own Body and Body scheme - Increased ideational skills - Improved to initiate purposeful motor actions in the environment - Increased participation in physical activities - Obtained organizational skill for sequential functions - Improved adaptive responses in motor, social and cognitive areas - Improved engaging in some heavy work activities

Sensory Modulation Deficits	Sensory processing - provide to obtain variety of appropriate sensory inputs through purposeful activities - experiencing deep pressure and vibration through proprioceptive activities - involve with tactile discrimination activities - Sensory Diet- participate in planned activity and sensation to feel calm, alert and organize appropriately (only trained therapist) - Sensory Protocol (Wilbarger Protocol) (only trained therapist) Intervention Strategies for Oral defensiveness (only trained therapist) Alert Programme to regulate her/his own arousal level (only trained therapist) - sensory diet - proprioceptive activities - vestibular activities	- Improved body awareness and body scheme - Increased muscle tone and endurance - Improved Eye-Hand Coordination in gross motor activities - Increased eye movements - Achieved gravitational security - Increased balancing activities/ functions - Improved spatial orientation - Achieved regulating arousal level - Achieved sensory modulation - Improved organization skill - Increased attention in gross motor activity - Engage in more heavy works/ activities - Increase concentration - Ability to do more daily living activities and self-care - Improved eating - Improved endurance in activity - improve in self-control and concentration

Impairment	Intervention	Anticipated Goals & Expected outcome
	Functional Training Programme - Simulated environments and tasks - Train Specific time oriented activity routine - Participate in play and leisure activities - Adaptations and Changes in routine and interaction (supervision needed) - Travel training	- Independent in mobility and self care in different environment - Independent travelling on public transport - Increased participating in games and sports - Promote self-esteem, socialization and emotional well-being

3. Intervention

Therapist provides, or directs and supervises, the therapy intervention in a manner consistent with examination data, evaluation and the care-plan.

- Intervention is based on examination, diagnosis, prognosis and care plan.
- Provided under direction and supervision of the therapist.
- Intervention is altered in accordance to the change in status and response of the client.
- Intervention may be multidisciplinary on occasions to meet the needs of the client.
- Intervention can be individualised or in a group setting.
- Individualised intervention sessions should be of minimum 30 minutes duration.
- Group session should have a minimum number of 4 clients per group and duration from 45 to 60 minutes.
- Group should be homogeneous as regards to their rehabilitation outcome and activities.
- Frequency of intervention will depend on the client's need identified by the therapist and assessment and client's/caregiver's ability to attend therapy sessions.

4. Documentation

Document is referred to as an entry in the client's record. This could be in the form of initial assessment, assessment, special tests, progress notes, re-assessments and reports on therapy outcomes. It should also include the IEP and checklists for care-plans if applicable.

- All handwritten documents should be duly entered and signed with ink; electronic entries should have appropriate security and confidentiality features.

- Documentation of all the episodes of care must be done on the same day.

- All client-related documents are confidential.

- All documentation related to therapy should be filed within the same day in designated folder of client's file.

- All correspondence related to the client should be filed promptly in client's file.

- All reports either internal or external should be copied and filed within the same day in designated folder of client's file.

- Requests for external reports should be filed in designated folder of client's file.

5. Referral

- Client referral may be either internal or external.
- All referrals need to be documented and explained to clients/caregivers.
- External referral should include formal letter and a short status report.

6. Discharge

Discharges are the process of ending an episode of therapy services when anticipated goals and expected outcomes have been achieved or other reasons eg: moving to other agency, reaching plateau of development, long illness.

- Discharge is based on therapist's assessment and findings when anticipated goals and outcomes have been achieved.
- Discharge plan should include possible referral and follow ups if applicable.
- All discharge reports should be clearly documented.

Personnel

1. Code of Conduct

- Therapists recognise the individuality of each client and respect their differences.

- Therapists' conduct should not be viewed as abusive, harassing or discriminatory against clients and associates.

- Therapists should obtain informed consent from client/caregiver before treatment or related activities.

- Therapists should disclose nature of proposed intervention and expected outcomes to clients / caregivers.

- Therapists should accept responsibility for therapy management within the scope of practice and should exercise sound judgment.

- Physiotherapists should not delegate responsibility to a less qualified person for an activity that requires the skill, knowledge and judgement of physiotherapists.

2. Recognised qualification

- Physiotherapists employed in early intervention programmes should preferably be from institutions accredited by NCSS and Singapore Physiotherapy Association (SPA).

- All therapists are strongly encouraged to obtain SPA membership within their first year of employment.

3. Job description for Physiotherapist

Inter- relationship

- Clients: children with disability in Special School
- Medical Professionals and other support service personnel
- Administration personnel

Reporting Structure

Duties and Responsibilities

Physiotherapy Treatment

- Assess and identify individual needs of clients and formulate / develop and implement appropriate individualised physiotherapy programmes. These would aim to facilitate, restore, improve or maintain movement and functional abilities.
- Work with clients on a one-to-one basis, group or special setting based on their levels of function and severity of disability.
- Liaise with various disciplines involved in the rehabilitative treatment process.

- Evaluate and document clients' physiotherapy needs and progress at regular intervals, monitor training programmes and review their effectiveness.

- Provide consultation, support and update the clients' progress and status to caregiver and all those involved in the rehabilitation team.

- Refer clients to respective specialists for consultation and appropriate intervention.

- Evaluate, prescribe and fabricate/purchase assistive devices to improve function as required by the client.

- Train and supervise caregivers in maintenance of therapy programmes.

- Involve in discussions of client – related issues with caregivers and members of the caregiver team.

Administration

Professional / Staff Development

Other Activities

Maintenance

General Duties

Immediate Subordinate

- Physiotherapy support staff

Special School

- Involve in individual and group activity programmes conducted for children in special school setting

- Train and teach school teachers/assistants in relevant basic techniques of client handling to facilitate implementation of IEP in the classroom setting.

- Liaise with and teach parents basic client handling skills to ensure and encourage continuity of physiotherapy programmes at home and at school.

- Provide support and counselling to family members/carers of client if required.

4. Dress code

The desired dress code policy combines the professionalism of the business look with the comfort of an informal but smart look.

Professional Image

- Therapist should project an image of professionalism, reliability, conscientiousness and competence.

Consideration for Dressing

- The golden rule of dressing in the new millennium is to apply audience analysis and to consider what one's image objective is. Staff should determine whom they would be dealing with so that what they wear matches the people and situation. Dressing should be in accordance with people in contact and prevailing situations.

Working Days (Smart Professional)

- Mondays to Friday, staff should dress to project a professional Image. The recommended clothing for staff is:

Recommended for Men

- Plain or stripped Long/ Short sleeve shirts.
- Plain solid colour Polo T-Shirt.
- Long Pants of solid colour.

Recommended for Women

- Skirts with Blouses with collars.
- Skirt Suits, Pant Suits.
- Pants with Shirts/Blouses/ Polo T-Shirt.
- Baju Kurung / Punjabi Suite

5. Client's confidentiality

- Therapist should act in the client's best interest.

- Information relating to clients status/ condition may not be communicated to a third party not involved in client's care without prior consent of the client.

- Information from professional reviews/ case conference shall be kept confidential unless the members of the review committee and client/ caregiver consent to the release of the information.

- Therapists can disclose information to appropriate authority on official request and it is necessary to protect the welfare of the client.

6. Continuing education

- Therapists should be actively participating in Continuing Education Programme (CEP) within their organisation, NCSS and professional bodies.

- Therapists should organise weekly/fortnightly in-service sessions within their dept/organisation.

- Smaller agencies should collaborate with other agencies and organise in-service training.

- Therapists should attend at least two therapy related workshops within a calendar year.

- Therapists are strongly encouraged to attend therapists' Networking meetings on a regular basis.

- Therapist should spend 80 - 100 hours. in CEP per year or 5% of total annual man-hours.

7. Resources

The department should have adequate resources to enhance and expand the therapy practice.

It is recommended that the department take the following measures to develop the resources

- At least one professional journal

- Purchase of at least two therapy related books every year.

- Each department to have internet access for further research and development

Organisation And Management

1. Administration of Therapy Services

- Therapy service should have mission, purposes and goals
- Therapy service should define the scope and limitation of therapy service provision.
- Therapy service should have a written organisational plan which:
- Describes relationships between therapy service and other components of the organisation.
- Ensures that service is directed by a therapist
- Defines supervisory structures within the service
- Ensures compliance with NCSS requirements for therapy service.
- Ensures compliance with NCSS Standards of practice and Best Practice Guidelines for VWOs/ Community Therapy Services.

2. Physiotherapist's monthly report

- All therapists should submit completed monthly reports to the respective department head within the first week of the month.
- Completed departmental monthly report to be submitted to the head of the school within the second week of the month.

- Individual and departmental monthly report should indicate if the monthly targets are achieved.

- All monthly individual and departmental reports should be collated at the end of each quarter and annually for annual reports.

- All reports should be in Excel document.

3. Meetings

- Therapists should have at least one departmental meeting per month.

- Departmental head/appropriate staff should report departmental progress at monthly organisational meeting.

- All departmental meetings should be minuted and filed.

- Therapist without administrative responsibility should not attend more than four meetings a month.

- Department head/in charge should report the outcome achieved by the department to the head of the organisation within the first 10 working days of the month.

4. Inventory for equipment / resources

Equipment refers to all the items in the therapy department used for therapy delivery, administration, continuing education and caregiver training.

- Department should maintain an inventory for therapy equipment/resource/office equipment.
- All equipment should be listed using organisational coding.
- Stocks of consumable items should be monitored to ensure proper supply.
- Review of equipment for wear/tear and potential safety hazard.
- Assess need to stock/order of equipment

5. Environment and safety guidelines

- The safety of the client is of paramount importance during therapy sessions and when participating in any activity involving a department's staff.
- Department should ensure strict infection control.
- Clients should not be left unattended at any time.
- Client safety should be ensured at all times; injury and falls should be minimised through proper department layout and written safety guidelines.

- Therapy areas should be free from obstruction as children may have physical/cognitive/perceptual limitations.

- Department should ensure that equipment, training devices and the environment is clean and safe for use.

- Department should have a written preventive maintenance plan for all therapy equipment.

- In case of injury or accident to the client a report should be made to school nurse (if applicable) or any relevant person, and recorded in the school accident book. All accidents during therapy sessions must be reported to appropriate authorities as soon as possible.

- It is recommended that all staff should be certified First Aid provider.

- Department should maintain a First Aid box.

- In case of fire the organisational fire evacuation plan should be followed.

Appendices

Appendix A

PHYSIOTHERAPY DEPARTMENT
Initial Assessment Form

General Information

Name: Age: Sex:

D.O.B: Race: Client's ID:

Address: Tel. No:

Referred by:

Reason for referral to Physiotherapy:

History

Developmental/Social Medical

Current Concerns (Chief Complains)

Functional Status and Activity Level

System review

Gross Motor functions: (Lower Limbs)

Muscle tone: Hypo tonic Normal Hyper tonic

Range of motion:

Joint		*Active R.O.M*	*Passive R.O.M*
Hip	*Right*		
	Left		
Knee	*Right*		
	Left		
Ankle	*Right*		
	Left		

Tightness / Contracture /Deformity:

Muscle Power: (Please Tick)

Right Lower Limb	Good	Fair	Poor
Left Lower Limb	Good	Fair	Poor

Ambulatory Status: (Please Tick)

Has to be carried	Bottom Shuffling	Moves by rolling
Moves by creeping	Moves by crawling	Kneeling
Kneel walking	Assisted Walking	Walk

Sitting Balance: (Please Tick)

Sitting	Static:	Good / Fair / Poor
	Dynamic:	Good / Fair / Poor
Standing:	Static:	Good / Fair / Poor
	Dynamic:	Good / Fair / Poor

Posture (Please Tick)

Sitting	Good / Fair / Poor
Standing	Good / Fair / Poor

Functional Status/ Activity/ Mobility:

Living Environment:

Home environment

School environment

Access constraints

Recommendation:

Child will benefit from Physiotherapy Intervention Yes / No

Recommended session per week:

Envisaged therapy outcome:

Physiotherapist's Signature:

Date of Assessment (Screening):

Appendix B

PHYSIOTHERAPY DEPARTMENT
Assessment/Re-assessment Forms

Name	D.O.B:	Sex:
Father's name	Mother's name	
Caregiver's name	Contact Numbers	
Address		
Child's Class/ grade		

2. HISTORY

Birth / Developmental History

Social History

Medical / Surgical history

3. LIVING ENVIRONMENT

Home

Lift landing	Stairs to climb	Steps at toilet
Mobility independent	Assisted	Dependent
Walker/ Collator	Buggy/Manual/ Motorised wheelchair	

School/ Class

Lift landing	Stairs to climb	Steps at toilet
Mobility independent	Assisted	Dependent
Walker/ Rollator	Buggy/Manual/ Motorised wheelchair	

4. CHIEF COMPLAINT (S) / CURRENT CONDITION

5. GENERAL HEALTH (Observational)

Build	Nutrition	Drooling
Facial grimace		

6. HIGHER FUNCTION

Sleep	Speech	Memory
Orientation	Hearing	Vision
Perception	Cognition	

7. SYSTEMIC REVIEW

MUSCULOSKELETAL

Atrophy	Hypertrophy

Muscle length/ tightness (specify muscles)

Contracture (specify muscle / joint)

Deformity (specify joint; use special assessment if required)

Range of Motion (specify joint; use special assessment if required)

Upper limbs:

Lower limbs:

Clinical tests

Muscle power (Refer to Manual Muscle Chart)

Upper limbs:

Lower limbs:

NEUROLOGIC

Tone/ Involuntary Movements

Spasticity	Hypotonic	Normal	Rigidity
Athetosis	Dystonia	Chorea	Tremor

Reflexes/ Responses

Gait

Clinical tests

8.AMBULATORY STATUS

Independent / Assisted

Creeping Crawling Bottom shuffling Walking Stair Climbing

Assisted with aides (Orthosis / Stick / Rollators / Wheel-chair, self propelled)

Walking Stair Climbing Indoor Mobility Community Mobility

Dependent

Buggy Carried by caregiver Wheeled by caregiver

9. INDEPENDENT LIVING SKILLS

Transfers	Bed mobility	Toileting	Dressing
Feeding	Money concept	Taking public transport	

10.OTHER TESTS/ SPECIAL TESTS

11. INTERVENTION PLAN

12. PHYSIOTHERAPY GOALS

Short term / Intended therapy outcome

Long term / Intended therapy outcome

Anticipated events that could effect the outcomes

13. DATE OF REVIEW (6 months from assessment)

14.Date of IEP Meeting/ Case conference for this child:

Signature (PT)

Name

Date

Appendix C

External Report Format
Therapy Services

General Information

Name:	Age:	Sex:
D.O.B:	Race:	Client's ID:
Address:		Tel. No:

Referred by:

Reason for referral to Physiotherapy:

History

Developmental / Social/ Medical

Current Concerns (Chief Complains)

Functional Status and Activity Level

Clinical findings

Current Intervention Provided

Therapy Goals/ outcomes achieved since last assessment:

Recommendations

Signature of therapist & date

Appendix D

THERAPY SERVICE
CLIENT/ CAREGIVER SATISFACTION QUESTIONNAIRE

Satisfaction with Physiotherapy/ Occupational Therapy/ Speech Therapy Service

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For each of the following questions, please tick the rating that best expresses your opinion.

1. I am satisfied with the treatment provided/ recommended by therapist.

1 **Strongly Disagree** 非常不同意	**2** **Disagree** 不同意	**3** **Neutral** 没意见	**4** **Agree** 同意	**5** **Strongly Agree** 非常同意

2. Regular therapy as per client's need is provided at scheduled appointment.

1 **Strongly Disagree** 非常不同意	**2** **Disagree** 不同意	**3** **Neutral** 没意见	**4** **Agree** 同意	**5** **Strongly Agree** 非常同意

3. The instructions/ home programme given by the therapist was helpful.

1 **Strongly Disagree** 非常不同意	**2** **Disagree** 不同意	**3** **Neutral** 没意见	**4** **Agree** 同意	**5** **Strongly Agree** 非常同意

4. This service has helped the client to function better.

1 **Strongly Disagree** 非常不同意	**2** **Disagree** 不同意	**3** **Neutral** 没意见	**4** **Agree** 同意	**5** **Strongly Agree** 非常同意

5. The overall quality of therapy service is satisfactory.

1 **Strongly Disagree** 非常不同意	2 **Disagree** 不同意	3 **Neutral** 没意见	4 **Agree** 同意	5 **Strongly Agree** 非常同意

Total Score = __(a)__

Average Total Score = __(a)__ / 5

= _____

Appendix E

THERAPY SERVICES
MONTHLY REPORT DOCUMENT

Agency/Programme: _____

Name: **Designation:** **Month:**

Part 1: Monthly Profile

Monthly Profile	No. Working Days (A)		Annual Leave (B)	Medical Leave (C)	Other Leave (D)	(E)	**No. of Days Worked F = A - (B+C+D+E)**		**Total Working Hours G = (F X 8 hours)**
	Details of Extra Hours Worked						**Extra Hours Worked (I)**	**Time Off (Hours) (H)**	**Total Hours Worked J = (G-H+I)**
	Date								
	Event(s)								
	Hours								

Part 2: Direct Intervention

Individual Intervention Session	Clients receiving Therapy Intervention Sessions										**% of Delivered Individual Sessions**
	Weekly	Fortnightly	Monthly	Consultation (Intervention once in two months or above)	No. of clients In Indv. Session	No of Scheduled Individual Session	Sessions cancelled by parents	Sessions cancelled by therapists	Sessions cancelled due to school/ org activity	No. of delivered session	
Number											
Group Intervention Session	Weekly	Fortnightly	Monthly	Consultation (Intervention once in two months or above)	No. of clients In Group Session	No of Scheduled Group Session	Sessions cancelled by parents	Sessions cancelled by therapists	Sessions cancelled due to school/ org activity	No. of delivered session	**% of Delivered Group Session**
Number											

Intervention Session (Total)	Total No of clients receiving therapy service	Total No. of scheduled Intervention sessions	Total number of delivered intervention session	**% of total Delivered Therapy Session**	Hrs spent on individual therapy intervention	Hrs spent on group therapy intervention	Total Hrs spent on therapy intervention (Individual & Group) (K)	**% of total Delivered Therapy Hours**
Number/Hours								

Assessment/ Review/ Caregiver Training	Initial Assessment	Assessment	Case Review / IEP	Case conference	Caregiver Training/ Supervision of TA/ Functional Training/ Outings	Others	Total Hours on Assessment/ Review/ Caregiver Training (L)	**Total Hours Of Direct Intervention (K +L)**	**% of delivered hours in Direct Intervention**
Number									
Hours									

Details of Caregiver Training/ Supervision of TA/ Functional Training/ Outings conducted

Date	Title / Name of the course / seminar / talk / workshop	Hours

Part 3: Administrative Work

Admin. Work	Documentation and filing of Assessment / Review / ISP	Monthly reports / Status report etc.	Phone calls to parents, clients	Letter to school / hospital / others	Writing Minutes / Vetting Minutes etc.		Supervision Of staff Therapist Therapy aide (Specify the no of staff)	Others	**Total Hours spent on Admin. Work**	**% of time spent in Admin Work**
Number										
Hours										
Meeting(s)	Department	Organisation	Initial Assessment	IEP/ ISP	Projects	Other	**Total No. of Meeting(s)**	**Total Hours Spent on Meeting(s)**		**% of time spent on Meeting(s)**
Number										
Hours										

Part 4: Training and Continuing Education

Training Conducted	Talks/ workshops, In-service Training Conducted						Preparation Time	**Total No. of Training Conducted**	**Total Hrs. of Training Conducted (Inc. preparation time)**
	Therapists	Network Meeting	Others						
Number									
Hours									

Details of Training Conducted	
Date	**Title/ name of the course/ seminar/ talk/ workshop**

Training Attended	Talks/ workshops, In-service Training/ Networks/ Special Interest Groups etc. Attended	**Hours**	**Total No. of Training Attended**	**Total Hrs. of Training Attended**
Date				

Part 5: Projects undertaken [To include Research activities (presentation/publication), creation of Assessment Tools, Care Path, and development of Therapy protocol etc.]

Date	Description of Project	% of Completion	Hours	Total Hours Spent

NOTE: Please do not write in the shaded box

Monthly Report Summary

Indicators for therapist/ therapy department	Number/Hours	% of scheduled tasks
Work -hours spent on Direct Intervention		
Delivered Scheduled Therapy Session		
Time spent on Administrative Work and Meetings		
Man – hours spent on Training		
Therapy Outcome Achieved following 6 monthly review		
Projects completed		
Satisfied Service Recipients		
Compliance to Safety Checks (please report any accidents in the department)		
Total number of clients served during the month		

Explanatory notes to the Monthly Report Document

1 Please mark 'NA' if information requested is not relevant to your work.

2 Part 1 refers to the monthly profile. The most important component is to calculate the total number of hours worked during the month. If it is a common practice to work on one Saturday, please include that in the number of days worked and multiply accordingly. The average working hours for a typical day is eight. Please compute accordingly if you work for eight and half hours a day.

3 Part 2 or Direct Intervention explains the nature of work you do. The first row summarises 'individual intervention' and the second row summarises 'group intervention'. Direct Intervention includes: Individual and group intervention, time spent on initial and detailed assessment, case review/IEP, case conference, caregiver training etc.

Note: *'consultation' is referred to as any intervention with a frequency of either once in two months or more. It is important to have a 'time table' of the clients to be seen for the month and to keep an attendance of the clients seen. This helps in filling the form.*

The calculation of % of delivered session is based on the following:

(Total no. of delivered session / Total no. of scheduled session) X 100%

The calculation of % of delivered therapy hours is based on the following:

(Total hours of delivered therapy intervention/ Total working hours during the month) X 100%

Note: *Please provide details of the parent/caregiver training sessions conducted in the table provided*

4 Part 3 refers to Administrative Work including time spent for documenting assessment/review and items mentioned in monthly report.

5 Part 4 refers to Training and Continuing Education.

6 Part 5 refers to Projects undertaken by the therapist or being an active member in the project team.

***Note**: Projects refer to involvement in research, publication of professional materials, development of therapy resources, formulating practice protocols and assessment tools. 85% of the projects should be therapy-related.*

The following is a quick reference on the Best Practise indicators:

- 80% of the total working hours is spent on direct intervention.
- 90% of the scheduled therapy sessions are delivered.
- Therapy Service achieves 70% of the targeted therapy outcomes at every six-monthly review of individual care plans
- Therapy Service achieves 100% of the targeted project.
- Department achieves 80% satisfaction from the service recipients (clients/caregivers)
- Department staff will spend at least 3% of the work-hours in continuing therapy education and in-service training per year.
- Department has 100% compliance to safety guidelines at any given time.

REFERENCES

1. Carolyn Kisner and Lynn Allen Colby (1996) *Therapeutic Exercise, Foundation and Techniques*: JAYPEE

2. APTA (2001) *Guide to Physical Therapy Practice, Second Edition*

3. NCSS (1998) *Guidelines for Practicing Therapists in VWOs*

4. NCSS (2001) *Standard of Practice for Physiotherapists & Occupational Therapists working with adults with Intellectual disabilities*

5. WHO (2001) *International Classification of Functioning, Disability and Health, FINAL DRAFT*

6. Winnie Dunn (2000) *Best Practice Occupational Therapy, In Community Service with Children and Families*: SLACK

