PHYSIOTHERAPY SERVICES IN THE NORTH EASTERN HEALTH BOARD REGION

BY

SENIOR PHYSIOTHERAPISTS IN THE NORTH EASTERN HEALTH BOARD REGION

1995
This report is concerned with the North Eastern Health Board area and its aspirations of the community to meet these needs in accordance with the WHO developmental model. It presents a structure to show how the Board area and its needs were developed effectively, in line with the aspirations of the community and the WHO development of rehabilitation services. This report identifies that there is a tremendous need to improve the present physiotherapy service in the North Eastern Health Board region. It highlights the deficiencies in the present level of service delivery and identifies the areas that show the greatest deficiency. It discusses the issues that influence the provision of the physiotherapy service ie, environmental and historical. It highlights how the existing service has developed with traditional professional attitudes in mind. It identifies how the present grading structure no longer meets the needs of the population. It suggests that client groups are targeted with respect to their needs and that services be provided accordingly.
This report is concerned with identifying the needs of the population of the North Eastern Health Board area and recommends a comprehensive incremental plan to meet these needs in accordance with Health Board policies and service plans. It was completed in line with the aspirations of the Health Strategy for the 1990’s.

It presents a structure upon which the physiotherapy service can be developed effectively, shows how the service can be delivered uniformly throughout the Health Board area and recommends an incremental plan of how professional staff can meet these needs.

It examines how concern for the patient must transcend from the hospital to the community and highlights the importance of providing a comprehensive service regardless of location. Furthermore, it introduces an appropriate structure of knowledge upon which rehabilitation services are based in the context of the present body of knowledge presented by the WHO (1980) and suggests ways in which this structure can be used in the future development of services.

The principal difficulties encountered were the absence of a standardised method of monitoring and auditing physiotherapy and lack of knowledge of the epidemiological distribution of disease in this country.

This report identifies that there is a tremendous need to improve the present physiotherapy service in the North Eastern Health Board region. It highlights the deficiencies in the present level of service delivery and identifies the areas that show the greatest deficiency. It discusses the issues that influence the provision of the physiotherapy service ie. environmental and historical. It highlights how the existing service has developed with traditional professional attitudes in mind. It identifies how the present grading structure no longer meets the needs of the population. It suggests that client groups are targeted with respect to their needs and that services be provided accordingly.
RECOMMENDATIONS OF THE REPORT

GENERAL RECOMMENDATIONS

* The concept of impairment, disability and handicap be used as a basis for development of outcome measures in physiotherapy.

* Accurate definition of client groups be made available by the Department of Health.

* Regional and national data bases on client groups and their needs are developed.

* That the grading structure be changed to reflect the duties and responsibilities of physiotherapy staff and encourage mobility with regards to promotion.

* The grading structure be altered to allow the development of specialisation.

REGIONAL RECOMMENDATIONS

* A physiotherapy services manager be provided in order to develop and deliver a co-ordinated, equitable and accessible physiotherapy service for a population of 100,000.

* Staffing be targeted at various client groups needs particularly in the area of community care.

* The physiotherapy needs of the client groups be further evaluated by the physiotherapy services manager.

* The physiotherapy service be put in place to meet those needs as identified.

* The physiotherapy service be provided in the location most suitable for the patient/client.

* The Comprehensive programmes be established in the area of primary care to utilise the available skills of the physiotherapist.

** Overall recommendation for the above: Physiotherapy Services Manager to be appointed for the implementation of the above.

* The Physiotherapy and Health Board Managers support and encourage the development of the service so as to improve access and equity for all the client groups and the population of the region as a whole.

* A structured approach to post-graduate education be developed in the North Eastern Health Board Region to facilitate the recruitment and retention of staff.
* Staffing levels be increased in an incremental manner.

* Information Technology should be made available to all physiotherapy services so as to record standardised statistics based on established national standards (both clinical and organisational) to which audit mechanisms can be applied.

* Rehabilitation beds be established in each area and the appropriate level and skill mix of rehabilitation staff be assigned to these beds.

* Adequate support staff including secretarial, portoring and aide staff be made available to the physiotherapy services.

The physiotherapy profession will endeavour to monitor and review services with a view to continual development and change where indicated. The report proposes that appropriate time must be allocated to projects of this kind in the future so that the physiotherapy profession can endeavour to develop and deliver an efficient and quality service.
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INTRODUCTION

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1.4 THE PROFESSIONAL BODY OF PHYSIOTHERAPY
1.5 PRACTICE OF PHYSIOTHERAPY
1.6 AIMS OF THE REPORT
1.1 SUMMARY

Physiotherapy in Ireland has developed over the last ninety years into a recognised and valued part of health care. It has achieved autonomy and through its association the I.S.C.P. maintains both clinical and administrative standards. The I.S.C.P. also liaises with other associations through the World Confederation of Physiotherapists.

Physiotherapy is client focused and aims at the prevention or reduction of impairment, disability and handicap in order to enable the individual lead as independent a life as possible.

1.2 INTRODUCTION

In modern medicine the role of physiotherapy is fast attaining its full potential and recognition. It is becoming increasingly valued as a method of treating a wide variety of diseases in a non-invasive and empowering manner. This is due, in part, to public concern with a more holistic way of achieving a good health status with minimal pharmaceutical intervention.

1.3 A BRIEF HISTORICAL REVIEW OF PHYSIOTHERAPY IN IRELAND

The physiotherapy profession in Ireland dates back to 1905 when the first School of Physiotherapy was founded in Dublin. The first examinations were held in 1908 and a second School of Physiotherapy was opened in Dublin in 1955. In 1983 a four year honours degree course was instituted. The first degrees were awarded in 1986 by both the University of Dublin and the National University of Ireland. Prior to this those who successfully completed the course were awarded diplomas by the universities and were admitted to membership of the Chartered Society of Physiotherapy (London).

In 1983 the Irish Society of Chartered Physiotherapists was founded having previously been a Board of the Chartered Society of Physiotherapy (London).

The Society is a member of the World Confederation for Physical Therapy (W.C.P.T.) and the Standing Liaison Committee of physiotherapists within the European Community (S.L.C.P.).

In February of 1994 the Department of Health recommended to the Department of Education that in accordance with the European Directive of 21st December, 1988 the Irish Society of Chartered Physiotherapists be recognised as the official body for accreditation of physiotherapy courses in Ireland.

The major contribution of accreditation is the assurance of quality education through consultation and evaluation. Continued quality improvement of physiotherapy education is the responsibility of both the educational institutions and members of the profession as a whole.

1.4 THE PROFESSIONAL BODY OF PHYSIOTHERAPY

Chartered Physiotherapists have a well developed professional association with selective entry
and ethical code which places constraint and regulation upon its members. Physiotherapy forms a distinctive culture within the health service. There is knowledge, competency skill base, and undisputed expertise peculiar to the group. There is a well developed clinical and managerial autonomy and an acceptance of the clinical role in society, as indicated by the Professions Supplementary to Medicine Act (G.B.).

The professional body, the Irish Society of Chartered Physiotherapists (I.S.C.P.) has a vital role to play in the setting of standards of practice, development of clinical and managerial skills, industrial relations, education and training and liaison with the World Confederation of Physiotherapists. It is organised in a democratic fashion and has regional branches corresponding to the Health Board areas.

Specific interest groups in clinical management and industrial relations issues also have access to the governing board or council which has a policy and standard making role. The President of the Society is a member of the society and elected by the members of the general body. (See Appendix I for the structure of the Irish Society of Chartered Physiotherapists).

1.5 THE PRACTICE OF PHYSIOTHERAPY

Physiotherapy is a health care profession which primarily adopts a physical approach aimed at the prevention, treatment and alleviation of a wide range of disorders.

The aim of physiotherapy is to promote excellence in the administration of care and constantly to evaluate means and methods of professional practice.

Physiotherapy, as a profession in health care, examines, assesses and plans treatment programmes, monitors and evaluates patient responses, counsels and advises patients and carers. In addition, physiotherapy may provide adaptive devices and mobility aids.

1.6 AIMS OF THE REPORT

The aims of this report are to:

* Examine the current levels of physiotherapy service in the North Eastern Health Board Region
* Identify deficiencies in the service
* Apply a recognised method of calculating staffing needs
* Examine the issues which influence the provision of the physiotherapy service
* Recommend changes where necessary
* Recommend a plan for the incremental growth of the service in accordance with the National Health Strategy and the North Eastern Health Board.
CHAPTER TWO

EMPLOYMENT PATTERNS

2.1 SUMMARY

2.2 NATIONAL EMPLOYMENT PATTERNS

2.3 REGIONAL EMPLOYMENT PATTERNS
2.1 SUMMARY

The present grading structure leaves little scope for promotion within the service. Low staffing levels and, in many cases, poor working environment means that physiotherapists carry unacceptably high case loads. This leaves little opportunity for professional development and staff morale suffers. As a result, skilled and experienced staff are being lost from the public service to private practices and other countries.

2.2 NATIONAL EMPLOYMENT PATTERNS

According to the Irish Society of Chartered Physiotherapists there are approximately 1032 members of the society in Ireland. Those members who are practising are employed in the following areas:

* Health Board Hospitals
* Private/Voluntary Hospitals
* Community Care
* Private Practice
* Research

Physiotherapy services do not, at present, measure well against the criteria of comprehensiveness and equity. It is obvious that there has not been a uniform approach to comprehensive and equitable service planning. As reported in the Commission on Health Funding (September 1989) "service arrangements have developed over time rather than on any planned response to objectively determined needs".

Thus patients with similar needs have access to different levels of service depending largely on the Health Board area in which they live. Table 1 details the distribution of paramedical staff, by whole time equivalents per 100,000 (WTE), employed by the Health Boards in the community and in the hospitals. Of the eight Health Boards the North Eastern Health Board has the third lowest physiotherapy staffing levels (Commission on health funding, 1989).
### TABLE 1

**HEALTH BOARD PHYSIOTHERAPY STAFF, 1987**
(Number per 100,000 population)

<table>
<thead>
<tr>
<th>Region</th>
<th>Physiotherapists</th>
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<tbody>
<tr>
<td>Eastern</td>
<td>2.15</td>
</tr>
<tr>
<td>Midland</td>
<td>8.54</td>
</tr>
<tr>
<td>Mid Western</td>
<td>4.93</td>
</tr>
<tr>
<td>North Eastern</td>
<td>6.36</td>
</tr>
<tr>
<td>North Western</td>
<td>13.91</td>
</tr>
<tr>
<td>South Eastern</td>
<td>7.06</td>
</tr>
<tr>
<td>Southern</td>
<td>7.63</td>
</tr>
<tr>
<td>Western</td>
<td>8.76</td>
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</table>

**Note:** Wholetime equivalents

Ref: Government Publication on Health funding. Health Boards staffing levels only. This does not include Voluntary Services or Private Institutions.
2.3 REGIONAL EMPLOYMENT PATTERNS

In 1988 there were 30.75 physiotherapists working in the North Eastern Health Board area (Table 2).

<table>
<thead>
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<th>PLACE OF EMPLOYMENT</th>
<th>1988</th>
<th>1994</th>
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<tr>
<td>Hospital</td>
<td>16.75</td>
<td>18.25</td>
</tr>
<tr>
<td>Community</td>
<td>3.00</td>
<td>4.40</td>
</tr>
<tr>
<td>Voluntary Hospital</td>
<td>5.00</td>
<td>10.00</td>
</tr>
<tr>
<td>Private Practice</td>
<td>6.00</td>
<td>12.50</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td>30.75</td>
<td>45.15</td>
</tr>
</tbody>
</table>

There has been an increase of 14.40 physiotherapists over a six year period. The areas that show the greatest increase in staffing levels are in the Voluntary Hospitals where the number has increased by 100% to 10 physiotherapists working on a full-time or equivalent basis, and private practice where the number has increased by 100% to 12.5. Escalation of the number of therapists working in both these areas reflects the increased need for the services. There has been an increase of 1.4 physiotherapists in the community and 1.5 in the hospital. This would indicate that services in the hospital and community are markedly underdeveloped.

The present level of employment has created many problems for the development and delivery of the service. These can be outlined as follows:

* **Professional Development**

The existing grading structure does not facilitate the delivery of a quality service. There is a limited opportunity to develop skills in specialist areas, for example, orthopaedics, neurology etc. Due to this there is a loss of skilled physiotherapists to the private sector and to other countries.

* **Case Loads**

Due to the low availability of qualified physiotherapists in respect of the demand for services, waiting lists are long. In an effort to reduce waiting lists staff carry unreasonably high case loads which leaves little time for recording patient information, research, administration, data collection, skill and professional development.
* Secretarial and Support Staff

Due to a lack of secretarial and support staff in many areas, physiotherapists must carry out tasks outside their professional domain which could be delegated to others. The availability of support staff (aides/porters) would allow more time for direct patient intervention.

* Conditions of Employment

There have been problems in the area of staff retention. To encourage physiotherapists to remain in the workplace, flexibility in working hours should be encouraged, for example part-time or job-sharing. Staff, availing of part-time/job-sharing/flexi-time should retain their clinical specialty and job status.

* Lack of Appropriate Facilities for Service Delivery

This can be sub-divided under two headings:-

a. Hospital Programme

Facilities vary considerably within the region. Problems needing attention include:-

* Lack of treatment space within acute hospitals (especially in Monaghan General and Louth General Hospitals)

* Poor location of the physiotherapy department in Our Lady’s Hospital, Navan

* Poor staff facilities (changing room, tea room, toilet and showers)

* Poor administrative facilities

* The age and type of equipment is a problem throughout the area with possible safety implications for both physiotherapists and patients. An incremental replacement plan will improve safety standards and combined purchasing of capital equipment by all areas may lead to a more favourable negotiated price.
b. **Community Programme**

In the community local health centres, in many instances, provide poor facilities. With the need for development, these should be reviewed. Problems identified include:-

* Poor administration facilities
* Lack of separate storage space close to offices and therapy rooms
* Lack of separate treatment and office facilities in some cases
* Over crowding of existing office space
* Poor staff facilities
CHAPTER THREE

ROLE OF THE PHYSIOTHERAPIST

3.1 SUMMARY

3.2 DEFINITION

3.3 REFERRAL FOR PHYSIOTHERAPY

3.4 TREATMENT AND ASSESSMENT

3.5 HEALTH PROMOTION

3.6 EDUCATION AND TRAINING

3.7 MANAGEMENT

3.8 RESEARCH

3.9 PROFESSIONAL DEVELOPMENT
3.1 SUMMARY

The physiotherapist has a broad and varied role in the assessment and treatment of patients. Referrals are received from a variety of practitioners. Treatment is both hospital and community based in a number of locations. The role of education and training is important for both undergraduate and post-graduate therapists and this is of particular benefit to allied professionals, patients and their carers.

Areas of the physiotherapist’s work in need of development are health promotion, management skills, research and professional development policies.

3.2 DEFINITION

The role of the physiotherapist is broad and includes clinical assessment and treatment, health promotion, education and training, management, research and professional development (Appendix II). The physiotherapist respects, at all times, the rights and dignity of each individual.

Clinical physiotherapy skills involve accurate assessment and problem solving abilities combined with the implementation of an effective treatment based on that assessment. Treatment plan based on that assessment includes advice on self-help, manual techniques, exercise programmes and electrical modalities (Appendix III). The physiotherapist has an obligation to regularly update these skills through course attendances, review of journals and networking.

Health promotion is an increasingly important aspect of the physiotherapist’s role and involves education of the public and early detection and intervention to prevent ill-health.

Management skills are vital to all clinicians and, in particular, to those in senior and in-charge positions (Chapter 8). The clinicians have an obligation to manage their time and clinical skills to ensure that the public receive the maximum benefit. Those in senior positions have obligations to maintain efficient work practices and develop professional and organisational skills and in co-operation with the relevant employing and professional bodies.

The science of physiotherapy is being developed constantly by research into clinical modalities and service organisation. Research may range from departmental audits to major clinical trials. Information is networked within the profession via journals and newsletters and the Irish Society of Chartered Physiotherapists.

3.3 REFERRAL FOR PHYSIOTHERAPY

3.3.1 Community Physiotherapy

The community physiotherapist receives referrals from the following sources:

* Director of Community Care and Area Medical Officers
Public Health and Special Nursing Services
* Consultant Hospital Doctors and General Practitioners
* Physiotherapists external to the service
* Other Allied Health Professionals
* Self referrals

Referred patients are prioritised and assessed when the Community Physiotherapist is next in that area. Generally this is within two weeks with the exception of urgent respiratory referrals which are seen within a few working days.

3.3.2 Hospital Inpatient Physiotherapy

Referrals are accepted from the following:-
* Consultant staff
* Non-consultant Hospital Doctors

Referred patients are seen within twenty four hours between Monday and Friday and urgent new referrals are seen at the weekend. Non-urgent referrals are seen on the following Monday.

3.3.3 Hospital Outpatient Physiotherapy

Referrals for physiotherapy are accepted from the following:-
* Doctors - GPs, Consultants and Area Medical Officers
* Physiotherapists external to the service
* Dentists

Time spent on waiting lists varies depending on the workforce available and the urgency of the referral. Those deemed urgent are accommodated as early as possible. More chronic cases may wait up to 12 weeks.

3.4 TREATMENT AND ASSESSMENT

On initial assessment a full examination is made of the presenting injury or condition. The past and present case histories are recorded together with the information from the referring professional. Subjective and objective assessments are performed. A clinical diagnosis is made from the information collected from assessment procedures and is used for planning therapy objectives and measuring progress. There are three district locations where physiotherapists work at present i.e. community, inpatients and outpatients.
3.4.1 Community Physiotherapy

The physiotherapist’s assessment will determine type, intensity and duration of treatment. For example, some referrals may require advice and education. These patients may be discharged following two visits. However, patients with neurological disabilities may never be discharged from the service. They may require intensive input in terms of handling and overall management from the physiotherapist.

Treatments are carried out in the patient’s homes, in health centres, day care or long-stay units or in the county clinics. School visits may also take place. Involvement in case conferences, both at local level and in specialised centres, is an important aspect of the physiotherapist’s role in the treatment of the chronically ill.

Initial reports are sent to the referees and, in some instances, to the Director of Community Care. These include assessment, long and short term goals and treatment plan. Follow up reports are provided on discharge, during a period of change or when equipment is being recommended.

3.4.2 Hospital Inpatient Physiotherapy

After assessment a treatment plan is devised and implemented. Due to the acute nature of the illness communication with the medical and nursing staff is vital. Appropriate physiotherapy can be instrumental in the early discharge of patients from the hospital. A comprehensive discharge plan can reduce the incidence of readmission and physiotherapists should be involved in this process from an early stage. This may include referral to outpatient or community physiotherapy where rehabilitation may be continued.

3.4.3 Hospital Outpatient Physiotherapy

Following the diagnosis, a programme of therapy is decided on in consultation with the patient. Specific goals are set out and agreed. Depending on the requirements one or more treatment modalities are used. The type, duration and intensity of the therapy will depend on the needs of a given patient at a given time. Regular re-assessment of the patient is carried out so that the progress made and the efficiency of the intervention used is noted and changed if necessary. Treatment may be on a one to one basis or may progress to group therapy e.g. back class, ante-natal or post-natal classes. On completion of treatment, the patient is referred back to their doctor together with a report of the treatments used and the progress made.

3.5 HEALTH PROMOTION

Health promotion is an increasingly important aspect of physiotherapy and involves education of the public and early detection and intervention to prevent ill health (Thow et al, 1990). Due to the workload in secondary and tertiary care, not enough emphasis has been put on the physiotherapist’s role in primary care. It is important to develop this role as the long-term benefits of such a service are widely recognised. Areas needing attention include back care and lifting, active elderly groups and exercise promotion.
3.6 EDUCATION AND TRAINING

In many cases an integral part of the physiotherapist's role is the training and education of peers, allied professionals, patients and their carers and undergraduate therapists.

The sharing of knowledge and skills with other professions is crucial to the development of an integrated team approach to patient care. Physiotherapists are often requested to talk to nursing and medical staff on their particular areas of expertise, for example, back care, musculo-skeletal assessment and the prevention and treatment of sports injuries.

In an effort to improve patient health and quality of life it is essential to educate them and their carers regarding disease process and associated disabilities. This fosters independence and encourages them to share a responsibility for their own health status. This is as true for the elite athlete wishing to return to competition as for the severely handicapped person.

Supervision of undergraduate physiotherapists on clinical placement is an important feature of the experienced practitioner's work. In this role the therapists act as teacher, demonstrator and assessor. This process assists both the student and the qualified therapist as it encourages good clinical practice.

3.7 MANAGEMENT

Physiotherapy managers are responsible for ensuring the optimum use of limited manpower and all other resources. They act as catalysts to initiate and develop new fields of service and widen service provision. Management skills are vital to all clinicians and particular attention should be given to the training of those in senior and in-charge positions. All therapists have an obligation to manage their time and clinical skill to ensure the public receive the maximum benefit.

3.8 RESEARCH

Research is the least developed aspect of the professionalisation of physiotherapy. Physiotherapy managers have a key role to play in promotion and encouraging clinical research and the evaluation of practice. Research may involve major clinical trials or simple departmental audits. Information is networked within the profession via journals and newsletters and the Irish Society of Chartered Physiotherapists.

3.9 PROFESSIONAL DEVELOPMENT

Staff need the appropriate educational programmes to maintain and augment their knowledge and skills. Standards are being set to cover all aspects of development, education and training. This includes the induction process, continuing education programmes, the policy regarding external education and links with national clinical interest groups.
CHAPTER FOUR

CLASSIFICATION OF CLIENT GROUPS

4.1 SUMMARY
4.2 INTRODUCTION
4.3 PRIMARY PREVENTION
4.4 SECONDARY PREVENTION
4.5 TERTIARY PREVENTION
4.6 CLIENT GROUPS
4.1 SUMMARY

The medical model, as expressed in the International Classification of Disease (I.C.D.) 1980, provides a limited concept of disease as it confines itself to the outcome of 'cured or died'. This does not include the many other International Classification of Impairment, Disability and Handicap (I.C.I.D.H.) 1980, outcomes of illness which fall between these two categories. However, the W.H.O. (1980) adequately describes a model on which the practice of physiotherapy can be based.

4.2 INTRODUCTION

This chapter outlines the concepts of primary, secondary and tertiary prevention and details the client groups with which the physiotherapist is concerned.

Before attempting to describe the client groups of the physiotherapy profession, it is necessary to examine the present model of service delivery and to evaluate to what extent physiotherapy is encompassed in this model. The medical model of illness in which physiotherapy and all medical teaching has been based is generally considered to be limited to the identification of the characteristics of disease. The kernel of the situation is represented by the concept of disease which may be depicted as a sequence:

Etiology ----> Pathology ----> Manifestations (International Classification of Disease, 1980)

It is based on the concept that when something abnormal occurs within an individual, a chain of causal circumstances, the etiology, gives rise to changes in the structure of the functioning of the body, the pathology, and when these make themselves evident they are described as manifestations or signs and symptoms.

This model is adequate to describe acute illness because the ultimate outcome is that the patient is either cured or dies. Improvements in health care in the last century have resulted in the survival of many who would previously have died. In Ireland, in the period 1968 - 1972, 224 people died as a result of stroke. This figure dropped to 123 in the period 1988 - 1992 (Department of Health, 1994). This has increased the prevalence of people who are disabled and who have to live with permanent signs and symptoms. For example, in the stroke patient it is impossible to provide a complete cure. Instead, caring rather than curing, becomes the main concern of those dealing with these patients and attempts are made to alleviate the impact of the signs and symptoms. This area requires a different problem solving approach to clinical practice (Granger, 1984). The field of rehabilitation concerns itself with disablement and identification of signs and symptoms. The scope of the medical model fails to include the consequences of disease and subsequently fails to identify appropriate outcome goals for rehabilitation.

In order to encapsulate the scope of rehabilitation the World Health Organisation addressed this problem in 1980 and developed appropriate outcome goals for rehabilitation. The International Classification of Impairment, Disability and Handicap (I.C.I.D.H., 1980), a
supplement to the International Classification to Disease (I.C.D.) was developed and is used as a model within which the client group domains are addressed. In this the consequences of disease are divided into three categories and are depicted as a sequence.

**Disease----> Impairment----> Disability---->Handicap (I.C.I.D.H., 1980)**

* **Impairment** is defined as the direct physiological consequences of a disease or disorder.

* **Disability** is any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.

* **Handicap** is a disadvantage for an individual resulting from an impairment or disability that limits or prevents the fulfilment of a role that is normal (depending on age, sex, social and cultural factors) for that individual.

In the context of disease the approach to rehabilitation can be depicted as a sequence:

**Primary Prevention---->Secondary Prevention---->Tertiary Prevention**

OR

**Reduction of Impairment---->Reduction of Disability---->Reduction of Handicap**

The essence of physiotherapy is to prevent or alleviate the consequences of disease i.e. ultimately to prevent or reduce the level to which an impairment or disability is expressed as a handicap. Often the level of handicap can be markedly reduced without making any impact directly at the level of impairment. Therefore, it is suggested that in order to reduce the level to which disease is expressed as handicap, health care resources could be more focused in the area of primary prevention. Further research is necessary to evaluate the domains in which health care resources are most effective. This can be done by the use of valid scales and measurements kept by rehabilitation professionals.

**4.3 PRIMARY PREVENTION**

Primary prevention in relation to disease aims to prevent or reduce impairment. The physiotherapist’s involvement in this domain is in the areas of education, research and preventative programmes.

In the area of primary and preventative care the physiotherapist’s involvement can be listed as follows:

* Backcare and lifting advice
* Incontinence advice
* Ante-natal classes
* Post-natal classes
* Relaxation and Stress Management
* Training of other Health Professionals
* Sports Injury Prevention
* Pre-operative Chest Physiotherapy
* Active Elderly Groups
* Training of Carers
* Lifestyle Programmes
* Child Development awareness
* Exercise Promotion

4.4 SECONDARY PREVENTION

Secondary prevention aims to prevent or reduce disability. At this level early rehabilitation is seen as a priority. The physiotherapist is involved in the following areas:

* Acute Neurology
* Orthopaedics
* Mobility Training
* Intensive Care
* Special Care
* Medical Chests
* Surgical Chests
* Burns
* Acute Trauma
Cardiac Rehabilitation
* Fractures
* Arthroplasty
* Orthopaedics
* Soft Tissue Injuries
* Trauma
* Congenital Abnormalities
* Rheumatology
* Neurology
* Respiratory Physiotherapy
* Gynaecology
* Dermatology

4.5 TERTIARY PREVENTION

Tertiary prevention aims to prevent or reduce the incidence of handicap. The physiotherapist works as part of a multi-disciplinary group to :-

* Integrate the disabled into ordinary life
* Improve the physical ability to access buildings and encourage problem solving techniques
* Change attitudes towards disability and impairment
* Help the disabled function in their environment

4.6 CLIENT GROUPS

The physiotherapist treats a wide range of people whether he/she is employed in hospital, community or private practice. The physiotherapist’s involvement in these areas is based on a multidisciplinary approach. The client groups can be categorised as follows :-
### 4.6.1 Elderly

- Stroke
- Alzheimers Disease
- Respiratory Disease
- Parkinsons Disease
- Orthopaedic Conditions
- Non-specific immobility problems
- Arthritis
- Other

### 4.6.2 Physical Handicap - Children

- Cerebral Palsy
- Spina Bifida
- Muscular Dystrophy
- Developmental Delay
- Orthopaedics
- Cystic Fibrosis
- Visually Impaired
- Other

### 4.6.3 Physical Handicap - Adults

- Multiple Sclerosis
- Head Injury
- Para-tetraplegia
- Stroke
* Orthopaedic
* Arthritis
* Other

4.6.4 Mental Handicap
- Downs Syndrome
- Congenital Abnormality
- Developmental Delay

4.6.5 Psychiatric
- Psychogeriatrics
- Anxiety
- Stress
- Any physical ailment
CHAPTER FIVE

METHODS USED IN THE ANALYSIS OF PHYSIOTHERAPY NEEDS OF THE NORTH EASTERN HEALTH BOARD REGION

5.1 INTRODUCTION

5.2 STATISTICAL ANALYSIS OF HOSPITAL PHYSIOTHERAPY RECORDS

5.3 STATISTICAL ANALYSIS OF COMMUNITY PHYSIOTHERAPY RECORDS

5.4 ANALYSIS OF INPUT TO PHYSIOTHERAPY CLIENT GROUPS

5.5 CALCULATION OF OPTIMUM PHYSIOTHERAPY STAFFING NEEDS

5.6 INFORMATION OBTAINED FROM GPS AND OTHER HEALTH PROFESSIONALS

5.7 INFORMATION OBTAINED FROM HEALTH BOARD MANAGERS

5.8 QUESTIONNAIRE
5.1 INTRODUCTION

This chapter outlines the methods used to measure existing services and determine the physiotherapy needs of the N.E.H.B. Region.

Additional and supportive information was gained by doing an extensive literature review.

5.2 STATISTICAL ANALYSIS OF HOSPITAL PHYSIOTHERAPY RECORDS

Within the last year all departments in the North Eastern Health Board Region were encouraged to keep records in a similar manner. The following characteristics were examined:

a) Number of referrals
b) Number of patients treated
c) Number of visits
d) Sex
e) Age
f) Distance travelled by patients for treatment
g) Diagnosis - (I.C.D. coded)
h) Source of referral
i) GMS holders

5.3 STATISTICAL ANALYSIS OF COMMUNITY PHYSIOTHERAPY RECORDS

A statistical method of recording patient data was developed by the community physiotherapists in the North Eastern Health Board Region. The following information was collected:

a) Number of referrals
b) Number of patients treated
c) Number of treatments
d) Sex
e) Age
f) Treatment venue
g) Diagnosis
h) Source of referral
i) Numbers discharged

Statistical analysis of community records was carried out by review of charts and by using the distribution of disease.

5.4 ANALYSIS OF INPUT TO PHYSIOTHERAPY CLIENT GROUPS

A detailed study was made by each senior of the input in terms of Whole Time Equivalent per client group e.g. Child Physical Handicap in Community, Orthopaedic Inpatient etc. This provides a detailed description of existing and non-existing services in the region and how input varies in different hospitals and community care areas.
5.5 CALCULATION OF OPTIMUM PHYSIOTHERAPY STAFFING NEEDS

The method used in the calculation of physiotherapy staffing levels was one which was developed in the U.K. by Vallow et al in 1980. It has been used extensively throughout Britain and Ireland and has been adopted by the Irish Society of Chartered Physiotherapists in Management as an acceptable guideline for calculating staffing levels. The approach is based on defining workloads in a clinical profession, the calculation of "patient input hours", calculation of "on duty hours" per Whole Time Equivalent (WTE), the frequency of treatment and the total workload implications of a referral.

5.6 INFORMATION OBTAINED FROM G.P.S AND OTHER HEALTH PROFESSIONALS

Information was obtained from GPs, Directors of Community Care, Public Health Nurses, Occupational Therapists and Speech and Language Therapists. A meeting with the GP representatives was held to identify current problems and share ideas on future quality physiotherapy care.

5.7 INFORMATION OBTAINED FROM HEALTH BOARD MANAGERS

A number of meetings, both formal and informal, were held with members of the Health Board and Hospital Management team.

5.8 QUESTIONNAIRE

A questionnaire was sent to third and fourth year U.C.D. and T.C.D. physiotherapy students (Table 3). They were asked to identify what specialities they would like to work in and what conditions of employment they considered to be important to them. The following method was used to collect information :-

* 80 questionnaires were sent to U.C.D & T.C.D. Schools of Physiotherapy.

Question 1 asked "What attracts you to work for a district?" This question included broader issues like rotation scheme, secretarial back-ups etc. The respondent was given 14 choices and asked to list in order of preference 1 - 14 (1 was the highest preference and 14 the lowest).

Question 2 was aimed more specifically at work aspects of the physiotherapy profession "What specialities interest you most?" The respondent was given 10 choices and asked to list them in order of preference (1 was the highest and 10 was the lowest).

The objective of the questionnaire was to decide what a newly qualified physiotherapist looked for in a job, so as to aid future recruitment in the North Eastern Health Board Region.
| TABLE 3 QUESTIONNAIRE  
<table>
<thead>
<tr>
<th>QUESTION 1</th>
<th>WHAT ATTRACTS YOU TO WORK FOR A DISTRICT?</th>
<th>Please answer in order of preference 1, 2, 3, etc.</th>
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<tbody>
<tr>
<td>Rotation Scheme</td>
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<tr>
<td>Varied Caseload</td>
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<td>Good Support System</td>
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<td>Opportunity to Specialise</td>
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<td>Team Spirit</td>
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<td>Good Facilities</td>
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<td>Attractive Location</td>
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<td>Good Promotion Prospects</td>
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<tr>
<td>Secretarial Backup</td>
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<td>Reputation</td>
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<td></td>
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<tr>
<td>Accommodation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good Social Life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHAT SPECIALTIES INTEREST YOU MOST?</td>
<td>Please answer in order of preference 1, 2, 3, etc.</td>
<td></td>
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<td>Orthopaedics - Inpatient</td>
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<tr>
<td>Orthopaedics - Outpatient</td>
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<td>Geriatrics</td>
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<tr>
<td>Gynaecology</td>
<td></td>
<td></td>
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<tr>
<td>Sports Injuries</td>
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</table>
CHAPTER SIX

ANALYSIS OF THE PHYSIOTHERAPY NEEDS OF THE N.E.H.B. REGION

6.1 SUMMARY
6.2 INTRODUCTION
6.3 STATISTICAL ANALYSIS OF HOSPITAL RECORDS
6.4 STATISTICAL ANALYSIS OF COMMUNITY RECORDS
6.5 PRESENT LEVELS OF PHYSIOTHERAPY SERVICE
6.6 CALCULATION OF PHYSIOTHERAPY STAFFING NEEDS
6.7 COMPARISONS OF PRESENT LEVELS WITH OPTIMUM STAFFING LEVELS
6.8 INFORMATION OBTAINED FROM G.P.S AND OTHER HEALTH PROFESSIONALS
6.9 INFORMATION OBTAINED FROM HEALTH BOARD MANAGERS
6.10 RESULTS OF QUESTIONNAIRE
6.11 DISCUSSION
6.1 SUMMARY

Figures expressed in Table 14 reflect the fact that it is impossible to provide a comprehensive, quality and effective service to the North Eastern Health Board population with present staffing levels. Prioritisation is necessary and ethically difficult and at present favours acute in-patients. Waiting lists are inevitable in out-patient departments. Services for geriatrics, mental and physical handicap are totally under-developed in all countries. In all areas of the Health Board there are client groups who do not receive any physiotherapy service whatsoever. For example, there is no community physiotherapy service whatsoever in Co. Monaghan. This is partly due to the historical development of the profession in the region.

6.2 INTRODUCTION

This chapter presents the results of the study and the present physiotherapy services. It outlines the delivery of service to a range of client groups and identifies the shortfalls.

6.3 STATISTICAL ANALYSIS OF HOSPITAL RECORDS

The method used for the collection of data continues to be refined so as to create information. However, for this report it was found that the method is not yet standardised. Information collated was deemed not to be scientific and therefore was not included in the report.

6.4 STATISTICAL ANALYSIS OF COMMUNITY RECORDS

The method used for the collection of data continues to be refined so as to create uniformity. As in the case of hospital data collection, the method is not yet standardised and therefore the information was not included in the report.

6.5 PRESENT LEVELS OF PHYSIOTHERAPY SERVICE

6.5.1 Primary & Preventative Care

A total of 2.46 wholetime equivalents are involved in primary and preventative work (Table 4 and Appendix IV). The majority of this input is in Louth with Our Lady of Lourdes and Louth County Hospital devoting 1.6 wholetime equivalents to this area and community services providing 0.2 wholetime equivalents.

Back care and manual handling, incontinence advice, ante-post-natal and pre-operative chest physiotherapy are carried out in the hospitals. Child development awareness and referrals from developmental clinics are managed in Counties Louth and Meath by community services.

Back care and manual handling are not covered in Our Lady’s Hospital, Navan and input to ante-natal classes only occurs in Monaghan. Post-natal classes are absent in Co. Meath.

6.5.2 Elderly

3.55 wholetime equivalents provide a service to the elderly in the North Eastern Health Board area (Table 5 and Appendix IV).
Continuing care in Dundalk and Trim receive 1.7 wholetime equivalents. Part of the 1.1 wholetime equivalent in Cavan covers continuing care beds also. Other general hospitals provide services as part of the general cover.

Community care physiotherapy for the elderly is sparse at 0.5 wholetime equivalents. It is absent in Cavan and Monaghan.

6.5.3 Physical Handicap

Child physical handicap is covered in the community in Louth and Meath with 0.6 and 0.7 wholetime equivalents respectively (Table 6 and Appendix IV). Cavan, Monaghan and Our Lady of Lourdes cover this group in outpatients with a total of 0.48 wholetime equivalents. Adult physical handicap have a community service in Co. Louth only, while out-patients provide a total of 0.43 wholetime equivalents in the general hospitals with the exception of Our Lady’s Hospital, Navan. Cover for inpatient physically handicapped adults is minimal at 0.09 wholetime equivalents in the region.

6.5.4 Mental Handicap

There is no service for those with mental handicap in Monaghan (Table 7 and Appendix IV). Co. Cavan has a minimal service at 0.1 wholetime equivalents in Cootehill. Community physiotherapy services are provided in Louth and Meath with 0.25 wholetime equivalents and 0.6 wholetime equivalents respectively. Voluntary services in Drumcar provide the only service to adults with mental handicap in the region.

6.5.5 Psychiatric Patients

Physiotherapy input for psychiatric patients is almost non existent and only occurs in Monaghan with 0.2 wholetime equivalent input (Table 8 and Appendix IV).

6.5.6 Acute Hospital

* The physiotherapy input of 42% of optimum vallow levels in the orthopaedic area in Our Lady’s Hospital, Navan is very low considering this is the orthopaedic centre for the region. Levels of input in Gynae/Obstetrics and Paediatrics reflect the low priority given to these areas (Table 9B and Appendix IV). It also reflects the low level of development in the area of primary care.
### TABLE 4 WTE PHYSIOTHERAPY INPUT FOR PRIMARY & PREVENTATIVE CARE (1994)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Our Lady's Hospital, Navan</td>
<td>0</td>
<td>0.1</td>
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<td>0.3</td>
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</tr>
<tr>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>TOTAL WTE/CLIENT GROUP</td>
<td>0.50</td>
<td>0.57</td>
<td>0.03</td>
<td>0.53</td>
<td>0.63</td>
<td>0.10</td>
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</tr>
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TABLE 5 WTE PHYSIOTHERAPY INPUT FOR THE ELDERLY (1994)

<table>
<thead>
<tr>
<th>Location</th>
<th>Elderly * Inpatient</th>
<th>Elderly Outpatient</th>
<th>Elderly Community</th>
<th>TOTAL WTE/ELDERLY</th>
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<tr>
<td>St. Olivers Hospital, Dundalk</td>
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<td>0.4</td>
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<td>Our Lady of Lourdes Hospital, Drogheda</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cavan General Hospital</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Community Monaghan</td>
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<tr>
<td>TOTAL WTE/LOCATION</td>
<td>2.05</td>
<td>1.2</td>
<td>0.50</td>
<td>3.75</td>
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</table>

* The figures listed under "Elderly inpatient" include patients in continuing care and respite care. Patients over 65 presenting with Neurological, Medical or Orthopaedic conditions are included in Table 9 under their headings.
<table>
<thead>
<tr>
<th>WTE PHYSIOTHERAPY INPUT FOR CHILDREN AND ADULTS WITH A PHYSICAL HANDICAP (1994)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOCATION</strong></td>
</tr>
<tr>
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</tr>
<tr>
<td>Our Lady's Hospital, Navan</td>
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<tr>
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<td>Cavan General Hospital</td>
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<td>Louth General Hospital</td>
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<td>Community Louth</td>
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<td>Community Meath</td>
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<td>Community Cavan</td>
</tr>
<tr>
<td>Community Monaghan</td>
</tr>
<tr>
<td>TOTAL WTE/LOCATION</td>
</tr>
</tbody>
</table>
TABLE 9 WTE PHYSIOTHERAPY INPUT IN THE ACUTE HOSPITALS (1994)

<table>
<thead>
<tr>
<th></th>
<th>Chest &amp; Neurological/Medical</th>
<th>Surgical</th>
<th>Inpatient/Orthopaedics</th>
<th>Gynae/Obstetrics</th>
<th>Paediatrics</th>
<th>Outpatient Orthopaedics/Musculo-Skeletal</th>
<th>TOTAL WTE/ACUTE HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our Lady’s Hospital, Navan</strong></td>
<td>0.9</td>
<td>0.7</td>
<td>1.3</td>
<td>N/A</td>
<td>0</td>
<td>1.8</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Our Lady of Lourdes Hospital, Drogheda</strong></td>
<td>1</td>
<td>0.7</td>
<td>0.7</td>
<td>0.4</td>
<td>0.6</td>
<td>4.02</td>
<td>7.42</td>
</tr>
<tr>
<td><strong>Cavan General Hospital</strong></td>
<td>0.7</td>
<td>0.3</td>
<td>0</td>
<td>0.14</td>
<td>0.2</td>
<td>1.5</td>
<td>2.84</td>
</tr>
<tr>
<td><strong>Louth General Hospital</strong></td>
<td>0.8</td>
<td>0.5</td>
<td>0.15</td>
<td>0.1</td>
<td>0</td>
<td>1.55</td>
<td>3.10</td>
</tr>
<tr>
<td><strong>Monaghan General Hospital</strong></td>
<td>0.67</td>
<td>0.4</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>1.25</td>
<td>2.62</td>
</tr>
<tr>
<td><strong>TOTAL WTE/LOCATION</strong></td>
<td>4.07</td>
<td>2.6</td>
<td>2.25</td>
<td>0.74</td>
<td>0.9</td>
<td>10.12</td>
<td>20.68</td>
</tr>
</tbody>
</table>
TABLE 9B WTE PHYSIOTHERAPY INPUT IN THE ACUTE HOSPITALS EXPRESSED AS A % OF OPTIMUM STAFFING LEVELS (VALLOW)

<table>
<thead>
<tr>
<th></th>
<th>Chest &amp; Neurological/Medical</th>
<th>Surgical</th>
<th>Inpatient/ Orthopaedics 1:15 High 1:30 Routine</th>
<th>Gynae/Obstetrics 1:60</th>
<th>Paediatrics 1:15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Lady's Hospital, Navan</td>
<td>58.8 %</td>
<td>74 %</td>
<td>42 % *</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Our Lady of Lourdes Hospital, Drogheda</td>
<td>62.5 %</td>
<td>55.5 %</td>
<td>54.2 % *</td>
<td>26 %</td>
<td>12.9 %</td>
</tr>
<tr>
<td>Cavan General Hospital</td>
<td>40.4 %</td>
<td>79 %</td>
<td>N/A</td>
<td>21.5 %</td>
<td>17.6 %</td>
</tr>
<tr>
<td>Louth General Hospital</td>
<td>40 %</td>
<td>53.5 %</td>
<td>N/A</td>
<td>27.2 %</td>
<td>N/A</td>
</tr>
<tr>
<td>Monaghan General Hospital</td>
<td>39.4 %</td>
<td>58.8 %</td>
<td>N/A</td>
<td>23 %</td>
<td>8 %</td>
</tr>
</tbody>
</table>

* Based on a mixture of trauma and routine orthopaedic beds
6.6 CALCULATION OF PHYSIOTHERAPY STAFFING NEEDS

The following section gives the existing and optimum staffing levels for the service. The existing levels have been based on historical factors and show an obvious shortfall. The optimum staffing levels have been calculated by the use of the method developed by Vallow et al, 1980.

<table>
<thead>
<tr>
<th>UNIT</th>
<th>EXISTING LEVELS</th>
<th>OPTIMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth County Hospital</td>
<td>4.00</td>
<td>8.64</td>
</tr>
<tr>
<td>Our Lady of Lourdes Hospital</td>
<td>9.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Cottage Hospital</td>
<td>0.50</td>
<td>1.50</td>
</tr>
<tr>
<td>St Oliver Plunkett Hospital</td>
<td>1.00</td>
<td>1.80</td>
</tr>
<tr>
<td>St Brigid’s and Ladywell</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Drumcar Services</td>
<td>1.00</td>
<td>10.45</td>
</tr>
<tr>
<td>Community Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>0.80</td>
<td>6.15</td>
</tr>
<tr>
<td>Paediatric</td>
<td>1.20</td>
<td>3.60</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>17.50</td>
<td>55.35</td>
</tr>
</tbody>
</table>

Table 10 outlines the present staffing levels and the optimum staffing levels using the criteria described by Vallow et al for County Louth. Health Board and Voluntary hospitals have approximately one third of the recommended staffing levels. The shortfall is particularly evident in the areas of mental handicap and community services for physical handicap and geriatrics. Staffing in the hospital services is 42.41% of recommended staffing levels (Table 14).
Table 11 outlines the existing and the optimum staffing levels using the criteria described by Vallow et al for County Meath. Present staffing levels are approximately one quarter of the recommended Vallow level. Staffing in the general hospitals is 34% of the recommended level (Table 14). Community services for mental handicap, physical handicap and geriatrics are 11.3% of the recommended level (Table 14).

<table>
<thead>
<tr>
<th>UNIT</th>
<th>EXISTING LEVELS</th>
<th>OPTIMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Lady's Hospital, Navan</td>
<td>5.00</td>
<td>14.50</td>
</tr>
<tr>
<td>Geriatric Continuing Care</td>
<td>0.3</td>
<td>2.00</td>
</tr>
<tr>
<td>Respite/Rehab</td>
<td>0.25</td>
<td>1.00</td>
</tr>
<tr>
<td>Special Care Unit + Adult Unit</td>
<td>0.65</td>
<td>2.00</td>
</tr>
<tr>
<td>Sheltered Workshop and Meath Unit</td>
<td>0.00</td>
<td>0.35</td>
</tr>
<tr>
<td>Geriatric Day Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>Paediatric</td>
<td>0.00</td>
<td>5.00</td>
</tr>
<tr>
<td></td>
<td>1.00</td>
<td>6.00</td>
</tr>
<tr>
<td><strong>TOTAL:-</strong></td>
<td><strong>7.40</strong></td>
<td><strong>27.85</strong></td>
</tr>
</tbody>
</table>

<p>|</p>
<table>
<thead>
<tr>
<th>UNIT</th>
<th>EXISTING LEVELS</th>
<th>OPTIMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavan General Hospital</td>
<td>4.00</td>
<td>10.50</td>
</tr>
<tr>
<td>Geriatric Longstay</td>
<td>0.50</td>
<td>2.00</td>
</tr>
<tr>
<td>Respite/Rehab</td>
<td>0.00</td>
<td>0.65</td>
</tr>
<tr>
<td>Day Care</td>
<td>0.00</td>
<td>0.25</td>
</tr>
<tr>
<td>Holy Family School, Cootehill</td>
<td>0.30</td>
<td>3.10</td>
</tr>
<tr>
<td>Community Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>0.50</td>
<td>2.00</td>
</tr>
<tr>
<td>Paediatric</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5.30</td>
<td>20.50</td>
</tr>
</tbody>
</table>

Table 12 outlines the existing and the optimum staffing levels using the criteria described by Vallow for County Cavan. Staffing levels in Cavan are approximately one quarter of the recommended Vallow level. Staffing in the General Hospital is 38.1% of the recommended level (Table 14). Community services for mental handicap, physical handicap and geriatrics are 13% of the recommended level (Table 14).
TABLE 13

OPTIMUM STAFFING LEVELS FOR COUNTY MONAGHAN

<table>
<thead>
<tr>
<th>UNIT</th>
<th>EXISTING LEVELS</th>
<th>OPTIMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monaghan General Hospital</td>
<td>2.80</td>
<td>8.50</td>
</tr>
<tr>
<td>St. Davnet's Psychiatric Hospital</td>
<td>0.20</td>
<td>1.60</td>
</tr>
<tr>
<td>St. Mary's Hospital, Castleblaney</td>
<td>0.00</td>
<td>2.10</td>
</tr>
<tr>
<td>Other Long Stay Geriatric</td>
<td>0.00</td>
<td>0.80</td>
</tr>
<tr>
<td>Clogher House Training Centre + Rehab Workshop</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Special School</td>
<td>0.00</td>
<td>0.50</td>
</tr>
<tr>
<td>Community Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Paediatric</td>
<td>0.00</td>
<td>2.00</td>
</tr>
<tr>
<td>TOTAL:</td>
<td>3.00</td>
<td>18.50</td>
</tr>
</tbody>
</table>

Table 13 outlines the existing and the optimum staffing levels using the criteria described by Vallow et al for County Monaghan. Staffing levels are approximately one sixth of the recommended levels. Staffing in the General Hospital is 33% of the recommended level (Table 14). Community services for geriatrics, mental handicap and physical handicap are non-existent. Recommended Vallow levels are 8.4 WTE for this area.
Acute hospital physiotherapy services (including out-patients) in the North Eastern Health Board are underdeveloped by 63% according to the Vallow recommendations (Table 14). Services to geriatrics, mental and physically handicapped are under-staffed by 89%. Physiotherapy service for psychiatric patients is virtually non-existent.

6.7 COMPARISONS OF PRESENT LEVELS WITH OPTIMUM STAFFING LEVELS

Comparisons of present levels of staff with optimum staffing levels show major shortfalls, particularly in the community (Charts 1a & 1b). It is unrealistic to hope to achieve optimum levels, but it gives a base-line from which to begin.
1994 Levels/Optimum staffing levels in the acute hospitals

Including voluntary services
Chart 1b
1994 Levels/Optimum staffing levels in the community

<table>
<thead>
<tr>
<th></th>
<th>Louth</th>
<th>Meath</th>
<th>Cavan/Monaghan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>4.5</td>
<td>2.4</td>
<td>0.8</td>
</tr>
<tr>
<td>Optimum</td>
<td>24.7</td>
<td>20.35</td>
<td>19.5</td>
</tr>
</tbody>
</table>

Including voluntary services and services to the elderly
6.8 INFORMATION OBTAINED FROM G.P.S AND OTHER HEALTH PROFESSIONALS

At this meeting there was a discussion on common problems and on a protocol for referral to the Physiotherapy Service.

Physiotherapy Services in the N.E.H.B. accept referrals from G.P.s on an equal basis to the Consultant Hospital Doctors. Up to 50% of outpatient referrals are from this source, with the greatest number involving musculo-skeletal problems. Access to this service often negates the urgent referral of patients to surgical and orthopaedic clinics, thereby reducing the demands on these services.

At present, the major problem with the physiotherapy out-patient service (hospital and community) is that the demand exceeds the available resources. The G.P.s have an appreciation of this problem and refer only one in three of those they feel would benefit from physiotherapy.

All departments have waiting lists which fluctuate with referral rates and staffing levels. These are continuously reviewed to assist service delivery in an equitable manner.

The centralisation of services with regard to hospital out-patient departments is also considered a problem. The G.P.s feel that patients living outside the immediate catchment area of the hospital are disadvantaged.

Many patients referred for physiotherapy by G.P.s have previously been seen by Hospital Consultants. The G.P.s feel that referral should have been made at this point.

G.P.'s feel the discharge summaries sent to them are of great benefit but would appreciate these in respect of every patient.

A pilot project contracting out G.M.S. patients to private practice is being carried out in Navan. Potential problems were identified by the physiotherapists, in that if non public sector physiotherapists were to be employed to treat G.M.S. patients in G.P. practices, problems of fragmentation, duplication, continuity, quality, centralisation of data collection and accountability may occur.

(Many problems were common to the physiotherapist as well as the G.P.s). In addition, the physiotherapists feel that the lack of prioritisation given by G.P.s when referring patients, make waiting lists difficult to assess and manage.

In summary, the problems identified are :-

* Demand exceeds the resources of the service

* The patient in out-lying areas must travel unreasonable distances for out-patient hospital services

* Lack of communication following discharge of patients
G.P.s feel that they are having to refer patients who should have been referred by Consultant Hospital Doctors when reviewed by them.

Lack of control if all physiotherapists employed to treat G.M.S. patients are not responsible to one manager ie. a physiotherapy services manager.

6.8.1 Recommendations

* Appointment of a physiotherapy services manager with adequate resources to meet the needs of all G.M.S. patients in an equitable manner.

* Initiation of out-reach clinics to provide an equitable service for all G.M.S. patients with transport difficulties. These could be located either in G.P. group practices or health centres.

* Outcome of treatment be communicated to the patients’ G.P. upon completion of treatment irregardless of them being the primary referrer.

* G.P.s and Consultant Hospital Doctors must discuss the point at which patients must be referred for physiotherapy.

* A protocol for referral was drawn up by the physiotherapists and approved by the G.P. Unit regarding the prioritisation of patients for physiotherapy (Appendix V).

* The recruitment of the Physiotherapy Services Manager be made in advance of service development. This will enable him/her to recruit suitable staff, assess and monitor the service given by all physiotherapists contracted by the N.E.H.B.

6.9 INFORMATION OBTAINED FROM HEALTH BOARD MANAGERS

A meeting was held on 4th August, 1993 to present the Interim Report to Dr. A. Mc Loughlin and Mr. L. Walsh who put forward the following points for discussion:

* Obvious inadequate physiotherapy staffing

* The development of Physiotherapy Services Managers posts for three catchment areas of 100,000 population

* The incremental development of staffing targeting the following service areas:
  * Child Care
  * Health Promotion
  * Mental Handicap
  * Physical Handicap
  * Care of the Elderly
  * Psychiatric

* Development of out-reach Day Hospitals for the Elderly and Mental Handicap
Respite Care to include assessment and rehabilitation from Physiotherapy and Occupational Therapy

The present status of all acute hospitals will remain unchanged ie. no plans for downgrading

Plans of future developments for the Elderly, Mental Handicap and Physical Handicap services were considered urgent. Senior staff in each county compiled and forwarded these plans to the relevant managers.
6.10 RESULTS OF QUESTIONNAIRE

6.10.1 Question 1

The following are the results of the questionnaire survey which was sent to the third and fourth year U.C.D. and T.C.D. Schools of Physiotherapy.

80 questionnaires were sent to U.C.D. and T.C.D Schools of Physiotherapy

59 replies were returned = 73.75% response

Results of student responses to question 1 show that good training opportunities and good facilities of work rate top of the list of their preferences with 16.8% and 13.7% respectively (Table 15). Accommodation and secretarial back-up rate lowest on their list of preferences with 0.7% and 0.35% respectively.

"Good training opportunities" was the number one priority with 16.8% of respondents.

13.7% of the respondents felt that good facilities were the number one priority when looking for a job. This emphasises the need for all departments within the Health Board to have comparable facilities. Poor facilities in some areas result in difficulty recruiting as prospective employees go to the area with better facilities.

12.3% of the respondents felt that rotation scheme was their top priority. The low level of staffing in most areas means that rotation schemes are very limited. A newly qualified physiotherapist wants to get a variety of experience.

11.9% of respondents put "team spirit" as their top requirement when looking for a job. Good team spirit projects a positive image to both work colleagues and the public when staff are happy in their work.

9.8% of respondents felt that having a "varied caseload" would attract them to a new job.
<table>
<thead>
<tr>
<th>% STUDENT PREFERENCE OF AREAS OF PHYSIOTHERAPY</th>
<th>FIRST PREFERENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good Training Opportunities</td>
<td>16.8%</td>
</tr>
<tr>
<td>Good Facilities</td>
<td>13.7%</td>
</tr>
<tr>
<td>Rotation Scheme</td>
<td>12.3%</td>
</tr>
<tr>
<td>Team Spirit</td>
<td>11.9%</td>
</tr>
<tr>
<td>Varied Caseload</td>
<td>9.8%</td>
</tr>
<tr>
<td>Good Support System</td>
<td>7.0%</td>
</tr>
<tr>
<td>Good Promotion Prospects</td>
<td>5.9%</td>
</tr>
<tr>
<td>Opportunity to Specialise</td>
<td>5.9%</td>
</tr>
<tr>
<td>Attractive Location</td>
<td>5.6%</td>
</tr>
<tr>
<td>Good Social Life</td>
<td>4.9%</td>
</tr>
<tr>
<td>Reputation</td>
<td>3.9%</td>
</tr>
<tr>
<td>Progressive Management</td>
<td>1.0%</td>
</tr>
<tr>
<td>Accommodation</td>
<td>0.7%</td>
</tr>
<tr>
<td>Secretarial Backup</td>
<td>0.35%</td>
</tr>
</tbody>
</table>
6.10.2 Question 2

Responses to Question 2 show that sports injuries and orthopaedics/outpatients are the specialties which rate as the highest preference with 18.24% and 17.54% respectively (Table 16). Community and gynaecology rate lowest at 3.85% and 2.1% respectively.

35.78% of respondents want to specialise in outpatient - orthopaedics and sports injuries. This reflects the upsurge in interest in sports in general over the past ten years. Outpatient departments treat a variety of these conditions and have excellent experience to offer. A well equipped, well staffed O.P.D. run by an out-patient Senior Physiotherapist could be used to attract newly qualified staff.

25.26% of respondents said that their first speciality preference was paediatrics and neurology (12.63% paediatrics / 12.63% orthopaedics). This is very encouraging as there is a need to expand these services in all areas. Recruitment in this area has been difficult.

6.11 DISCUSSION

The low priority given by third and fourth year physiotherapy students to progressive management and secretarial back-up reflects the lack of understanding of the processes involved in administering a physiotherapy service by students. There is no management module in their training. This is currently being addressed through the management group of the profession today, the I.S.C.P. in association with U.C.D. Trinity College have indicated that it is their intention to pursue this in the near future.
<table>
<thead>
<tr>
<th>Specialty of Physiotherapy</th>
<th>First Preference %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sports Injuries</td>
<td>18.24</td>
</tr>
<tr>
<td>Orthopaedics - Outpatients</td>
<td>17.54</td>
</tr>
<tr>
<td>Neurology</td>
<td>12.63</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>12.63</td>
</tr>
<tr>
<td>Orthopaedics - Inpatients</td>
<td>11.92</td>
</tr>
<tr>
<td>I.C.U. - Respiratory Care</td>
<td>9.82</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>7.01</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>4.21</td>
</tr>
<tr>
<td>Community</td>
<td>3.85</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2.10</td>
</tr>
</tbody>
</table>
CHAPTER SEVEN

DELIVERY OF SERVICE
AND PLANNING FOR THE FUTURE

7.1 SUMMARY
7.2 INTRODUCTION
7.3 PRIMARY AND PREVENTATIVE
7.4 PHYSIOTHERAPY FOR THE ELDERLY
7.5 FUTURE SERVICES FOR THE ELDERLY
7.6 PHYSIOTHERAPY FOR CHILDREN WITH PHYSICAL HANDICAP
7.7 FUTURE SERVICES FOR CHILDREN WITH PHYSICAL HANDICAP
7.8 PHYSIOTHERAPY FOR ADULTS WITH PHYSICAL HANDICAP
7.9 FUTURE SERVICES FOR ADULTS WITH PHYSICAL HANDICAP
7.10 PHYSIOTHERAPY FOR CHILDREN WITH MENTAL HANDICAP
7.11 FUTURE SERVICES FOR CHILDREN WITH MENTAL HANDICAP
7.12 PHYSIOTHERAPY FOR ADULTS WITH MENTAL HANDICAP
7.13 FUTURE SERVICES FOR ADULTS WITH MENTAL HANDICAP
7.14 PHYSIOTHERAPY FOR THE PSYCHIATRIC PATIENT
7.15 FUTURE SERVICES FOR THE PSYCHIATRIC PATIENT
7.16 PHYSIOTHERAPY IN THE ACUTE HOSPITAL
7.17 FUTURE SERVICES FOR THE ACUTE HOSPITAL
7.1 SUMMARY

The role of the physiotherapist in primary and preventative care should be acknowledged by the Health Board and services developed accordingly. This would include adequate resource allocation i.e. staff, budget etc.

Services for the elderly are underdeveloped throughout the region with limited input into most areas, most notably in the community. Such shortfalls have led to inadequate follow through of patients and more patients requiring long-stay beds.

The future of physiotherapy for the elderly lies in the provision of a relevant service regardless of patient location. Since the ultimate aim is the retention of the elderly person at home, the service must endeavour to achieve this by identifying patients 'at risk'. Assessment and rehabilitation may take place as in an in-patient, 'out-patient, day hospital or community setting as appropriate. This will require an adequately staffed, team-oriented service.

Services to children with physical handicap fall significantly below the recommended levels. This is most notable in the Cavan/Monaghan area where the only service available is in the acute hospital.

The provision of a specialist senior physiotherapist in paediatrics in the North Eastern region would enable the service to develop in a co-ordinated manner. It is important that sufficient basic grade staff and treatment facilities be made available. These children should be treated in an appropriate location with regard to their particular problems e.g. centre, home or school.

Services for the adult with physical handicap are sparse. Physiotherapy is provided in the acute hospital setting during an acute exacerbation of disease. There is minimal follow-up in outpatient departments at present.

Provision of an ongoing monitoring and treatment service is required in the community with access to in-patient assessment and rehabilitation where necessary is vital if this category of patient is to be maintained in the home environment. The carers and families of these patients require ongoing support and education to reduce the need for admission to long term care.

The service to children with mental handicap consists of community physiotherapy and voluntary institutions - St. Mary’s Hospital, Drumcar. The community service is non-existent in Cavan/Monaghan while in Meath and Louth home visits, health centres and special care units receive a service. There is not sufficient input to meet the needs of these children.

Treatment for children with mental handicap often last for many years and some may never be fully discharged from the services. These children require intensive input in the preschool years. Resources both in terms of staff and facilities need review. Future development should occur in the community with particular attention being paid to the Cavan/Monaghan area.

Physiotherapy for adults with mental handicap is provided by voluntary institutions. St. Mary’s Drumcar provides a physiotherapy service and limited day care in Dundalk and Drogheda. This client group have been given a low priority and their physiotherapy needs require further investigation and assessment.
The community service needs to be developed and adequately staffed. This would be done following investigation of this group's needs. Co-ordination between voluntary and statutory bodies should be encouraged.

Physiotherapy for psychiatric patients is present for those who present with physical problems. They are referred by nature of their physical diagnosis, and are categorised by their physical disability.

At present, physiotherapy is provided to all areas of in-patient care in the acute hospital. The quantity of cover is variable and in many instances requires review if it is to be brought up to recommended levels. This is particularly evident in patients requiring intensive respiratory or rehabilitative care. The out-patient department receives a wide range of referrals which are treated with a problem solving approach.

The staff and support facilities presently available in the acute hospital are insufficient to meet the needs of the acutely ill patient. The areas of rehabilitation and education need to be developed so as to create a basis for successful discharge into the community, where the patients care must be followed up. To create the optimal environment for service and staff development, senior specialist therapists should be employed in key areas.

7.2 INTRODUCTION

This chapter outlines the delivery of service to a range of client groups. These groups include the elderly patient, children and adults with physical and/or mental handicap, psychiatric patients and those attending acute hospital.

The physiotherapy service, like all health services, exists to serve the patient/client and this has always been reflected in the ethos of the physiotherapy profession and training. The service, however, must be even more consumer orientated and accessible.

The recommendations have taken into consideration the key principles of equity, quality of service and accountability. Any change to the existing service must be on the basis of increasing health status and quality of life.

This chapter details ways in which these improvements can be achieved.
7.3 PRIMARY AND PREVENTATIVE

Early intervention programmes are essential in order to prevent the development of impairment, disability and handicap. The value of physiotherapy intervention at this level has been identified (Sluijs, 1991). At present physiotherapy involvement is under-developed. Often physiotherapy is sought only when a disease or disorder manifests itself. The number of primary and preventative programmes vary from county to county in the North Eastern Region (Table 4) With more emphasis on health promotion in our society it is imperative that the physiotherapists skills are utilised maximally as part of a multi-disciplinary and multi-sectoral approach (Department of Health, 1994).

The following sections describe areas in which the physiotherapist involvement could be developed.

7.3.1 Back Care and Manual Handling

Back pain is one of the major causes of absenteeism at work with 830,000 days lost in the U.K. nursing profession in 1983 (Stubbs et al. 1993). 31% of all accidents in the workplace are due to the failure of manual handling techniques (European Directive, 1993).

As part of their caseload physiotherapists have been working in the area of back-care for many years. They have the expertise necessary to spearhead the campaign on health promotion, health and safety, backcare, manual handling, risk assessment and injury prevention.

The physiotherapy service currently provides:

* One to one treatment of patients including advice on ergonomics
* Manual handling courses for Health Board staff and in some regions carers

The physiotherapy input in the area of backcare and manual handling programmes within the Health Board Region ranges from 0.05 WTE in Co. Monaghan to 0.35 WTE in Co. Louth (Table 4). At present it is focused in the area of patient care and inservice training for staff.

7.3.1a Recommendations

Primary care programmes be developed in the following areas:

* **Manual Handling Courses**

  - Health Board staff to include adequate induction training and regular review for previously trained staff.
  
  - Industry - Since the introduction of the Health Safety and Welfare at Work Act, 1989 the onus is on the employer to provide training for all employees involved in any form of manual handling. The physiotherapist should be involved in presenting a package which industry could purchase.
* **Back Schools**

The back school, as an adjunct or even as an alternative to physiotherapy treatments has been in existence for over 22 years. The experience gained in Sweden and in the British back schools indicates that the system is valuable, cost effective and has an acceptable success rate.

The overall objective is to encourage the patient to take responsibility for looking after his/her back (Zlabber & Moffett, 1989). It encompasses early public education, specific education and treatment to all patients with all forms of low back pain, alterations of industrial sites, job descriptions, care of the patient in hospital before and after surgery, pain control and the development of educational materials for the back pain of all segments of society (White et al, 1983).

Improved spinal ergonomics combined with physiotherapy produced the "back school" approach to patient education, where improved understanding reduces fear and improves patients ability to cope with their back problems (Itall & Iceton, 1983; White et al, 1983; Zachrisson & Forsell, 1980).

* **Backcare education in schools**

As with most preventative programmes the most appropriate group to target is the young, as they have not yet developed intractable bad habits (postural and lifting). This should begin in primary school and be followed-up in second level. Such a programme could be jointly funded by the Department of Education, thus fulfilling the shaping a healthier future, for a multi-second approach.

* **Ergonomic assessment**

Poor design and layout of the work-station can cause and perpetuate back pain. Assessment and recommendation in this regard is within the remit of the physiotherapist and should be used more routinely both within the hospital, schools and industry. This could be incorporated into the manual handling package for industry.

7.3.2 **Womens Health**

In the document Shaping a Healthier Future (Department of Health, 1994) the issue of womens health is clearly identified as a priority. The role of the physiotherapist can be divided between the following areas :-

* Continence advice
* Ante-natal care
* Post-natal care

7.3.2a **Continence Advice**

The prevalence of continence problems in women post-natally, peri- and post menopausal is perceived as high. The extent of the problem is difficult to determine as there is a wide
variation in it's reported prevalence (Ashworth, Hagan, 1993). The role played by the physiotherapist in the area of continence promotion is being accepted and valued. Currently this service is being provided within the framework of the general outpatient department by non-specialist physiotherapy staff. The physiotherapy input in continence advice varies from 0.07 WTE in Cavan/Monaghan to 0.4 WTE in Co. Louth (Table 4). This indicates that the service overall in the region is poor.

7.3.2b Preventative

This can be addressed primarily through target groups. It involves identifying "at risk" groups and using education to increase awareness of continence problems. It can also prevent problems occurring. This may be done by:

* Supplying patient information leaflets to G.P. Surgeries
* Ante-natal screening
* Post-natal education
* The use of local womens groups as an opportunity to educate and advise

7.3.2c Curative

This involves referral to a specialist physiotherapist clinic where a holistic approach is adopted. Patients can also be treated in the community or at home. A cure rate of approximately 70% is possible using a comprehensive treatment regime (Laycock, Jerwood 1993).

7.3.2d Recommendations

* Staff with specific interest and training in this area should administer this service.
* Comprehensive ante-natal screening to identify women "at risk" of developing continence problems.
* A separate examination room to respect the privacy and dignity of the patient is required in each area.
* Provision of specialist equipment in each area.

7.3.2e Ante-Natal Care

The physiotherapist can offer the expectant mother information in the areas of exercise, breathing control, posture, backcare and lifting, positioning and relaxation. The physiotherapist is part of the combined midwifery/physiotherapy team in conducting the preparation for labour. The only unit within the region offering this combined service is in Co. Monaghan with 0.03 WTE (Table 4).

7.3.2f Recommendations

* This service should be available in all areas in consultation and cooperation with the midwives.
* These classes should be available in selected Health Centres/Out Reach.
* Women at risk of developing post-natal back pain and continence problems be identified at this stage.

7.3.2g Post-Natal Care

The physiotherapist assesses the mother for a graduated programme of exercises to enable her to improve muscle tone, maintain continence and self image. Instruction on backcare is also given with a view to injury prevention.

All hospitals with maternity units offer post-natal classes or individual treatment where required. Some patients are seen by the Community Physiotherapists. Treatment input varies from zero in Co. Meath to 0.45 WTE in Co. Louth (Table 4).

7.3.2h Recommendations

* A physiotherapist specifically trained in obstetrics and gynaecology be available in each area.
* That a physiotherapy service be available routinely for those women identified antenatally as at risk.
* Physiotherapy should be available in the location most appropriate for these women e.g. Health Centres/Home/Hospital.

7.3.3 Health Promotion

In the Shaping a Healthier Future (Department of Health. 1994) the value of regular light exercise is acknowledged as a priority target for the year 2000. The benefits of exercise are well documented.

* Improved cardio-respiratory
* Enhanced musculo-skeletal function
* Weight control
* Prevention of osteoporosis
* Promotion of well being

There are two dimensions to exercise in society: the "fitness culture" versus the "sedentary lifestyle". Followers of the "fitness culture" need to be educated regarding the appropriate use of exercise and the effects of training. The biggest challenge, however, for the physiotherapy profession is to install an interest in physical exercise and awareness of it's benefits in the "sedentary group". He/she is in an excellent position to address these issues through a primary health care programme as part of a multi-disciplinary team. At present, this service is delivered on an ad hoc basis. There is huge scope for development in this area.
7.3.3a Recommendations

To develop exercise promotion programmes in:-

* Schools - in association with Physical Education teachers
* Community - through groups e.g. sports, elderly, womens associations etc
* Workplace - through social club schemes

7.3.4 Relaxation and Stress Management

Due to the demanding life-styles of many people nowadays the incidence of stress related illness is on the increase. Stress can often manifest itself as physical illness and a holistic approach in treatment is preferable (Crews B., 1990). Relaxation, massage, exercise and pain relieving modalities can be offered to these patients.

Common stress related conditions include :-

* Chronic pain
* Cardiac disease
* Respiratory disease (e.g. asthma)
* Chronically ill patients

At present the demand for this service is low. This is because referees are, to a large extent, unaware of what the physiotherapy profession can offer.

7.3.4a Recommendations

* That relaxation and stress management programmes be established in all areas.

7.3.5 Child Development Awareness

The new born infant has many abilities which enables him to feed, grasp and cry for attention. Normal motor development depends on intact nervous, musculo-skeletal and sensory systems. The paediatric physiotherapist has skills to assess the motor development of an infant from birth and institutes a treatment programme to prevent or minimize any disability or handicap in later life by facilitating normal movement patterns. The physiotherapist works as part of the early development (multi-disciplinary) team. At present, this service is provided through Community Care with 0.05 WTE in Co. Louth and 0.05 WTE in Co. Meath. Cavan/Monaghan has no such service as there is no community physiotherapy.

7.3.5a Recommendations

* To facilitate mother and child this service is ideally delivered in the childs home or local Health Centre whichever is deemed more appropriate.
* That a comprehensive service be available in all areas.
The service is delivered under direction of a specialist senior in paediatrics.

7.3.6 Pre-Operative Chest Physiotherapy

The value of pre-operative chest physiotherapy has been documented with regard to reduction of complications such as post-operative chest infections and pneumonia (Gallon, 1992). This is regarded as part of routine physiotherapy in the acute hospital setting but with present staffing levels this is not always possible. The service is provided in all the acute hospitals. However, input ranges from 0.01 WTE in Monaghan General Hospital to 0.3 WTE in Our Lady of Lourdes Hospital, Drogheda (Table 4).

7.3.6a Recommendations

* The Service be available on a comprehensive and continuous basis in all hospitals.

7.3.7 Post-Operative (Rehab and Chest Physiotherapy)

Post-operative chest physiotherapy is given routinely to all post-operative patients in acute hospitals to help prevent or reduce respiratory or circulatory complications (Bourne & Jenkins, 1991). Currently all patients receive post operative chest physiotherapy.
7.4 PHYSIOTHERAPY FOR THE ELDERLY

Maintenance of mobility, chest physiotherapy, reduction of pain and improving range of movement, prevention of deformity, evaluation of symptoms and goal setting are some of the aims of physiotherapy for the elderly patient.

Evaluation of symptoms and goal setting are carried out together with other members of the multi-disciplinary team.

Present services for the elderly can be identified as follows:

* Care of the acutely ill patient
* Outpatient physiotherapy
* Community physiotherapy
* Continuing care of geriatric patients in longstay units.

7.4.1 Care of the Acutely Ill Patient

**Acute Hospital**

Quantity of treatment varies from hospital to hospital and depends on staffing levels and the length of stay in medical and surgical wards.

Facilities for the treatment of the acutely ill inpatient are particularly inadequate in Monaghan General Hospital and Louth County Hospital. All Health Board hospitals report difficulty in the implementation of primary and preventative and tertiary programmes for the elderly as inpatients due to staff shortages.

**Community**

The acute elderly patient is being treated more frequently in the home by the GP along with the community support services. The physiotherapy service is sparse and inadequate, putting severe pressure on acute hospital resources.

7.4.2 Out Patient Physiotherapy for the Elderly

**Acute Hospital**

Patients over 65 years, referred to out patient departments, usually present with neurological, rheumatological or respiratory problems. Physiotherapy treatment for the elderly following discharge from the acute hospital setting is often at the out patient department. In Monaghan, physiotherapy at the outpatients department is the only service available following discharge. The quantity of physiotherapy varies and is dependent on staffing levels and out patient facilities.
Non-Acute Hospital

Outpatient physiotherapy in the community is also available to the elderly patient. Input ranges from 0.4 WTE in St. Josephs Hospital, Trim to 0.6 WTE in Cavan General Hospital (Table 5).

7.4.3 Community Physiotherapy

Community physiotherapy for the elderly should be provided to:

* Provide rehabilitation when transport/access to outpatients/outreach clinics is impossible
* Institute preventative programmes at local levels
* Follow up patients who have been discharged from acute hospitals
* Teach carers handling skills in their own home

At present there is no community service for Cavan/Monaghan and there is sparse community service in Louth and Meath. As a result of this, treatment is difficult. The physiotherapy service has become mainly advisory rather than therapeutic in nature. Physiotherapy input ranges from zero in Cavan/Monaghan to 0.4 WTE in Co Louth (Table 5).

7.4.4 Continuing Care for the Elderly in Longstay Units

The physiotherapist is involved in the prevention of complications of immobility in the continuing care setting. Physiotherapy treatment input ranges from zero in County Monaghan to 1.0 WTE in Co Louth (Table 5).

7.4.5 Respite Care

Physiotherapy input into respite care in the area consists mainly of assessment of functional mobility and treatment. The input ranges from zero in Monaghan to 0.25 WTE in Meath (Table 5).
7.5 FUTURE SERVICES FOR THE ELDERLY

7.5.1 Introduction

With more emphasis on early discharge, patients are often discharged from hospital before rehabilitation has been completed. The problems which this creates are as follows:

a) Many patients are unable to return directly to their homes and so occupy continuing care beds in longstay hospitals or private nursing homes.

b) Others return to their homes without appropriate support services. This often leads to re-admission to the acute hospital or long-term care being sought.

Patients who are discharged too early often fail to attain the potential which they may otherwise achieve with appropriate rehabilitation. Optimum functional capacity with adequate training of carers and adaptations to the home environment will increase the chance of patients being retained at home. Early intervention programmes are essential in order to prevent the development of long-term disability and to provide the opportunity for the elderly to reach their full physical potential. At present this is not being achieved as treatment of the elderly as in-patients is mainly channelled in the area of disability i.e. the areas of impairment and handicap are virtually excluded. For example, in the treatment of the stroke patient the physiotherapist may wish to employ techniques to reduce spasticity, facilitate proprioception and balance and increase range of motion etc. These are focused in the area of impairment and should be carried out as part of the overall treatment programme, to assist in the achievement of outcome goals.

The physiotherapist also has a major role to play in the prevention of handicap. Adequate treatment in the areas of impairment and disability for the stroke patient will result in a reduction of handicap in most cases. For example, the physiotherapist, as part of the rehabilitation team, educates the patient and carers. He/she can provide aids and appliances and facilitate environmental adaptations to assist in re-integration into ordinary life. Physiotherapists have always been concerned with the quality of their intervention. For some time the gap between acute and long term care has been noted. Due to the recent policy of reducing length of stay in acute hospitals this gap has been widened and the quality of care has suffered. To bridge this gap it is suggested that a structure for the provision of rehabilitation services must be addressed. When the medical consultant considers that the patient is fit for discharge an appropriately staffed structure for rehabilitation should be made available. Any such structure would have direct community access.

Physiotherapists identify and classify clinical phenomena in their clinical practice and are among those who are skilled in the prediction of outcome goals for patients. They use direct measurements at different levels of function. For example, if a patient is admitted because he/she has a total hip replacement, the physiotherapist can measure impairment (e.g. range of movement, swelling, leg length and pain), and disability (e.g. walking ability, velocity of walking), and a host of other measures including any handicap which may present as a consequence of the operation. On the basis of this evaluation the physiotherapist can prescribe a programme of exercises/treatment for that patient and can also give the patient an accurate indication of how long it may take to reach their goal.
7.5.2 Recommendations

The following have been identified as areas in which the physiotherapy service needs to be developed:

* Assessment and rehabilitation of the elderly as acute hospital in-patients
* The acute elderly patient at home
* The elderly in assessment and rehabilitation units
* At day hospitals
* Day centres
* The chronic elderly patient at home
* The respite patient
* The convalescent patient
* The subvention patient
* Long-stay patients in continuing care

7.5.2a Assessment and Rehabilitation of the Elderly as Acute Hospital In-Patients

The acute elderly inpatient requires maximum physiotherapy input in an adequately staffed rehabilitation unit. This is a labour intensive area of physiotherapy work and therefore requires a satisfactory level of support services e.g. porters and physiotherapy helpers.

7.5.2b Physiotherapy for the Acute Elderly Patient at home

There is a growing trend in primary care to keep the elderly patient who has suffered an acute episode at home. Examples are CVA, respiratory problems etc. This can only be done if there is an appropriately staffed, multi-disciplinary community team. Physiotherapy input can:

* Rehabilitate and mobilise the patient
* Educate and empower the patient and carer
* Liaise with other members of the team
* Refer to other physiotherapy services as appropriate.

7.5.2c Physiotherapy for the Elderly in assessment and Rehabilitation Units

The geriatrician assesses patients in the acute hospital setting and refers them to the appropriate unit. For example, if they require rehabilitation they are admitted to the unit where the rehabilitation team is based. The Vallow report on recommended staffing levels indicates a ratio of 1 physiotherapist per 15 geriatric assessment/rehabilitation beds. An adequate level of support services is necessary.

7.5.2d Physiotherapy Facilities at the Day Hospital

It is widely accepted that the geriatric day hospital makes an important contribution to the management of disabled elderly patients (Brocklehurst et al, 1980). Benefit has been identified in terms of shortened inpatient stay, delayed hospital admission, prevented admission and relief on other outpatient services (Anand et al, 1982).
Physiotherapy is important in the treatment of elderly patients attending the day hospital and results in both short and long-term improvement in mobility (Finlay et al, 1990).

Physiotherapy in the day hospital is necessary for patients with stroke, Parkinson's disease, other neurological conditions, chronic obstructive airways disease, orthopaedic and arthritic conditions. The physiotherapist aims to improve mobility, independence and quality of life by using his/her skills to normalise muscle tone, reduce pain, increase muscle strength and joint range of motion. The Vallow report on staffing recommendations indicate a ratio of 1 physiotherapist per 15 patients and support services as necessary.

7.5.2e  Physiotherapy for Patients at Day Centres

Day centres are the ideal location to initiate physiotherapy health promotion programmes in line with the Health Strategy recommendations. Physiotherapy would also be provided on a consultant basis to identify potential problems so that treatments can be provided in the appropriate setting.

7.5.2f  Physiotherapy for the Respite Patient

At present respite beds are used mainly to facilitate the carers of home-based patients rather than the patient themselves. However, if it is considered on assessment that the patient's handicap may be reduced with rehabilitation then some provision should be made for adequate rehabilitation in the most appropriate area.

7.5.2g  Physiotherapy for the Convalescent Patient

Patients who, although medically stable, have not reached their full functional capacity often need access to convalescent beds. Physiotherapy for assessment and treatment planning should be made available to these patients. Those who require physiotherapy should be referred to the rehabilitation unit or day hospital, as appropriate.

7.5.2h  Physiotherapy for the Subvention Patient

A number of elderly patients requiring subvention will require a physiotherapy service. The aims of physiotherapy in this area are to attempt to reduce the patient's handicap and consequently reduce the level of subvention. The level of service required is unknown at present. Presently there is no public physiotherapy service to private nursing homes. In some areas there is a private service available. Patients requiring treatment should have access to community physiotherapy or to the day hospital as necessary.

7.5.2i  Evaluation and Assessment of Longstay Patients in Continuing Care

Deterioration of mobility is a common presenting feature of illness in the elderly and is one of the reasons why patients are admitted into long-term care. These patients need assessment to ascertain to what extent they will benefit from treatment intervention, advice or palliative care.
Ambulation is a priority for all patients with the aim of producing therapeutic benefits and improved independence. There is a need for a review procedure for patients allocated to continuing care beds whose level of disability and handicap improves with a view to relocation or discharge. A request for physiotherapy review can be made by the visiting GP or the Rehabilitation Manager. It is important that an appropriate level of service is provided and maintained.
7.6 PHYSIOTHERAPY FOR CHILDREN WITH PHYSICAL HANDICAP

Present services for children with a physical handicap are outlined and objectives of treatment are described. The problems of the present service are identified and recommendations for development of the physiotherapy services are discussed.

Present services for children can be identified as follows:

* Community physiotherapy for physical handicap
* Outpatient physiotherapy for physical handicap
* Voluntary services

7.6.1 Community Physiotherapy for Physical Handicap

Community physiotherapy for this group is provided in:

* Child’s home
* Health Centres
* Play schools
* Schools
* Hydrotherapy pools

7.6.1a Child’s Home

Home visits are provided in Louth and Meath. This service is not available in Cavan/Monaghan. Input ranges from zero in Cavan/Monaghan to 0.5 WTE in Meath (Table 6).

7.6.1b Health Centres

Physiotherapy assessment and treatment is carried out in health centres as appropriate in Louth and Meath. This service is not available in Cavan/Monaghan. Input ranges from zero in Cavan/Monaghan to 0.2 WTE in Meath.

7.6.1c Play Schools

Community physiotherapists visit play schools to facilitate integration of the physically handicapped child. This service is available in Louth and Meath and absent in Cavan/Monaghan.

7.6.1d Schools

Community physiotherapists visit schools to facilitate integration and provide appropriate equipment. This service is available in Louth and Meath and is absent in Cavan/Monaghan.
7.6.1 Hydrotherapy Pool

Hydrotherapy is available for children in Meath. This service is not available in any other area.

7.6.2 Outpatient Physiotherapy for Physical Handicap

The only service available for the treatment of this client group in Cavan/Monaghan is at the Out Patient Department of the general hospitals. This is an inappropriate setting and limits the scope of the service. The total amount of physiotherapy input varies from 0.03 WTE in Monaghan to 0.25 WTE in Cavan (Table 6).

7.6.3 Voluntary Services

Sessional physiotherapy services are provided by the following voluntary organisations:

* Cerebral Palsy Ireland funds sessions in Meath and Monaghan.

* Cystic Fibrosis Association provides sessions in Louth, Meath, Cavan and Monaghan.

* Association of Spina Bifida and Hydrocephalus provides sessions in Louth, Meath, Cavan and Monaghan.
7.7 FUTURE SERVICES FOR CHILDREN WITH PHYSICAL HANDICAP

7.7.1 Introduction

The physiotherapist's role is vital in the management of physical handicap both in an assessment and a therapeutic role, to educate parents and prevent complications. Early referral is vital to initiate appropriate treatment thereby preventing complications and educating parents. Congenital and neo-natal impairments must be managed to offset the effects of growth and, in the case of neurological problems, to use central nervous system plasticity to its utmost.

The advantages of physiotherapy have been documented. The objectives are as follows:

* To prevent and minimise motor delay and maximise potential
* To normalise abnormal movement patterns
* To reduce sensory defensiveness
* To negate, as far as possible, the effects of other handicaps on motor development
* To encourage participation in sports and fitness programmes
* To maintain clear airways in the case of respiratory disability
* To promote good posture and to reduce or prevent potential deformities
* To advise and educate parents and carers as part of a multi-disciplinary team
* To support the child and family
* To assess and advise with regard to equipment and appliances

It is important to emphasise that most children referred are not acutely ill. The acute hospital department is not an appropriate treatment setting. Treatment often lasts many years and patients may never be fully discharged from the service. It is more pertinent for this client group to be seen in the community setting either in their own home (especially when they are very young), in the local health centre or at school.

Problems with the present service are outlined as follows:

* Delay in referral and implementation of treatment
* There is no specialist centre in the North Eastern region for the treatment of children with physical handicap
* There are no specialist physiotherapists specifically allocated for the treatment of children with physical handicap only
Many of those who require moderate or intensive physiotherapy can not be seen as frequently as required

There are poor treatment facilities for children with disability and there is a lack of funding for specialised equipment

In most counties there is no appropriate area designated for the treatment of these children

There is a lack of co-ordination between statutory bodies and voluntary services

Children are treated as part of a general service alongside other patients in out-patient departments

7.7.2 Recommendations

The following have been identified as areas which need development:-

* Multi-disciplinary localised assessment approach

* Physiotherapy in the home

* Physiotherapy in adequately equipped health centres/outreach clinics

* Physiotherapy in schools and play schools

* Hydrotherapy facilities

* Encourage a structured approach to services delivery between the Health Board and voluntary bodies

* Senior specialist physiotherapist to be appointed for the child with physical handicap

7.7.2a Multi-disciplinary localised assessment approach

Many of the children with physical handicap currently attend the Central Remedial Clinic (CRC) for diagnosis, assessment and treatment on a consultancy basis. Treatment is also provided by local therapists in consultation with their colleagues in CRC. CRC, as a resource, is invaluable. However, a similar multi-disciplinary team approach involving paediatricians, paediatric orthopaedic consultants, paediatric physiotherapists and other personnel, could be set up in the North Eastern Health Board to cater for their local needs. Those children who require specialities such as gait analysis, seating or special communication systems could still be referred to CRC. This more equitable approach would ultimately reduce stress on both parents and children. However, this would only work if the relevant qualified personnel are put in place.
7.7.2b Physiotherapy In The Home

Children with physical handicap are often best treated in their home environment when:-

* Children are under the age of five years
* Transportation is a problem
* Assessment of level of function at home is required
* Monitoring of equipment is required

7.7.2c Physiotherapy In The Health Centres

Physiotherapy to be provided at the health centre where appropriate.

7.7.2d Physiotherapy In Schools And Play Schools

Physiotherapy assessment should be made available for the child with physical handicap in both the school and pre-school environment as required.

7.7.2e Hydrotherapy Facilities

Hydrotherapy facilities should be made available in each county.

7.7.2f Senior Specialist Physiotherapist For The Child With Physical Handicap

It is recommended that children with physical handicap are managed by a physiotherapist who has the appropriate training and experience in this field. The role would include service monitoring, management and development.
7.8 PHYSIOTHERAPY FOR ADULTS WITH PHYSICAL HANDICAP

Present services for adults can be identified as follows:-

* Inpatient care of the acutely ill adult
* Out Patient Physiotherapy
* Community Physiotherapy
* Voluntary Services

7.8.1 Inpatient Care Of The Acutely Ill Adult With Physical Handicap

Physiotherapy for the acutely ill adult as an inpatient is in the area of intensive care, respiratory care and mobilisation. These patients are seen as part of the service to the medical wards in the acute hospitals.

7.8.2 Outpatient Physiotherapy For Adults With Physical Handicap

Physiotherapy treatment for adults with physical handicap is mainly carried out in the outpatient department. The total amount of physiotherapy input varies from 0.02 WTE in Monaghan General to 0.25 WTE in Cavan General Hospital (Table 6).

7.8.3 Community Physiotherapy For Adults With Physical Handicap

At present, there is no community service for Cavan/Monaghan or Meath and there is inadequate community follow up in Louth. Physiotherapy input ranges from zero in Cavan/Monaghan and Meath to 0.3 WTE in Co Louth (Table 6).

7.8.4 Voluntary Services

Action for Research in Multiple Sclerosis (A.R.M.S.) provides sessional physiotherapy in Meath.
7.9 FUTURE SERVICES FOR ADULTS WITH PHYSICAL HANDICAP

7.9.1 Introduction

At present physiotherapy services for the adult with physical handicap is inadequate and lack organisation. The physiotherapist's role is in the area of impairment, disability and handicap. However, present services confine physiotherapy to the area of disability, thereby precluding preventative programmes. Early referral is vital for effective physiotherapy intervention. The objectives include:-

* To obtain maximum independence and function
* To enhance mobility
* To educate patients and carers regarding the condition
* To reduce impairment, disability and handicap
* To maintain joint range of movement and prevent contractures

Problems with the present service can be identified as follows :-

* Insufficient staffing levels to meet need
* Delay in referral and implementation of preventative programmes
* Lack of structure for service delivery
* Lack of community physiotherapy
* Poor co-ordination between voluntary and statutory bodies
* Poor treatment facilities and lack of appropriate equipment

7.9.2 Recommendations

The following have been identified as areas which need development of physiotherapy services :-

* Adequate staffing levels to be provided
* Physiotherapy for the adult with physical handicap as acute hospital in-patient
* Review system for adults with physical handicap
* Physiotherapy for the adults with physical handicap at home
* Physiotherapy in health centres/outreach clinics
TABLE 7 WTE PHYSIOTHERAPY INPUT FOR CHILDREN AND ADULTS WITH MENTAL HANDICAP (1994)

<table>
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<th>LOCATION</th>
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<td>0.03</td>
<td>0</td>
<td>0</td>
<td>0.06</td>
<td>0.25</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>0.09</td>
<td>0.03</td>
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<tr>
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<td>0.1</td>
<td>0</td>
<td>0.5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.6</td>
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<tr>
<td>Cavan, Cootehill</td>
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<td>0.05</td>
<td>0.05</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.1</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>TOTAL WTE/LOCATION</td>
<td>0.03</td>
<td>0</td>
<td>0.35</td>
<td>0.11</td>
<td>0.8</td>
<td>0.50</td>
<td>0</td>
<td>0</td>
<td>0.09</td>
<td>0.03</td>
</tr>
</tbody>
</table>

TOTAL WTE FOR MENTAL HANDICAP = 1.91
TABLE 8 WTE PHYSIOTHERAPY INPUT FOR PSYCHIATRIC PATIENTS (1994)

<table>
<thead>
<tr>
<th>Location</th>
<th>Psychiatric Acute Hospital</th>
<th>Longstay</th>
<th>Community</th>
<th>TOTAL WTE/PSYCHIATRIC PATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louth Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Meath Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cavan Hospital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St. Davnets Hospital, Monaghan</td>
<td>0.05</td>
<td>0.15</td>
<td>0</td>
<td>0.20</td>
</tr>
<tr>
<td>TOTAL WTE/LOCATION</td>
<td>0.05</td>
<td>0.15</td>
<td>0</td>
<td>0.20</td>
</tr>
</tbody>
</table>
* Physiotherapy for the respite patient

* Develop co-operation between voluntary and statutory bodies in the provision of physiotherapy services

7.9.2a Adequate Staffing Levels to be Provided

An incremental increase in staffing levels is vital for the provision of a service to this group.

7.9.2b Physiotherapy for the Adult with Physical Handicap as Acute Hospital In-Patients

The acute adult in-patient requires maximum physiotherapy input. This is a labour intensive area of physiotherapy and requires optimum staffing levels and support of other services e.g. porters and physiotherapy helpers.

7.9.2c Review System for Adults with Physical Handicap

A register of patients with physical handicap should be drawn up to encourage regular reviews in order to monitor status and address their needs using a problem solving approach as part of a multi-disciplinary team. These reviews can take place in out-patient departments, outreach clinics or assessment and rehabilitation units.

7.9.2d Physiotherapy for the Adults with Physical Handicap at Home

It is necessary to have some physiotherapy visits for assessment of adults in their home environment. It is the location of choice in which to teach lifting and handling to carers and an appropriate home exercise programme.

7.9.2e Physiotherapy in Health Centres/Outreach Clinics

Health centres should be appropriately developed to provide physiotherapy at a local level.

7.9.2f Physiotherapy for the Respite Patient

At present, respite beds are used mainly to facilitate the carers of home-based patients rather than the patient themselves. The opportunity to continue rehabilitation should be encouraged and it is suggested that provision should be made for respite beds.

7.9.2g Develop Co-operation between Voluntary and Statutory Bodies in the Provision of Physiotherapy Services

It is recommended that voluntary and statutory bodies work together in the development of physiotherapy services.
7.10 PHYSIOTHERAPY FOR CHILDREN WITH MENTAL HANDICAP

Present services for children can be identified as follows :-

* Community physiotherapy for mental handicap
* Voluntary Institutions

7.10.1 Community Physiotherapy for Mental Handicap

Community physiotherapy for this group is provided in :-

* Child’s home
* Health centres
* Special care units
* Special schools

7.10.1a Child’s Home

Home visits are carried out in Meath and Louth. This service is not available in Cavan/Monaghan. Input ranges from zero in Cavan/Monaghan to 0.4 WTE in Meath (Table 7).

7.10.1b Health Centres

Health centres are used as bases for treatment by the community physiotherapist in Louth and Meath when appropriate. This service is not available in Cavan/Monaghan.

7.10.1c Special Care Units

There are special care units in both Cootehill, Co Cavan and Navan, Co Meath. Physiotherapy is provided in both with 0.05 WTE in Cootehill and 0.5 WTE in Navan (Table 7).

7.10.1d Special Schools

Limited physiotherapy is provided in the special schools in Navan (St Mary’s and St Ultan’s) and in Cootehill. There is no service available in other areas.

7.10.2 Voluntary Institutions

St Mary’s Hospital, Drumcar, Co Louth provides in-patient, special school and day-care facilities for children with mental handicap. There is no other voluntary service available in this area. Physiotherapy input in Drumcar is as follows:-

<table>
<thead>
<tr>
<th>Service</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Patient</td>
<td>0.03</td>
</tr>
<tr>
<td>Special School</td>
<td>0.06</td>
</tr>
<tr>
<td>Day Care</td>
<td>0.25</td>
</tr>
</tbody>
</table>
7.11 FUTURE SERVICES FOR CHILDREN WITH MENTAL HANDICAP

7.11.1 Introduction

The physiotherapist is an important member of the multi-disciplinary team in the management of mental handicap. Physiotherapy input includes assessment, facilitation techniques, exercise programmes, education of family, sensory integration and provision of appliances.

Objectives include :-

* Monitoring and promoting motor development
* Promoting good posture and preventing deformities
* Reduction of sensory defensiveness
* Negate as far as possible the effects of other handicaps on motor development
* Encourage participation in sports and fitness programmes
* Support the child and family
* Assess and advise with regard to equipment and appliances

Management of this client group occurs predominantly in the community, ideally to allow the service to follow the client to the most appropriate setting. Treatment often lasts many years and they may never be fully discharged from the service. Problems with the present service are outlined as follows :-

* No community physiotherapy in Cavan/Monaghan
* Inadequate physiotherapy staffing levels
* Insufficient treatment room and equipment
* Minimal physiotherapy service to the special schools
* No physiotherapy input for sports
* No senior specialist physiotherapist for this client group

7.11.2 Recommendations

The following have been identified as areas which need development :-

* Community physiotherapy to be made available to children with a mental handicap in Cavan/Monaghan
* Adequate space and equipment to be made available for a variety of treatment techniques

* Suitable staffing levels to be provided for this client group

* Physiotherapy involvement for sports for the disabled

7.11.2a Community Physiotherapy to be made available to Children with Mental Handicap in Cavan/Monaghan

Home physiotherapy visits should be made available to this client group in Cavan/Monaghan.

7.11.2b Adequate space and Equipment to be made available for a variety of Treatment Techniques

Appropriately equipped treatment facilities should be made available in local health centres, special schools and special care units.

7.11.2c Treatment to be made available at a variety of Locations to maximise benefit to Child

The physiotherapy service must be flexible to allow treatment to take place in the most appropriate location e.g. home, school, special care unit. Physiotherapy involvement for sports with adequate staffing levels in the community for the disabled should ensure participation in sports for this group.
7.12 PHYSIOTHERAPY FOR ADULTS WITH MENTAL HANDICAP

Present services for adults with mental handicap can be identified as follows:-

* Voluntary services

* Community physiotherapy for adults with mental handicap

7.12.1 Voluntary Services

St Mary’s Hospital, Drumcar, provides an in-patient physiotherapy service for adults with mental handicap. A day-care physiotherapy service is also provided in Hilltop Centre, Dundalk and Magdalen Centre, Drogheda. There is no other voluntary service available in this area. Physiotherapy input in Drumcar is as follows:-

<table>
<thead>
<tr>
<th>Service</th>
<th>Full Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult In-patient</td>
<td>0.5 WTE</td>
</tr>
<tr>
<td>Adult Day-care</td>
<td>0.1 WTE</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>0.6 WTE (e.g. seating assessments, home visits, splinting assessments, student lectures, back care and ergonomic assessment).</td>
</tr>
</tbody>
</table>

7.12.2 Community Physiotherapy for Adults with Mental Handicap

At present, there is no community service for adults with mental handicap in the region.
7.13 FUTURE SERVICES FOR ADULTS WITH MENTAL HANDICAP

7.13.1 Introduction

Physiotherapy input in this area includes respiratory care, balance and gait training, stretchings and passive movements for the immobile patient, hydrotherapy and assessment and referral to outside units e.g. seating, splinting and footwear specialists.

Problems with the present service are outlined as follows:-

* No Community service
* Inadequate in-patient physiotherapy staffing levels e.g. 1 physiotherapist for 253 adult in-patients resident in Drumcar
* No physiotherapy service available to Drumcar Park Enterprises (i.e. Workshop)

7.13.2 Recommendations

The following have been identified as areas which need development:-

* Community physiotherapy service
* Adequate staff for in-patient and day-care patients be provided for evaluation/assessment and appropriate treatment
* Adequate space and equipment to be made available
* Service development to co-ordinate voluntary and statutory bodies
* Physiotherapy to be provided for respite patients

7.13.2a Community Physiotherapy Services

Community physiotherapy services should be provided to treat mentally handicapped adults in the home, rehabilitation centre or sheltered workshops as appropriate.

7.13.2b In-Patient and Day Care

In-patients in continuing care should be catered for by increasing staffing levels. Day-care units should be adequately staffed to provide a service to this group.

7.13.2c Space and Equipment

Facilities in Day-care units, sheltered workshops etc. should be adequately equipped and large enough to provide physiotherapy treatment.

7.13.2d Co-Ordination of Voluntary and Statutory Bodies

Increased co-operation between the services would help to make it more efficient and effective.

7.13.2e Physiotherapy for Respite Patients with Mental Handicap

Where respite is required, physiotherapy should be available to this client group.
7.14 PHYSIOTHERAPY FOR THE PSYCHIATRIC PATIENT

Present services for psychiatric patients are as follows:

* Continuing care of psycho-geriatric patients in longstay units
* In-patient physiotherapy for psychiatric patients when requested

7.14.1 Continuing Care of Psycho-geriatrics in Longstay Units

Maintenance of mobility, chest physiotherapy, reduction of pain, prevention of deformity and evaluation of symptoms are some of the skills which the physiotherapist has to offer the psycho-geriatric patient in continuing care. At present this service is only available in Monaghan with 0.15 WTE in St. Davnet’s Hospital (Table 8).

7.14.2 Inpatient Physiotherapy for Psychiatric Patients when requested

In-patient physiotherapy for the psychiatric patient is in the area of respiratory care, mobilisation, reduction of pain and evaluation of symptoms. At present, this service is only available in Monaghan with 0.05 WTE physiotherapy cover in St. Davnet’s Hospital.
7.15 FUTURE SERVICES FOR THE PSYCHIATRIC PATIENT

7.15.1 Introduction

Psycho-geriatric patients like other elderly patients are admitted into long-term care for a number of reasons including:

* Immobility and the loss of independence

In the past patients were not encouraged to take exercise as part of the normal daily routine. Instead, many remained seated for long periods of time without any form of exercise whatsoever. This has resulted in reduced walking ability in this group. The present policy of maintaining the psychiatric patient in the community should result in a higher level of walking ability in this group (Crews, 1990). The patient will still continue to be categorised by nature of their physical diagnosis.

The objectives of physiotherapy are:

* To encourage mobility and fitness programmes
* To promote relaxation in stress related illness
* To promote good posture and to prevent potential deformities
* To maintain clear airways in the case of respiratory disability

The problems with the present service are as follows:

* Lack of structure for service delivery
* No physiotherapy in Louth, Meath and Cavan
* No community physiotherapy service
* Inadequate physiotherapy staffing levels

7.15.2 Recommendations

The following have been identified as areas which need development:

* Suitable staffing levels to be provided
* Treatment to be made available as part of the total physiotherapy service

The service should allow treatment to take place in the most appropriate location e.g. home or day care centres. Community physiotherapy should be made available where appropriate.
7.16 PHYSIOTHERAPY IN THE ACUTE HOSPITAL

Services in the acute hospital can be divided into two main categories:

A. In-patient
B. Out-patient

7.16.1 In-Patient

7.16.1a Introduction

In-patient physiotherapy involves the care of the acutely ill patient and aims at their optimal discharge into the community if possible, or placement in an appropriate care setting. Areas covered include pre- and post-operative care, medical, surgical, obstetrics, gynaecology, orthopaedics, paediatrics and rheumatology. The quantity of physiotherapy patients receive is dependent on the:

* Acuteness of the disease
* Availability of staff

Patients with a life-threatening respiratory condition always receive intensive intervention if requested and can require a 24 hour on call emergency service. However, this can lead to other less acute patients receiving a reduced level of service.

7.16.1b Medical Patients

The services to the medical wards involve mainly respiratory care, neurology and rheumatology. Respiratory care is mainly in the area of chest clearance, re-education of breathing techniques, increasing exercise tolerance and education and advice on prevention of further episodes to enable the patient to lead as active a lifestyle as possible.

Patients admitted with an acute neurological or rheumatological episode often need intensive rehabilitation over a prolonged period to achieve the necessary level of independence. These patients need a minimum of two treatment episodes everyday. At present this is not always possible. Physiotherapy input to the medical patient ranges from 0.67 WTE in Monaghan General Hospital to 1.0 WTE in Our Lady of Lourdes Hospital, Drogheda (Table 9).

7.16.1c Surgical Patients

Physiotherapy for the surgical patient includes pre-operative chest assessment and treatment where necessary, and explanation of the aims and techniques of post-operative treatments and post-operative chest care. The aim is to restore pre-operative status. Physiotherapy input ranges from 0.3 WTE in Cavan General Hospital to 0.7 WTE in both Our Lady of Lourdes Hospital, Drogheda and Our Lady’s Hospital, Navan (Table 9).

7.16.1d Orthopaedic Patients

The orthopaedic patient requires a high level of in-patient input. This, in physiotherapeutic terms, is a highly specialised area requiring supervisory skills of an appropriate trained...
specialist physiotherapist. In-patient orthopaedic services are available at Our Lady’s Hospital, Navan with 1.3 WTE for 82 beds and Our Lady of Lourdes Hospital, Drogheda with 0.7 WTE for 27 beds.

7.16.1 Obstetrics/Gynaecology Patients

Care of the obstetrics/gynaecology in-patients involves pre- and post-operative chest care, the treatment of musculo-skeletal problems and post-natal classes. It is through the post-natal classes that mothers are educated regarding promotion of continence, re-education of abdominal muscles, lifting and back-care. This is a vital aspect of preventative care and has been discussed in more detail in section 7.3.2. The total physiotherapy cover for obstetrics/gynaecology ranges from 0.1 WTE in Monaghan General Hospital to 0.4 WTE in Our Lady of Lourdes Hospital, Drogheda (Table 9).

7.16.2 Paediatric Patients

Care of the paediatric in-patient is in the areas of neo-natal screening, intensive care and respiratory care. This involves treatment of the child and advice for education of the parents. There are two paediatric units in the region and a visiting paediatrician to Monaghan General Hospital. Physiotherapy input is 0.1 WTE in Monaghan General Hospital, 0.20 WTE in Cavan General Hospital and 0.6 WTE in Our Lady of Lourdes Hospital, Drogheda (Table 9).

7.16.3 Rheumatology Patients

There is no consultant rheumatologist in the North Eastern region and such patients are seen mainly by the medical physicians or the orthopaedic surgeons if surgery is required. Many of these patients are treated outside the region at specialist rheumatological clinics. Input to this group must therefore be allocated to the aforementioned specialists.

7.16.2 Out-Patients

The physiotherapy out-patient department receives a wide range of referrals predominantly musculo-skeletal and rheumatological in origin. Patients are treated using a problem solving approach with an increasing emphasis on self treatment and care. Physiotherapy input ranges from 1.25 WTE in Monaghan General Hospital to 4.02 WTE in Our Lady of Lourdes Hospital, Drogheda (Table 9).
7.17 FUTURE SERVICES TO THE ACUTE HOSPITAL

In order to create a patient focused service, consideration must be given to making the service more accessible. This would be best achieved by developing treatment from the acute hospital to smaller satellite clinics. The area of health promotion needs development within the community to assist in reducing the high proportion of preventable disease. The success of this initiative is dependant on having adequate resources both by way of staff and facilities.

A. In-Patients
B. Out-Patients

7.17.1 In-Patients

7.17.1a Medical Patients

Problems with the present service can be identified as follows:-

* Insufficient staff time
* Inadequate support staff (e.g. aides, porters etc.)
* Constraints on bed numbers
* Reduction of length of stay in hospital
* Lack of primary care programmes (e.g. exercise tolerance training)
* Lack of appropriate rehabilitation facilities
* Inadequate back-up services following discharge

7.17.1b Recommendations

The following have been identified as areas which need development:-

* A re-assessment of staffing levels so as to bring services in line with those recommended in the Vallow Report
* The provision of support staff to carry out basic mobilisation under supervision of a qualified therapist
* That assessment and rehabilitation beds be made available for patients requiring an intensive physiotherapy input when the need for acute care has ended
* The provision of adequate patient education whilst in hospital so as to encourage patients to take a more active role in their treatment
* That appropriate community services be available to the patient on their discharge e.g. home visits, day hospitals, day care etc.
7.17.1c Surgical Patients

Problems with the present service can be identified as follows:-

* Insufficient staff time
* Lack of comprehensive pre-operative patient assessment and education
* Inadequate support staff

7.17.1d Recommendations

Areas which need development are as follows:-

* Patients should receive pre-operative physiotherapy so as to prepare them for post operative care and so prevent complications such as chest infections (Bourne et al., 1993)
* That within the time available for in-patient treatment there should be time to intensively treat the acutely ill patient without detracting from the treatment of others
* The availability of the services of an appropriate aide to assist in the mobilisation of post operative patients

7.17.1e Orthopaedic Patients

Problems with the present service can be identified as follows:-

* The absence in Our Lady’s Hospital, Navan of a senior physiotherapist specialised in the area of orthopaedics
* The level of staffing in orthopaedics throughout the region is far below the national norm
* Inadequate facilities e.g. size and location of departments and hydrotherapy units

7.17.1f Recommendations

Areas which need development are as follows:-

* As in Drogheda a specialist senior therapist be appointed to the Regional orthopaedic unit in Navan
* The staffing of these units is appropriate to the number of beds and that as a result, in-patients receive adequate treatment and education so as to aid successful discharge
* That discharges are planned in association with other members of the health care team ensuring referral to appropriate out patient and community services
Facilities must be up-graded to allow for delivery of quality service

7.17.1g Obstetrics/Gynaecology Patients

Problems with the present service can be identified as follows: -

* Under utilisation of available specialist skills
* Lack of staff and equipment for the treatment of the high incidence of post natal incontinence

7.17.1h Recommendations

Areas which need development are as follows: -

* That all post natal patients receive detailed information regarding the potential problems of pelvic floor weakness and how these can be prevented
* That a comprehensive screening process be adopted to identify patients at risk in advance of problems occurring
* That facilities be provided to ensure optimal treatment of post natal incontinence

7.17.1i Paediatric Patients

Problems with the present service can be identified as follows: -

* The absence of a senior physiotherapist specialised in the area of paediatrics
* There is no comprehensive policy on the monitoring and evaluation of special care babies regarding motor development
* Inadequate staffing levels
* Lack of separate treatment facilities for the assessment and treatment of children

7.17.1j Recommendations

Areas which need development are as follows: -

* The appointment of specialist seniors in paediatrics
* Development of an assessment and monitoring policy for special care neonates
* That staffing of these units is appropriate to the services being provided
* Provision of separate facilities for the assessment and treatment of these children
7.17.2 Out-Patients

7.17.2a Introduction

Special attention is given to making this a patient friendly service by accepting referrals from General Practitioners and other allied professionals. At present many Dublin hospitals accept referrals only from their own consultants. This is advantageous in that many patients are seen in a more acute phase of their illness and consequently respond better to treatment. On the other hand it results in a significantly higher rate of referral which can lead to longer waiting times.

Problems with the present service can be identified as follows: -

* Centralisation of services leads to a problem of access for many patients with long distances to travel coupled with poor public transport

* Lack of input at primary care level resulting in a high proportion of patients incurring preventable illness e.g. back pain

* Insufficient staffing levels to cater for increased referral rate.

* The outpatient facilities generally do not allow effective delivery of services

* Under utilisation of physiotherapy skills at orthopaedic/fracture clinics

7.17.2b Recommendations

The following have been identified as areas which need development: -

* That out-reach clinics be set up at appropriate venues throughout the region so as to assist accessibility for all patients

* That the area of primary and preventative care be developed so as to reduce the incidence of disease

* That the staffing of the service be reviewed in accordance with the increasing number of patients referred to it

* That adequate facilities be available to deliver the service

* That a physiotherapist attends orthopaedic/fracture clinics to assist in reviewing and advising patients. This will help maximise effective use of outpatient time
CHAPTER EIGHT

STRATEGY FOR THE DEVELOPMENT OF THE PHYSIOTHERAPY SERVICE

8.1 SUMMARY
8.2 INTRODUCTION
8.3 CLIENT GROUPS
8.4 PRESENT GRADING STRUCTURE
8.5 PROPOSED GRADING STRUCTURE
8.6 QUALITY ASSURANCE
8.1 SUMMARY

It is suggested the physiotherapy service can be improved in the North Eastern Health Board Region by a re-organisation of delivery of service to target client groups. Grading structures must be changed to facilitate this development and quality assurance guidelines must be developed.

8.2 INTRODUCTION

The availability of appropriate physiotherapy services to the public in the North Eastern region is random, inadequate and often takes place in an inappropriate location. The needs of the population varies considerably in intensity, duration and location of treatment. Physiotherapy has been primarily hospital based, targeting acute conditions in central locations. The elderly, chronically ill, psychiatric patients and mentally handicapped have virtually no access to a physiotherapy service (Chapter 7). The reasons for the inadequacies are historical and include insufficient staffing levels, lack of management skills within the profession, and lack of targeting of client groups by the health service as a whole.

There is at present a very obvious desire to improve health services to the public by the Minister for Health, Department of Health, Health Board and physiotherapy managers. (Shaping a Healthier Future, Report on Elderly). The specific needs of client groups are varied (Chapter 7) and it is imperative that the service be appropriate for the requirements of the patients. To ensure an effective delivery of services, physiotherapy managers must be given the training, resources and authority to plan for the future. Senior clinical staff must ensure delivery of quality service to the patient in the most efficient and effective manner, and staffing levels must be improved to provide the service. Systems of auditing and measuring physiotherapy interventions must be developed and standards of practice set. Information technology and analysis of data will be among the future tools for evaluating the service.

8.3 CLIENT GROUPS

8.3.1 Health Promotion

Prevention of illness or disability is a basic principle of good health care.

It is envisaged that physiotherapists work closely with Health Promotion officers and the Department of Education in offering their skills in prevention of illness. Preventative methods would continue to be used in the therapists face to face contact with their patients. Health promotional activities would most appropriately take place in out reach clinics, outpatients and in the community, as well as education programmes targeting schools, workplaces and mother and baby groups.
8.3.2 Elderly

Physiotherapy has a major role to play in the target set by "Shaping a Healthier Future" of keeping 90% of those over 75 at home. The service must develop in line with the Health Board’s plan for Day Hospitals and Rehabilitation Units. It is vital that the service is flexible to follow the patient to the appropriate locations depending on his/her present needs.

Information technology will be vital in the efficient running of such a service. Consultation between therapists in different locations will be necessary for good care as a clinical senior in neurology in each Community Care area would be responsible for training junior staff and maintaining quality and standards.
8.3.3 Physical and Sensory Handicap

8.3.3a Children

The needs of the physically or sensory handicapped child changes with age and general health. The physiotherapist often makes the initial contact from health services with the family of a physically handicapped child. A good relationship between the therapist and the family is vital for effective intervention. Flexibility in terms of intensity of treatment, location and general management will be hallmarks of this service in the future. Clinical seniors in paediatric physical handicap would be responsible for training, auditing and standard setting for this service.

Future services must be developed in close co-operation with voluntary ongoing actions, and other professions. Increased staffing levels in the community will be necessary to cater for this group.
8.3.3b Adult

Priority must be given to intervention in the early stages of chronic disease so as to maximize effectiveness of input. This can be achieved by close co-operation and information sharing with general practitioners and other health care professionals. The development of a national database on physical handicap will facilitate delivery of services.

Services to this client group are most effectively managed in the community, while availing of services in out-reach clinics, day centres and voluntary organizations and out-patients.
8.3.4 Mental Handicap

8.3.4a Child

Physiotherapy services to this client group would most appropriately be based in the community, in liaison with the multidisciplinary team. Clinical specialists in mental handicap in each Community Care area would be responsible for training junior staff and the overall planning of clinical services as part of the early intervention team. The service must be flexible to follow the child into the most appropriate setting. The development of a national database on the needs of people with mental handicap will play a vital role in planning the service.
The community physiotherapist service, if adequately staffed would be the most appropriate setting for management of this client group. Flexibility of location of treatment and liaison with the multidisciplinary team and voluntary services would be vital.
8.3.5 Psychiatry

Services to the psychiatric patient would be part of the community service, while providing cover to the hospitals. Training must be provided to junior staff to develop special skills for this client group. Close liaison with the multidisciplinary team would be vital.

\[ \text{ACUTE HOSPITAL CARE} \rightarrow \text{PATIENT AT HOME} \rightarrow \text{DAY CARE} \rightarrow \text{CONTINUING CARE} \]

8.3.6 Acute Hospital

In line with "Shaping a Healthier Future" the physiotherapy service in acute hospitals must emphasise "appropriate care at the appropriate level". Flexibility of service must ensure that acute beds are not "held up" because of inadequate physiotherapy input. Seniors in charge of hospital services would deploy staff to ensure quick through put, and good communication and liaison with rehabilitation units, community physiotherapists and convalescent homes. Specialist seniors in target areas e.g. orthopaedics, respiratory care would monitor quality and standards of care, as well as ensuring adequate follow up on discharge to the community. Staffing levels in all hospitals must be increased to allow efficient and effective use of physiotherapy skills in the acute hospital, this may include intensive staffing of day wards, intensive care, orthopaedic wards etc.

8.3.7 Out-Patients and Outreach Clinics

The outpatient physiotherapy service in the North Eastern region is accessible to the public in terms of general practitioners referral, but not in terms of location. It is envisaged that smaller units in out-reach clinics, throughout the Board area would aid access to out-patient physiotherapy services. Health promotional activities such as ante and post natal classes, back care and lifting and continence advice may be most effectively carried out at local level. The location of such clinics would be in line with Health Board plans, however involvement of the physiotherapy managers at an early stage would be vital to ensure that the facility be effectively equipped and planned.

Deployment of physiotherapists to orthopaedic/fracture clinics may be an efficient use of staff. Data collection, auditing and standard setting for out-patient practice must be developed by physiotherapy managers.
8.4 PRESENT GRADING STRUCTURE

The present physiotherapy grading structure is no longer responsive to the service needs. The efficiency and effectiveness of future physiotherapy services will rely on good planning, management and communication skills among physiotherapy managers. The present grading structure (Appendix VI) allows for senior, and senior in charge hospital therapists on the basis of number of therapists employed. Seniors at present carry large caseloads thus leaving little space or time for management duties. The present structure also hinders the development of clinical specialist seniors, who should be responsible for clinical auditing, training and supervision of junior staff.

There is a high proportion of junior staff in the present structure. In practice many are highly qualified practitioners who have more than the minimum 3 years experience for senior posts. Many such therapists are lost from the service to private practice as the prospects of promotion in the present structure are so poor.

8.5 PROPOSED GRADING STRUCTURE

It is proposed that the following structure would be more appropriate in meeting the needs of the North Eastern region (Table 17). It is based on the British grading structure which encompasses the different levels of responsibility and skills needed for future physiotherapy practice (Appendix VII).

(a) Regional physiotherapy service managers
(b) Physiotherapist in charge
(c) Specialist senior
(d) Physiotherapists

(a) Regional Physiotherapy Service Manager

The role of this individual would be the management and planning of services for a population of 100,000 e.g. each Community Care area in North Eastern health Board.

Including:-

* Regional budgetary management
* Co-ordination of physiotherapy services for the region
* Development of policy and procedure
* Setting standards of care in conjunction with clinical seniors on which both organisational and clinical audit may be based
* Developing and service plans for client groups in co-operation with Health Board Managers

* Assist in developing an epidemiological database

* Ensure structural post graduate education for physiotherapy staff

(b) **Physiotherapist in Charge**

The physiotherapist in charge would be in charge of a hospital or Community Care area with a staff of 2 or more i.e. physiotherapists and assistants. The role would include:

* day to day running of unit
* local equipment/budgetary management
* data collection
* identification of local needs or trends
* reduced caseload
* overall responsibility for in-service training in the unit
* personnel management
* management of assistants

(c) **Speciality Seniors**

Clinical specialists are necessary to develop quality services in each hospital and Community Care area e.g. paediatric physical handicap, orthopaedics etc.

Duties would include:

* supervision and training of junior staff
* clinical audit
* research
* standard setting in conjunction with regional physiotherapist

(d) **Physiotherapists**

Junior physiotherapists should ideally have less than 3 years post qualification experience when scope for promotion is improved in a new grading structure. Newly qualified therapists require training and supervision by clinical seniors. Duties include:

* management of a clinical workload
* dealing with administrative duties associated with that workload i.e. record keeping, output statistics and time management
consolidation and augmentation of knowledge and skills learned as an undergraduate

8.5.1 Incremental Growth of Physiotherapy Services

The physiotherapy service in the North Eastern Health Board is grossly understaffed. Staffing levels must be substantially increased to provide an equitable service. A proposal for the incremental growth of staffing levels in the Health Board is charted (Chart II) for the North Eastern Health Board. This chart does not include the voluntary services.

In 1995 it is suggested that 14 new posts be created by North Eastern Health Board. Services to be targeted urgently are all Community Care areas, Our Lady's Hospital Navan and Louth County Hospital. Client groups to be targeted in 1995 will be paediatrics, the elderly and orthopaedics.

It is recommended that 7 new posts be created each year until 2000. These should be deployed to provide new posts for mental and physical handicap, the elderly and Health Promotion. Clinical senior posts must be included in the new staffing allocation.

8.6 QUALITY ASSURANCE

The quality improvement programme which will be adapted by physiotherapy managers in the North East will involve the following components:-

- Standards
- Audit
- Consumer satisfaction service.

8.6.1 Standards

The Association of Chartered Physiotherapists in management have begun to address the question of standard setting for physiotherapy in Ireland. These standards should be based on "professionally agreed levels of performance which reflect what is acceptable, achievable, observable and measurable" (Sale, 1990).

8.6.2 Audit

"Clinical audit is widely recognised as the systematic and critical analysis of the quality of clinical care, including the procedures used for diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient". Clinical audit - a policy statement from the Department of Health (Britain) launched on July 2, 1993. It will be the responsibility of the physiotherapy services managers to develop systems of auditing clinical, administrative and budgetary activities. (Dawson et al. 1993).
8.6.3 Consumer Satisfaction

Consumer satisfaction can be used as an indicator for measuring quality of service. The components to be measured include time on waiting list, time keeping, courtesy and efficiency of staff, and subjective benefits of treatment.

Much work has to be done on a national basis by physiotherapy managers in developing quality assurance indicators. The proposed regional physiotherapy service manager must be given the resources to help to achieve this task. Resources necessary would include information technology, secretarial backup, and support for research activities.
Table 17 Proposed Physiotherapy Structure
Chart II
Optimum Staffing Levels projected over six year period

Year Optimum

Numbers exclude voluntary service
* % of optimum vallow levels
CHAPTER NINE

CONCLUSION

9.1 CONCLUSIONS
9.1 CONCLUSIONS

1. Physiotherapy is a client-focused profession which aims to prevent and reduce impairment, disability and handicap.

Recommendations

That the Physiotherapy and Health Board Managers support and encourage the development of the service so as to improve access and equity for all the client groups and the population of the region as a whole.

2. The basing of physiotherapy practice on the medical model limits the scope of practice and does not allow for accurate outcome measurement.

Recommendations

That the concept of impairment disability and handicap (W.H.O. 1980) be used as a basis for development of outcome measures in physiotherapy.

3. Adequate data on epidemiology, client groups and physiotherapy services was not readily available for the purposes of this report. Delays were incurred as physiotherapy seniors analyzed each area to obtain this data.

Recommendations

* Accurate definition of the client groups by the Department of Health.
* Development of regional and national data bases on client groups and their needs.
* Information Technology be made available for all physiotherapy services.
* Standardisation of physiotherapy records.

4. To date there are no national standardised methods of auditing and quality assurance in physiotherapy.

Recommendations

* To establish national standards, both clinical and organisational, to which the audit mechanism can be applied.
* To apply these standards at a local level.
* That information technology be made available to facilitate auditing.
5. The physiotherapy services of each region have been developed in an ad-hoc manner.

Recommendations

A physiotherapy services manager is required in order to develop and deliver a co-ordinated, equitable and accessible physiotherapy service for a population of 100,000.

6. There is a very high level of interest in good training opportunities among undergraduate physiotherapists.

Recommendations

The development of a structured approach to post-graduate education in the North Eastern Health Board would greatly facilitate the recruitment and retention of staff.

7. Staffing levels in the North Eastern Health Board are inadequate to serve the needs of the client groups, particularly in Community Care.

Recommendations

* Staffing levels to be increased in an incremental manner.

* Staffing to be targeted at the various client groups particularly in the area of Community Care.

8. The large demand for physiotherapy services has led to waiting lists and prioritisation. The needs of the client groups are not met by the current structure.

Recommendations

* That the physiotherapy needs of the client groups be further evaluated by the physiotherapy services manager.

* A physiotherapy service shall be put in place to meet those needs as identified.

* That the physiotherapy service be provided in the location most suitable for the patient/client.
9. The public sector is losing skilled staff to the private sector because of poor promotional prospects.

**Recommendations**

* That the grading structure be changed to reflect the duties and responsibilities of physiotherapy staff and encourage mobility with regards to promotion.

* The grading structure be altered to allow the development of specialisation.

10. The area of primary care (i.e. health promotion) is becoming increasingly important as outlined in "Shaping a Healthier Future - Department of Health 1994". Physiotherapy has a unique contribution to make in this area but remains underdeveloped.

**Recommendations**

That comprehensive programmes be established in this area utilising the available skills of the physiotherapist.

11. There are no designated rehabilitation beds in the North Eastern region.

**Recommendations**

* That rehabilitation beds be established in each area.

* That the appropriate level and skill mix of rehabilitation staff be assigned to these beds.

12. There is insufficient secretarial and support personnel involved in physiotherapy services both organisationally and clinically.

**Recommendations**

* That adequate secretarial assistance be made available.

* That adequate portering/aide staff be made available.

Physiotherapy endeavours to prevent and reduce the levels of impairment, disability and handicap in society, so improving general health and quality of life by using professional physiotherapy skills in the spirit of caring and ensuring the human rights of all.

This philosophy is the basis upon which this report was compiled.
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                            Physiotherapy Journal-Vol 66 : 4 pages 112-114
Chairman
President
Vice-Chairman
Hon. Secretary
Hon. Treasurer
PRO
One Additional Council Member

Executive Board
Officers of Council: 7

Council: 23

Employment Groups: 3
Management 1*
Private Practice 1*
Teachers *

Others: 2
Editor of Journal 1
Student Delegate 1

President: 1
Co-Options: 4

Branches: 13

5* 2* 1* 1* 1* 1* 1* 1* 1*

Eastern 53%
Southern 10%
Western 7%
South Eastern 6%
North Eastern 6%
Mid-Western 6%
North Western 3%
Midland 5%
Overseas 5%
Special/Undergraduate
APPENDIX II
THE ROLE OF THE PHYSIOTHERAPIST

ASSESSMENT & TREATMENT

HEALTH PROMOTION

PHYSIOTHERAPIST

TRAINING & EDUCATION

PROFESSIONAL DEVELOPMENT

RESEARCH

MANAGEMENT
APPENDIX III

TREATMENT MODALITIES USED BY PHYSIOTHERAPISTS

Below are listed some modalities of treatments available to physiotherapists:

Short-wave
Interferential
Ultrasound
Laser
Faradism
Ultra-violet
T.E.N.s
Infra-red
Hot packs
Wax
Ice
Traction
Acupuncture
Hydrotherapy
Massage
Mobilisation techniques
Re-education of balance
Re-education of walking
Mobilising and strengthening exercises
Chest physiotherapy
Neuromuscular Stimulation
Contained in this appendix are bar graphs which summarise the physiotherapy input into the various client groups.
BAR GRAPH 4

W.T.E. PHYSIOTHERAPY INPUT IN PRIMARY & PREVENTATIVE CARE
EXPRESSED AS A PERCENTAGE OF CURRENT STAFFING LEVELS

BAR GRAPH A - HOSPITALS

% W.T.E.

4% 10% 6% 17.5% 4.3%

Our Lady's Lourdes Cavan General Louth County Monaghan Hospital Hospital Hospital Hospital Hospital Navan Drogheda Dundalk General Monaghan

BAR GRAPH B - COMMUNITY

% W.T.E.

10% 5.5%

Louth Community Care Meath Community Care
BAR GRAPH 5


Continuing Care/Respite Care/Community Care

LOUTH 1.4
MEATH 1.05
CAVAN 1.1
MONAGHAN 0.2
BAR GRAPH 6

W.T.E. PHYSIOTHERAPY INPUT FOR CHILDREN AND ADULTS WITH PHYSICAL HANDICAP

BAR GRAPH 6 (A) - CHILDREN

W.T.E.

| Region  | W.T.E.
<table>
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BAR GRAPH 6 (B) - ADULTS

W.T.E.

| Region  | W.T.E.
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</table>
BAR GRAPH 7

W.T.E. PHYSIOTHERAPY INPUT FOR CHILDREN AND ADULTS WITH MENTAL HANDICAP

BAR GRAPH 7 (A)  -  CHILDREN

W.T.E.

0.59 0.6 0.1 0
LOUTH MEATH CAVAN MONAGHAN

BAR GRAPH 7 (B)  -  ADULTS

W.T.E.

0.62 0 0 0
LOUTH MEATH CAVAN MONAGHAN
BAR GRAPH 8

W.T.E. PHYSIOTHERAPY INPUT FOR PSYCHIATRIC PATIENTS (1995)

W.T.E

LOUTH MEATH CAVAN MONAGHAN

0.2
W.T.E. PHYSIOTHERAPY INPUT IN OUR LADY'S HOSPITAL NAVAN
EXPRESSED AS A PERCENTAGE OF OPTIMUM STAFFING LEVELS (VALLOW)

BAR GRAPH 9 (B1)

59% 74% 42%

Respiratory Surgical Orthopaedics
Neurological (In-Patients)
Medical
BAR GRAPH 9(B2)

W.T.E. PHYSIOTHERAPY INPUT IN OUR LADY OF LOURDES HOSPITAL DROGHEDA

EXPRESSED AS A PERCENTAGE OF OPTIMUM STAFFING LEVELS (VALLOW)
BAR GRAPH 9(B3)

W.T.E. PHYSIOTHERAPY INPUT IN LOUTH COUNTY HOSPITAL
EXPRESSED AS A PERCENTAGE OF OPTIMUM STAFFING LEVELS (VALLOW)

Respiratory  40%  Surgical  54%  Gynae - Obstetrics  27%
Neurological  Medical

130
BAR GRAPH 9(B4)

W.T.E. PHYSIOTHERAPY INPUT IN MONAGHAN GENERAL HOSPITAL
EXPRESSED AS A PERCENTAGE OF OPTIMUM STAFFING LEVELS (VALLOW)
BAR GRAPH 9(B5)

W.T.E. PHYSIOTHERAPY INPUT IN CAVAN GENERAL HOSPITAL

EXPRESSED AS A PERCENTAGE OF OPTIMUM STAFFING LEVELS (VALLOW)

% W.T.E

- Respiratory: 40%
- Neurological: 79%
- Medical: 22%
- Surgical: 18%
APPENDIX V

INTRODUCTION

Physiotherapy out-patient departments in the North Eastern Health Board accept referrals from General Practitioners on an equal basis to the consultant hospital doctors. In some cases up to 50% of the referrals are from this source with the greatest number involving musculo-skeletal problems. Having access to this service negates the urgent referral of these patients to surgical and orthopaedic hospital clinics thereby reducing the stress on these services.

At present the major problem with the out-patient physiotherapy departments is that the need exceeds the resource. The GPs try to help this situation by sending only one in three of those they feel would benefit from physiotherapy.

All departments have long waiting lists which fluctuate with referral rates and staffing levels. The waiting lists are continuously reviewed and to help with the management of these lists, in an equitable manner, a meeting was held between the Physiotherapy Managers and General Practitioners from the GP Unit of the North Eastern Health Board to set up protocols for referral.

GENERAL PRACTITIONER PROTOCOLS FOR REFERRAL TO PHYSIOTHERAPY DEPARTMENT

The protocols devised are as follows :-

**Urgent Cases**

* Urgent cases will be seen within 72 hours.

* The word "urgent" should be written on the referral letter or included in any referral made by telephone

* If, following assessment, the patient's condition is not considered to be acute they will be given advice and offered an appointment within ( ) weeks.

* Urgent cases will include :-

    Acute respiratory conditions
    Acute/Severe pain due to :-
       Recent trauma
       Muscular/skeletal problems
    Inability to work due to pain and where job is in jeopardy if off work
    Neurological signs
    Spinal problems
Non-Urgent Cases

Will be seen within ( ) weeks.

High Priority :-

* Pain or discomfort due to muscular-skeletal conditions
* Respiratory conditions
* Neurological conditions
* Patients with reduced functional ability when physiotherapy intervention will effect significant benefit
  Mobility aids
* Uro-gynaecological conditions
* Bells Palsy

Low Priority :-

* All other referrals for chronic degenerative conditions
* Patients recently discharged from physiotherapy who have not responded to treatment.

All referrals should contain the following information :-

1. Patient’s Name
2. Patient’s Address
3. D.O.B.
4. Medical Card Number (if appropriate)
5. Diagnosis
6. Other relevant tests/results e.g. x-Ray, Blood tests

The GPs will be informed of the fluctuation of the waiting lists.
APPENDIX VI

PRESENT PHYSIOTHERAPY GRADING STRUCTURE

<table>
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<tr>
<th>Numbers Employed</th>
<th>Basic</th>
<th>Senior</th>
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<th>In-charge II</th>
<th>In-charge III</th>
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</tbody>
</table>

Ref: Physiotherapists working party report, July 1978

The In-Charge Grade I, II, III are graded as follows:

**GRADE 1**  Hospital with 5 but less than 12 physiotherapists

**GRADE 11** Hospital with 12 but less than 20 physiotherapists

**GRADE 111** Hospital with 20 or more physiotherapists

A requirement of three years satisfactory post qualification experience applies to all senior appointments and five years satisfactory post qualification experience applies to all In-charge appointments.
APPENDIX VII

STRUCTURE OF PHYSIOTHERAPY PROFESSION IN THE N.H.S.

District Physiotherapist 1

A physiotherapist who is responsible for the management and planning of services for a region with a population of 300,000 whether he/she has unit responsibilities.

District Physiotherapist 2

A physiotherapist who is responsible for the management and planning of services for a region with a population of 100,000 whether or not he/she has unit responsibilities. Also, an existing superintendent 1 who is responsible for the management and planning of services for a district in addition to his/her responsibilities.

Superintendent Physiotherapist 1

A physiotherapist who is in charge of 25 or more qualified staff and assistants.

Superintendent Physiotherapist 2

A physiotherapist who is in charge of 17 - 24 qualified staff or assistants.

Superintendent Physiotherapist 3

A physiotherapist who is:-

a) in charge of 9 - 16 qualified staff or assistants
or
b) in charge of a unit carrying out highly skilled or specialised work with at least one senior grade officer of the same profession
or
c) acting as a deputy to Superintendent Physiotherapist 1.

Superintendent Physiotherapist 4

A physiotherapist who is in charge of 2 - 7 qualified staff or assistant.
Senior Physiotherapist 1

A physiotherapist who is mainly undertaking highly skilled and specialized work beyond that covered in the training syllabus. Examples of such work might be research, development work in:-

a) the special difficulties of physically disabled children or the elderly
b) special techniques used for particular psychiatric problems
c) assessment procedures
d) splinting materials
e) neurology
f) the assessment and treatment of patients who are severely disabled or at special risk, for example, those with multiple disabilities and those in intensive care units including coronary care units, spinal injury units etc
g) the treatment of amputees
h) the treatment of the mentally handicapped. Such examples might, of course, be found in both hospital and community settings
i) either working single handed or responsible for one other qualified officer or assistant and mainly undertaking duties requiring the exercise of a particular expertise or ability or acting as a deputy to a Superintendent Physiotherapist 2 or 3.

Senior Physiotherapist 2

A physiotherapist who is:-

a) responsible for one other qualified officer or assistant or
b) carrying responsibilities greater than those of a physiotherapist of
c) working single handed or
d) mainly undertaking duties requiring the exercise of a particular expertise or ability

Such duties will entail the use of skills greater than those expected of a physiotherapist, for example, the treatment of patients presenting particular clinical and/or social problems

Physiotherapist

A physiotherapist who is working under the direct clinical supervision of a higher graded officer in the same profession.

The amount of time and level of expertise in the areas of clinical practice, research, teaching and management varies with grade and may be represented diagrammatically (Appendix II).