

Postural management for children with physical disabilities in
mainstream primary schools – a pilot study of the views of teachers
and teaching assistants.

A Report to the Posture and Mobility Group May 2008

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GLOSSARY

Postural management

Definition: A postural management programme is a planned approach encompassing all activities and interventions which impact on an individual's posture and function. Programmes are tailored specifically for each child and may include special seating, night-time support, standing supports, active exercise, orthotics, surgical interventions, and individual therapy sessions (Gerricke 2006).

Examples of special seating equipment and standing supports used in postural management:

Fig.1. Jenx Prone Stander



Fig 2. New Jenx Nursery Monkey

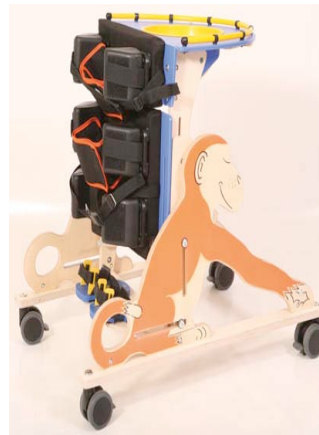


Fig 3. Jenx Beta with abduction block, hip supports and thoracics



(All pictures reproduced with kind permission of Jenx Limited)

Postural management for children with physical disabilities in mainstream primary school schools – a pilot study of the views of teachers and teaching assistants.

Executive Summary

The policy of educational inclusion has resulted in physically disabled children, some with complex needs, being educated in mainstream schools (Special Educational Needs and Disability Act 2001). This report presents the findings from a small pilot research project. Based on qualitative data gathered from four primary schools in Kent the report explores teachers and teaching assistants (TAs) understandings of postural management, and the barriers and facilitators to postural management in mainstream primary schools. Recommendations and implications for practice have been developed from the research after discussion with the project steering group. Steering group members included parents of children with disabilities, therapists and a specialist teacher.

Postural management for children with physical disability

A consensus statement on postural care has underlined the importance of delivering a consistent and integrated 24 hour programme of postural management to children with physical disabilities in order to limit longer-term health risks and to promote the child's comfort and active participation in functional activities. A postural management programme requires specialist equipment and daily exercises that ideally are incorporated into the children's routine at both home and school. To be successful it depends on every environment in which the child spends time being enabled to provide 24-hour postural management (Humphreys & Poutney 2006).

Definition: A postural management programme is a planned approach encompassing all activities and interventions which impact on an individual's posture and function. Programmes are tailored specifically for each child and may include special seating, night-time support, standing supports, active exercise, orthotics, surgical interventions, and individual therapy sessions (Gerrick 2006).

Schools play an important part in delivering postural management programmes to children with physical disabilities yet the majority of teachers and TAs are inexperienced and untrained. Insufficient numbers of occupational therapists and physiotherapists remains a barrier to providing consistent support to those responsible for managing postural management programmes for children with physical disabilities. Key recommendations of recent policy targeted at improving services for children with physical disabilities and their families, focus on the need to increase the knowledge and skills of all those working with disabled children and their families in order to keep pace with this changing population (Aiming High for Disabled Children 2007).

Design

This qualitative pilot study aimed to explore teachers' and TAs' views and experiences of delivering postural management programmes for children with physical disabilities in mainstream primary schools. A purposive sample of four primary schools in Kent was identified with assistance from the specialist teaching service and therapy managers in the area. Qualitative data gathered from individual and group interviews with 36 teachers and TAs were used to generate an explanatory framework around their experiences of managing postural care.

Research question(s)

RQ1 Explore the knowledge and understanding of teachers and TAs about postural management.

RQ2 Identify what barriers and facilitators exist in the delivery of postural management programmes in the mainstream primary school environment

RQ3 Investigate what types of information and support teachers and TAs require in delivering postural management programmes to children with physical disabilities in mainstream primary schools.

Key Findings & Recommendations

RQ1 Understandings of postural management in schools

1.1 A key finding from the research identified that 'postural management' is a health term and not widely used or understood by parents, teachers and TAs in schools. The steering group for the project suggested that 'postural care' or 'postural awareness' would be more appropriate terms to use in schools.

Recommendation: Develop a shared understanding and greater awareness of posture in mainstream schools between parents, therapists, teachers and TAs.

Recommendation: Make good posture a 'whole school' issue.

1.2 Teachers and TAs did have partial understanding of some principles of good posture, for example they could observe when children were sitting uncomfortably and when they were insufficiently supported. When carrying out therapy programmes with the children, they knew what to do but didn't always understand why they were doing it, and this resulted in a rigid adherence to programmes, which may disadvantage children. Teachers and TAs lack an overall framework that would assist them in making sense of their observations and experiences. Information and advice about managing the postural care needs of the child comes from a variety of sources leading to an incomplete jigsaw of advice and ideas. Very few teachers or TAs had personal experience of the longer-term benefits of postural management with children. Currently there is no formal training available for Initial Teacher Trainers (ITT), or Continuing Professional Development (CPD) for teachers or TAs, focusing on the postural needs of the disabled child in a mainstream school.

Recommendation: Develop a postural care framework for schools, as a basis for providing knowledge, skills, resources and support. Communicate this through a variety of different media within schools.

Recommendation: Training in schools should be more than a 'one off' event and needs to encompass basic training at ITT stage, general training for the whole school, and specific 'bespoke' training with one to one support targeted at individual child needs.

RQ2 Barriers to postural management and examples of good practice

2.1 Teachers & TAs described the emotional impact of caring for a child with physical disabilities at school, and shared their anxieties about possibly causing the child pain or discomfort when using equipment such as standing frames, or when implementing therapy programmes that included stretching exercises. This is not an issue currently acknowledged or addressed by schools or by health staff working in schools, there are no counselling or support services in place for teachers or TAs.

Recommendation: The emotional impact on teachers and TAs of delivering postural management programmes to children with physical disabilities needs to be acknowledged and support provided.

Recommendation: Regular meetings in addition to the annual review should be timetabled which allows difficult issues to be addressed and encourages an open and honest discussion between parents, TAs, teachers, therapists and where possible the child.

2.2 Teachers and TAs were critical of postural management equipment in schools and viewed it in largely negative ways. Equipment generally and standing frames particularly were seen as too bulky. They were perceived as separating the child from their peers and some items of equipment were viewed as uncomfortable for the child and restrictive. This compares with therapists' and parents' views of equipment. They viewed equipment more positively as enabling the child and having longer-term benefits. In some cases it seemed that equipment had been recommended and provided without careful consideration of where or how it was to be used in the school. Children's own views on equipment and postural care programmes are unknown.

Recommendation: Therapists need to work closely with schools in order to promote the integration of postural management programmes. Careful consideration of the school environment, how and where equipment will be used including storage should be carried out in consultation with teachers and TAs prior to issuing equipment.

Recommendation: Further research needs to be commissioned in order to identify children's views on their postural management and to inform a child centred approach.

2.3 There were many positive examples of where teachers and TAs had helped children who were initially reluctant to use equipment or engage in programmes. These teachers and TAs had made therapy sessions fun, involved other children and integrated therapy into the everyday routine of the class. For example, one teacher had used the child's stretching exercises as a basis for a warm up for the whole class PE session. Other strategies involved giving the child choice and control, for example over how long they stayed in equipment in order to gain their cooperation. Some teachers and TAs had found creative ways of integrating the programmes into the school routine so that they caused less disruption to the child's school routine.

Recommendation: Share good practice across schools and establish at local level a buddy system across schools, providing support and advice to those working with children with physical disability.

RQ3 Support & information

3.1 Teachers and TAs think in terms of 'doing' rather than 'knowing'. Most participants identified practical solutions when asked about the types of support they wanted. This included additional space to store equipment, additional TA support and additional space for the children to have what was described as a 'quiet area' for privacy and relaxation.

Recommendation: In planning school resources the views of TAs and teachers need to be taken into account. A knowledge transfer model of support needs to be developed focused on practical support for those managing children with physical disabilities on a daily basis.

3.2 Few teachers or TAs identified training as a specific need although most wanted more advice from therapists and closer working relationships between health and education to be established. Some teachers wanted to be more involved and understand more about postural management and wanted more input from therapists. Both teachers and TAs wanted planned regular visits from therapists and accessible advice. In some cases therapists were described as having built good working relationships with the school staff and providing an excellent level of support and advice when it was needed to the school, but this wasn't the case in all schools. In certain schools therapists visiting the school arrived without notice and at times that clashed with the child's break or lunch times. Therapy visits were described, in some instances as sporadic and teachers and TAs felt they were rushed and that they had insufficient time to ask questions.

Recommendation: Reasons for variation in therapy support provided to schools needs to be further explored. Insufficient numbers of therapists are available to provide a consistent service to schools, this gap needs to be addressed urgently in the light of the inclusion of increasing numbers of physically disabled children in mainstream schools.

Summary

Acknowledging the limits of this small scale qualitative pilot study several key findings have emerged. These have led to the development of recommendations intended to bring about positive change in how postural management programmes for children with disabilities are implemented and supported in schools. Principle amongst these recommendations is the need to develop a postural awareness framework for schools. This framework would enable schools to develop greater awareness of the importance of good posture for all children across a wide spectrum, thus engaging all school staff in issues which currently are largely the responsibility of untrained TAs. The framework would address the individual needs of those working with children with more complex needs. The research has provided greater insight into the experiences of teachers and TAs highlighting the emotional impact of this work. The study has also highlighted the dependence of schools for support from overstretched therapy services and the urgent need to address gaps in service if schools are to be adequately supported in this important role. In talking with teachers and TAs it became apparent that the child's own views on postural management were missing from our account. We currently lack insight and understanding of the child's perspective. Further research should be commissioned in order to explore their views and ensure future initiatives are child-centred.

Acknowledgements

The research project was carried out between October 2007 and March 2008. The lead researcher Dr Eve Hutton, Canterbury Christ Church University, was supported by the Steering Committee for the project which included: Professor Annmarie Ruston, Canterbury Christ Church University, Kirstie Coxon, SERDSU, University of Kent at Canterbury, Jan Jensen, Canterbury Christ Church University, Carol Daniel, Kent County Council, Claire Poole, Eastern & Coastal Kent PCT, Sharon Godden and Judi Mortimore who are both parents of a child with a disability.

The Project was funded by a research grant from the *Posture and Mobility Group* a national charity supporting research into the field of posture and mobility (www.pmguk.co.uk). Thirty-six teachers and TAs were interviewed in individual or groups interviews in four primary schools in Kent during February and March 2008. Eve Hutton would like to thank all the participating schools and the members of the Steering Committee. Particular thanks go to Jan Jensen and Kirstie Coxon who assisted in data collection and analysis of the data and special thanks to the parents on the Steering Committee who gave so generously of their own time.

Implications of the findings for health and education

Implications for health

- Possible inconsistencies in support provided to schools needs to be further explored and variations in service addressed.
- Therapists need to work closely with schools in order to aid the integration of postural programmes into the child's school routine.

- Therapists need to consider carefully the school environment, how equipment will be used in the classroom and other areas and the practical aspects of equipment in schools, including storage.
- Timing and planning of therapy input into schools need to take into account school routines.
- Teachers as well as TAs need to be knowledgeable about and involved with the child's postural management programme.
- Therapists need to link specific information and support provided for children into a wider postural management framework.
- Benefits of postural management need to be weighed carefully with any potential limits to a child's autonomy and integration of the child in school.

Implications for education

- Share good practice across school in the integration of postural programmes.
- Consider establishing at local level a buddy system of support across and between schools, providing emotional support and advice to those working with children with physical disability.
- Training for schools should not be a 'one off' event but needs to encompass basic training at a ITT stage, general training for the whole school, and specific training with one to one support targeted at individual child needs.
- Initiatives for schools should be targeted at all levels of staff including support, teaching and senior management
- Review communication within school to ensure maximum benefit achieved from therapy visits.
- Teachers, therapists and parents need to work together to develop and deliver training and support packages into schools.

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Full Report

Introduction

The need to improve services to children with disabilities and their families has gained momentum in the last 5 years with the publication of a series of government and independent reports these have highlighted extensive inequalities and gaps in services (Audit Commission 2002, Parliamentary Committee 2006). The recent publication of *Aiming High for Disabled Children* (DfES 2007) outlines government plans for addressing gaps in provision. A key recommendation of *Aiming High* is the need to increase the knowledge and skills of those working with disabled children and their families in order to keep pace with this changing population of children.

This report is timely as it presents the findings from a small research project funded by the *Posture & Mobility Group* (PMG). The project explores the views of teachers and TAs, a key group working with children on a daily basis, with the aim of considering the training and preparation they need in delivering postural support to disabled children (Special Educational Needs Code of Practice 2001).

Background

Statistical trends confirm that increasing numbers of children with complex disabilities are being educated in mainstream schools as a result of education inclusion policies (DfES 2003). Children educated within mainstream schools with physical disabilities require a wide range of support from both education services and the NHS (Lightfoot 2002, DfES 2007). An important element of this support focuses on the postural care needs of children. It is widely acknowledged that children with complex physical disabilities are at risk of long-term deformity that will compromise their function in adult life (Knapp & Cortes 2002). Conservative management of deformity, using a twenty-four hour postural management approach, can limit long-term problems and is a preferred treatment option (Scrutton, Damiano & Mayston 2004). A postural care programme requires specialist equipment and exercises that ideally are incorporated and integrated into the children's daily routine at both home and school. The programmes are specifically designed in order to prevent longer-term health risks and to promote the child's comfort and active participation in functional activities at home and school (Gerricke 2006). Health service personnel specifically occupational therapists and physiotherapists are involved in prescribing specialist equipment, designing the programmes and also supporting families and school staff in maintaining and managing the programmes. Recent reports have highlighted the lack of sufficient therapy provision available nationally (Parliamentary Committee 2006, DfES 2007). Gaps in therapy services has highlighted the importance of therapists working in educational settings in order to share more effectively their knowledge and expertise with teachers and TAs (Hutton 2008).

Enquiry in the field of postural management has advanced the design and prescription of equipment and explored the functional impact of improved posture on performance (Kangas 2002, Poutney, Mulcahy, Clarke & Green 2000, Hong 2005). The consensus statement on postural care (Gerricke 2006) has underlined the importance of delivering a consistent and integrated twenty-four hour programme at home and in school. With the requirement that every environment in which the child spends time is 'enabled' to provide postural management (Humphreys & Poutney 2006). There has to date been little research which has explored how this is to be achieved or how to achieve good outcomes of postural management that depend largely on the delivery of programmes by non-health professionals in complex social environments, including schools. A series of studies carried out by the Social Policy Research Unit based at the University of York have identified gaps in NHS services to children in mainstream schools in the North East and suggested that communication with teachers, necessary for understanding the child's health needs require improvement (Lightfoot 2002, Mukherjee, Lightfoot & Sloper 2000).

Service user consultation

The starting point for this project was a service review of occupational therapy and physiotherapy within a Primary Care Trust in Kent. Findings from the review and anecdotal evidence from local therapists indicated that teachers and TAs found it challenging to integrate postural care programmes into the school routine. This was the case even where the school had additional resourced provision for children with physical disability.

Consultation with a small group of parents of children with disabilities invited their views on how they felt their children's postural care programmes were being managed within the mainstream and special school environments. This consultation raised several important issues, amongst them the need for greater understanding about the barriers to physical, social and emotional development in the school setting and how these might be addressed to maximise the child's potential for educational progress. A further issue raised was around the term postural management – many parents felt that the term was meaningless, they found it difficult to see postural care as anything separate from what they did on a day to day basis to care for their child (Hutton & Coxon 2008).

In response to the above, and with the aim of identifying what type of support mainstream primary schools would value from occupational therapists and physiotherapists, this project has explored the views of teaching and support staff responsible for delivering postural management programmes in mainstream primary schools in Kent. The aim locally was to identify the views of teachers and TAs and explore what barriers and facilitators currently exist. At a wider level the study aims to contribute to the development of a framework which can guide those working with children with postural needs in mainstream schools (DfES 2004). As the outcomes of the study are disseminated and strategies developed it is hoped that there will be immediate benefits to children and families in terms of improved communication and collaboration between education and therapy services especially in the light of the creation of Children's Trusts. It is anticipated that these outcomes, will in the longer-term, lead to improved function and a better quality of life for the child.

Methodology and ethical approval

Ethical approval

The study was submitted for peer review and ethical scrutiny to Canterbury Christ Church University Faculty of Health & Social Care Research Ethics Committee. The committee is guided by standard operating procedures and overseen by the University Research Ethics and Governance Committee. As the study involved interviewing employees of the Local Education Authority approval was also sought from Kent County Council Research Governance Committee.

Design

This qualitative pilot study aimed to explore teachers' and TAs' views and experiences of delivering postural management programmes in mainstream primary schools. Qualitative data gathered from interviews and group interviews was used to generate an explanatory framework around teachers' and TAs' experiences of managing postural care (Glaser & Strauss 1967). Some areas and issues relating to the research topic had been previously identified during the service evaluation and consultation with parents, but this included parents and therapist's perspectives only. This study aimed to explore these and other emerging issues and priorities from teachers' & TAs' viewpoint.

Research question(s)

Explore teachers' and TAs' views of postural management programmes for children with physical disabilities within mainstream primary education

RQ1 Explore the knowledge and understanding of teachers and TAs about postural management.

RQ2 Identify what barriers and facilitators exist in the delivery of postural management programmes in the mainstream primary school environment

RQ3 Investigate what types of information and support teaching and TAs require in delivering postural management programmes to children with physical disabilities in mainstream primary schools.

Sample

A purposive sample of five primary schools was identified following discussion with the lead occupational therapist and physiotherapist in the locality. Their advice together with that of the specialist teaching service assisted in identifying a sample of primary schools. These included two mainstream schools additionally resourced for children with physical disabilities (designated status) and two mainstream (non-designated) schools. The schools had differing socio-economic profiles. One school was located in a rural area the other three schools were in towns. Numbers of children with disabilities attending the schools sampled varied between one and ten children. One of the designated schools was purpose built with disabled facilities and access, the other schools were older buildings that had been adapted and extended to accommodate disabled facilities.

Letters to Head-teachers providing information about the research invited the schools to participate in the study. One school declined as a new head-teacher had only recently been appointed and the school was undergoing a radical redesign. This left four school sites. The lead researcher visited the schools to speak to the Special Educational Needs Co-ordinator (SENCO). At this meeting dates and times for interviews and group interviews with teachers and TAs were negotiated. In all 4 SENCO's, 12 teachers and 20 TAs were interviewed in group or individual interviews between January and February 2008.

Data gathering techniques

The main techniques for data gathering were individual interviews and group interviews. Interviews provide rich data about an individual's experiences, feelings and attitudes and group interviews offer an opportunity to gain multiple and consensual views, ideally providing some insight into the kinds of processes that might be operating (Green and Thorogood 2004). An interview schedule was developed to structure the interviews and to provide a focus for the participants' responses. The interview schedule was developed with assistance from the steering committee.

In arranging the interviews and group interviews possible power dynamics between teachers and TAs were considered. It was decided inappropriate to combine teachers and TAs in a single group as it was felt that teaching staff would dominate the discussion. Therefore separate groups for teachers and TAs were organised. Interviews and group interviews lasted for approximately one hour and were facilitated by the lead researcher and a fellow academic as co-facilitator. All interviews were tape recorded and transcribed. Notes were taken during the interviews recording group dynamics and the observations of the co-facilitator. During the interviews with Head teachers and SENCO's, relevant background information about school policies and procedures on caring for physically disabled children, manual handling, and information about the nature and content of training provided to staff was gathered.

Data analysis

Qualitative data in the form of detailed transcripts of interviews and group interviews were analysed for each school using coding and theme generation. Part of the process of analysis included the identification of negative or discrepant information that ran counter to the themes identified (Silverman 2006). In order to check the accuracy of the interpretation of the findings, the preliminary findings from the interviews were shared with the project steering committee, this group included representation from parents, therapists and included a member of the specialist teaching service. Feedback from the group, which met twice prior to the development of the final recommendations from the report, was incorporated into the emerging analysis. Academic supervision from Canterbury Christ Church University and peer support from the research coordinator based at the South East Research Development Unit (SERDU) ensured a rigorous process of data gathering, analysis and interpretation.

Findings

The findings are organised into three sections to reflect the research questions the project set out to answer. **RQ1** addresses the knowledge and understanding of teachers and TAs about postural management. **RQ2** identifies a range of barriers and facilitators to the delivery of postural management programmes in mainstream schools. **RQ3** investigates what types of information and support teaching staff identify as important, in helping them deliver postural management programmes to children with physical disabilities.

Comments from the steering committee are included in order to add weight to a particular point raised or present a counter view of the therapists and parents, to those expressed by teachers and TAs. More detailed comments from the steering committee in response to the findings are included in matrix format at the end of this document.

All quotations are ascribed to a specific interview, not an individual. A matrix in the appendix provides codes (see Appendix 3 ii) for the quotations given below.

RQ1: Teachers & TA's understanding of postural management

Teachers and TAs were asked what they understood by the term 'postural management' and whether this was a term that they would ever use in their everyday work. The consensus was that they wouldn't use the term postural management. When asked what they understood by the term, the majority said it's 'how you sit, or stand'.

"I wouldn't use this term, its how you sit, how you walk – I never use it" DES1TA1

"No I don't use these – posture I mean its how one sits how one carry's one around"
MAIN2T

"We just say physical disability I don't think I've ever heard about it" DES2TA

One TA said it was about *"Keeping children comfortable"* DES2TA

Another said that it was about how staff manage their own posture *"Its about how staff manage their posture or backs when looking after children with PD"* MANI2TA2

This association in the minds of teachers and TAs of 'postural management' with the safe moving and handling of children emerges later in the interviews in relation to issues around training.

We shared these comments from teachers and TAs, with the steering committee. Responses varied with some members surprised and others not that school staff were unfamiliar with 'postural management'. One member suggested that therapists use this term frequently on their school visits, another suggested that it would be unusual to refer to postural management in school. A discussion developed about whether it was health professional 'jargon' and 'too technical'. It had already been suggested that it was difficult to separate out the postural needs of the child from other health, education and the social aspects of caring for a child, and that this might explain why school staff didn't refer to what was perceived as a medical or health term.

It was suggested that those working with children with more complex needs would have more familiarity with the concept of postural management. It was felt that a greater proportion of children with milder disabilities would be attending mainstream rather than special schools and that lack of exposure to children with more complex needs would account for the fact the teachers and TAs in mainstream were not familiar with postural management. One member of the steering group suggested that her life is *'full of experts, technical stuff and jargon'* and therefore using a term like postural management is *"natural, anyone looking after the child needs this"*.

Evidence of an underlying appreciation of good posture

Although the teachers and TAs didn't use the term postural management we looked for an underlying understanding of 'good' posture within their responses. We looked, for observations of the child being comfortable or uncomfortable and of observations by them of 'good' and 'bad' posture in the children they were working with.

"X wont sit because he doesn't feel stable, a normal chair is too low, his feet are never flat on the floor" DES1T

"The child has to be watched because he tends to fall over in his chair and he can't right himself, you often find him slouched in his chair " MAIN1T

Some comments show appreciation by TAs of the longer-term benefits for children with physical disabilities of, for example stretching and regularly changing position.

"We follow a routine everyday he goes into his stand up chair and then his walker" MAIN2TA1

"I do his stretches when I am changing him ..I get him to reach up to the ceiling" DES1TA

Concerns were expressed from a TA about a possible deterioration in a child's posture. *"Over time his legs have turned inwards, I've noticed that he stands on the side of his feet now .. now he is walking his legs have got worse"* MAIN2TA2

What sources of information do teachers and TAs use to help them deliver postural care to children?

The interviews and group interviews explored where teachers and TAs sought information about how they should manage the postural care needs of the disabled children. The interviews indicated that information comes to the school from several different sources and that these include a variety of formal and informal or ad hoc sources.

(1) Therapy support

Contact with either the child's physiotherapist or occupational therapist as a source of support and information was mentioned by many participants and commonly reported.

“OT and PT come in when the children need to be seen” MAIN1TA2

“Most of it comes from the physios ..they will give us a programme of exercises of things we need to do” DES2TA

Teachers and TAs particularly said that they followed these directions and instructions to the letter, they didn't feel empowered to question or challenge these recommendations.

“They are the experts, they say what needs to happen, we don't make decisions because we are not qualified to do this, we take their advice” DES1T1

A group of newly qualified teachers felt that they missed out on opportunities to spend time with the therapists when they visited the school and they wanted more involvement with therapists.

“As teachers we don't really know much about the programmes they are following – the physios come in and its usually the TAs they talk to” DES1T1

Comments from a member of the steering committee about close adherence to advice and information from the therapists was that this was positive. TAs were not there to question, adapt or interpret programmes of therapy. Another member suggested that a greater flexibility on the part of TAs and teachers about the implementation of therapy programmes was desirable leading to a more integrated approach to therapy as part of the child's school routine.

(2) Individual education plan (IEP)

When head-teachers and SENCO's were asked about sources of information on postural management all mentioned the child's IEP as recording essential information. One SENCO stressed that it was not practical to store detailed information about seating or equipment as part of the IEP. Although aware of the IEP few teachers or TAs during the interviews referred specifically to the IEP as a source of information.

“When the child starts school we have their files and things and find out medical bits and bobs and there is a hand over from the teachers” DES2T

(3) Peer support

Information about a child was also passed on between staff in the school, for example when a child transfers from one class to another, information about his or her needs, likes and dislikes are passed on. One teacher mentioned that by the time the child reached her class (year 5) procedures were well established. Comments from a member of the steering committee was that this was far too late to have things 'in place' and that programmes needed to be established and ready for when the child joins the school.

“When they get to that age its pretty much put in place” DES2T

(4) Transition periods

In the interviews transition periods were mentioned as a time when information is reviewed and shared. In one instance the transition between nursery to school was described as a time when information was shared and meetings took place to support the child and family adjust to transition to school. In these meetings information about equipment and postural needs were discussed.

(5) Parents

Parents provided essential information to the school staff about a child's specific needs, in relation to equipment and handling. Relationships between school staff and parents appeared to vary greatly; some teachers and TAs described very close positive relationships whereas communication with others was more problematic.

"I have talked with mum, I have a good relationship with her and would ask any questions, I asked her about the exercises and what she thought – should he do them or not" MAIN2T

(6) Children

The children themselves are also mentioned as providing a vital source of information to school staff about their programmes and how to use the equipment that has been provided for them.

"I just ask the child themselves, 'are you comfortable?" she can tell you how she feels, if she's comfortable and she would!" DES2TA

"They [the child] are the best person to tell us what they can and cant do, at the end of the day the child needs to say whether it feels comfortable" DES1T1

"X will remind us about what needs to be done and what is required, P will tell us if he is not comfortable for example in the hoist" MAIN1TA2

There was a comment from one TA that the child was not a *'reliable source of information'* This child has been told not to sit on the floor in a certain way *"he know this but doesn't say anything – he's quite happy sitting in the wrong position"* MAIN2TA1

(7) Training

There was no specific training that either the TAs or teachers had undertaken with regard to managing the child's postural needs in the mainstream classroom. Information about what they should do and how they should manage the child came from a variety of the other sources outlined above including their own past experience, or as one described it training 'on the job', therapists, other teachers and TAs, written records and files, the child's carer or parent and the child.

Manual handling training

When asked about training in postural management, without exception all TAs and a few teachers mentioned that they had attended the paediatric manual handling course provided by the local education authority. The focus of the training is on the safe moving of animate and inanimate loads with an emphasis on risk assessment and safety of the staff.

Participants did associate, or possibly confuse postural care and postural management with manual handling because it focuses on protecting posture and back care, and possibly because of the use of the term 'posture'. Opinion was divided about the usefulness and relevance of the course to the work they were doing.

"We all did a manual handling training, but that was about how if he fell over you would lift him without injuring yourself" MAIN2 TA2

"The early training is taken seriously but it is more about protecting our posture"
MAIN1TA1

"It makes you think about you are managing things, its about minimising the risk to yourself" MAIN1 TA2

One member of the steering committee commented that because the course presented generic material there is little direct relevance to the particular individual issues a child presents with.

One TA did mention that when they were having particular problems transferring a child a manual-handling trainer came and visited the school to provide specific advice which was helpful.

Initial teacher training (ITT) & continuing professional development (CPD)

More TAs than teachers said that they had completed the manual handling training and this brought us to a discussion with teachers about the adequacy of their ITT training and training more generally available to them post qualifying linked to meeting the needs of children with physical disabilities. Some teachers mentioned that they would have appreciated the opportunity to undertake the manual handling training (DES1T1).

Teachers, particularly those more recently qualified, said they had little exposure as part of initial teacher training to physical disability. This lack of experience led to feelings of anxiety and stress when they first had to accommodate a child with a physical disability in their class however they suggested that anxiety was overcome once they 'got to know' the child. Teachers suggested that they would like to have more information about physical disabilities; they felt that as teachers they 'should' know this and were often embarrassed to ask therapists or parents for more information about a child's condition.

"I was a little nervous at first as I hadn't taught a child with PD before, I was afraid of letting him down or not being prepared it was fear of the unknown – when I got to know him everything was OK" MAIN2T

“They don’t train you to look at SEN ..you are not even clued up on what difficulties the children have – you could do a whole degree on that” DES1T1

However it wasn’t possible at all times, in schools to have someone who knew the child well working along side them.

“I had to take X at lunch time and I thought I have no idea what I am doing- you cant just go and ask, he gets scooted around at lunch time when people have breaks and you end up covering – it may be for only 20 minutes but anything can happen in those 20 minutes” DES1T1

When we shared these findings about the teachers and TAs lack of access to training with our steering committee members, they acknowledged that gaps in training existed. One member suggested that schools need training about different types of disability alongside training offered jointly to schools by therapists and manual handling trainers. General training needs to be supplemented by bespoke support as one teacher commented.

“No amount of training would have helped – I actually had to do it [handle the child] myself” MAIN2T

The idea that there needed to be a balance between bespoke hands on training and more generic training was debated between the members of the steering committee. One member said that parents should be able to ‘sit in’ and be involved in training school staff. Another wondered how appropriate any generic training could be because each child was so individual and different.

RQ2: Barriers & Facilitators to the delivery of effective postural care in mainstream schools

(1) Emotional factors

A major and unexpected finding related to the several incidences where Teachers & TAs highlighted how anxious they felt about placing the child in the seating or standing equipment in the ‘wrong’ way. They also said that they felt concerned and upset when a child expressed pain or discomfort when carrying out exercises or using a piece of equipment.

“I didn’t want to use the equipment improperly and hurt him, I was afraid of letting him down” MAIN2T

“Its not a nice experience for them, they have to do things, to manipulate their bodies and stretches and stuff like that, its not nice” DES1T1

“I don’t want to start doing something and do it wrong” DEST1

Several teachers mentioned that they had very little experience of disability and that as newly qualified teachers this lack of prior experience contributed to their feelings of anxiety. Discussion amongst the steering committee members in response to these comments from teachers and TAs raised possibility that anxiety originated from lack of training, knowledge and information. A member of the steering committee also suggested that the emotional impact of working with children with PD some of whom are terminally or very ill was not generally acknowledged and that there needed to be more recognition and emotional support available for staff. Another member suggested that having staff who were confident in handling and managing the child was important because children 'pick up' on confidence and someone who is confident will "give a child more confidence in themselves".

(2) Practical factors

Equipment

One of the principle reasons for providing equipment to disabled children in schools is to promote the child's learning and engagement with the curriculum; postural support is provided in order to maintain or improve posture with the aim of enhancing a child's school experience. It was disappointing therefore to note that there were several instances described in the interviews where the equipment provided appeared to act as a barrier to learning.

When referring to a standing frame one TA suggested that, *"Maybe it interferes with his concentration because it's uncomfortable for him?"* MAIN2TA1

One TA described how long it took for a child using a powered wheelchair to get to the front of the class to contribute *"It takes a lot of time for him to move to the front of the class, get out of his chair and contribute to the blackboard"* MAIN1TA2

Instances were described where the equipment seemed inappropriate, suggesting insufficient consideration had been given to how the equipment would be used or the environment in which it would be used in.

One TA suggested that she was concerned about a new chair

"..he has fallen off the seat because there is no strap, its like an office chair but heavy and hard to move around' when asked if she felt the child was 'sitting well' she replied "I don't think he does, he seems to be sitting (demonstrates thrown back in the chair) and his feet are like this (demonstrates) and sometimes he is leaning forward in a slouched position".

There was one notable exception to these examples where TAs described a child's 'dramatic' improvements in independent walking as a consequence of the regular use of a walking frame within school, seeing this improvement had an impact on the whole school and convinced staff of the value of their work (MAIN1TA1).

Attitudes towards postural equipment in schools

Several TAs expressed concerns about standing frames or 'standing chairs'. These came under criticism from school staff generally in the interviews. Several mentioned how this equipment separated the child from the rest of the class. In all instances the standing frame was being used at times when the rest of the class was sitting.

"It elevates the children and puts them at different levels, and from year 5 they start to recognise that they are different" DES1T1

"He always had a bigger chair than everyone else, but that was a different scenario, now he's standing up you can see he is completely different to the other children and that is singling him out" MAIN2TA2

One member of the steering committee suggested that these examples demonstrate that the standing frames are not being used appropriately. TAs described how for practical reasons it may be difficult to integrate the equipment into the class routine as indicated by the therapist, as the example below illustrates.

"X has a new stander and he cant go into the stander in the class so he's having to be separated, some of the things I am doing are actually taking away the whole ethos of inclusion" DES1TA1

There were several descriptions by Teachers and TAs of discomfort around the notion of using the equipment's positioning devices typically straps and foot-plates, which restricted the child's autonomy and freedom of movement. Many described this in terms of feeling that the child was 'stuck' in a piece of equipment.

"It would be good if he could get out of his chair, get onto the carpet and do something with music, join in more" MAIN1TA2

"He is stuck in his chair again, and he's being excluded because they don't want to take the risk of him going out" MAIN1T

"He's always stuck in his chair, and its wrong" DES1TA1

"You feel bad because they have to go in it, its got straps and knee-blocks" DES1TA1

"He's just stood up and strapped into this contraption, it reminds me a bit of the film Frankenstein, with the monster strapped to the table and then they tilt it up" MAIN2TA

"He will try anything to get out of his chair" DES1TA1

For others being in the equipment meant that the child became more dependent on the TA.

"The chair it maybe makes him feel more uncomfortable whereas the other children can move around how they want to, he is dependent on you to help him, it becomes more difficult for him I suppose" MAIN2TA1

Comments from the steering committee challenged these largely negative views about equipment indicating that the child *'sees the equipment differently because it helps them feel more like their able bodied peers'*. Another steering group member suggested that there was a danger of a 'one size fits all' approach in perceptions about equipment. Another suggested that disabled children are "realistic – they want to be included as much as the can be but they understand when they cannot be included'.

The steering committee were surprised, and possibly saddened, by the negative comments expressed by staff about the equipment. They suggested that these perceptions were likely to influence their work and may be communicated albeit indirectly to the children they worked with. Members of the steering committee who use equipment on a daily basis and have become familiar with it possibly underestimate the general public's perceptions of disability equipment, this is despite manufacturers producing more attractive and child friendly designs.

There were descriptions from teachers and TAs about how children with PD had become more accepting of the equipment over time. Initial resistance from the child to using a piece of equipment, had been overcome by teaching and support staff using a range of strategies to encourage the children.

"She was reluctant to use her stander and now she is OK and we fit this in every other day if we can – she used to get quite tearful and stuff and now she is OK" DES1TA2

"He was really anti using it (standing frame) at first because he said it hurt his legs, and I used to hate putting him in it, but now he's OK" MAIN2T

When asked how this change in the child's attitude to using the equipment had come about, one Teacher described how she had negotiated with the child and given him control by allowing him the option of coming out of the equipment. Both described making the use of the equipment fun in some way. Other children being involved in the child's use of the equipment seemed to help *"her friends strap her feet into it, she's not alone"* DES1TA2

It appeared that children's acceptance and their willingness to co-operate and work with the teachers and TAs varied. Age may be a factor, several suggested that children became more aware of their disability and difference at years 5/6.

" ..from year 5 they start to recognise that they are different" (DES1T).

Another influence on the child's willingness to cooperate was how the teacher manages the child in class. In one Mainstream school the TAs suggested that one teacher had made a big difference in the child's attitude to taking part in PE. " He used to cry, and it used to be heart-breaking .. I don't know how things changed but with Mrs .. things just changed, she makes things interesting" (MAIN2TA1).

It may be that children go through phases of acceptance towards having to use equipment, without there being any specific reason *" last year the children were absolute monsters, but this year they seem to have come on in leaps and bounds"* (DES1TA2)

Attitudes of other children in the schools towards equipment

There were several comments from Head-teacher's, SENCO's, teachers and TAs of the acceptance by other children of the needs of children with PD, a tolerance and acceptance of their equipment within the classroom and the wider school environment.

"I think they are used to it, it doesn't bother them and it doesn't affect the children around them either, they know it [equipment] is helping" DES1TA2

One teacher described how, when new to a school and unfamiliar with how to include a child with physical disability in PE she took her lead from one of the other children in her class.

"I remember playing rounders with a child with CP and another little boy without being asked said to him 'right you hold the bat and I will run for you' – they make allowances" DES1T1

Space to accommodate equipment

Storage space and space to accommodate equipment in classrooms was mentioned frequently. But although an issue in all the schools we visited opinion varied, particularly between teachers and TAs, with regard to how much of a problem lack of space was. Lack of space was more of an issue for the TAs, who move and manage the equipment more frequently than for teachers, who mentioned having to adjust their classroom layout but often only did this at the beginning of the school term. The purpose built schools mentioned problems and limitations of space as much as older schools which did not have purpose built facilities.

These comments from teachers were typical of teachers adapting their classes to accommodate the needs of the child with a disability.

"It's a bit of a shuffle and a struggle but its not really a problem" MAIN2T

'You just have to make room for it, you have to think about your classroom space' DES1T1

The TAs in contrast suggested lack of space was more of a problem *"I would like bigger classrooms with the right sized equipment for the children"* DES1TA1

"Classes are small and transfers have to happen outside the classroom" MAIN1TA1

Lack of space to move around in the classroom was identified as a potential risk hazard.

"I wish the classroom had a bit more room, there are lots of trip hazards, there is not enough room, there is always something that she could hit herself on" DES1TA2

"We've got children moving around and different activities going on, we cant always move the chair around" MAIN2 T

(3) Integration of postural management into school routine

When asked did the postural management programmes and activities associated with caring for the child with PD interfere with the child's school experience? Opinion was divided. Even within the same school opinions varied. One factor that did appear influential was whether the children needed help with toileting and how many other children were using the toilet facilities at the same time, usually break times, and also the flexibility of the staff with regard to how routines could be adjusted to accommodate particular lessons and breaks that the child didn't want to miss.

"He misses two 10 mins from the end of lessons because of toileting, but he joins in with everything else" MAIN1T

Some described how they attempted to minimise the impact of on the school experience.

"They do miss out on things, we try to miss out on PE or Art" DES1TA

"Exercise for X definitely eats into class time – it affects his break times and our break times the children do tend to miss out on the same things" MAIN1TA1

There were several examples of where TAs and teachers had integrated the postural care programmes into the school routine, actively encouraging other children to join in with stretching routines as part of a normal PE session, was a good example of this approach.

"If we know we can incorporate into the whole class, he didn't like doing his exercises on his own but as soon as we did this as a warm up he would do it because all the children were involved" DES1T1

"I included a warm up and stretch session in PE and he said to the TA that he loves that now – he used to hate PE" MAIN2T

"I just fit it [therapy] around so that the child doesn't miss out, they all go out to play" DES1TA2

There were some good examples of how TAs in one school had adapted and used the knowledge gained from the frequent visits of therapists to make the therapy programmes and recommendations around small pieces of equipment more acceptable to the children.

"We have sourced pens that look 'ordinary' and that the children are happy to use and the clear slopes for handwriting that the children like more" MAIN1TA1

RQ3: Information & support requested by teachers & TAs

(1) Practical resources

Respondents were asked, at the end of the group interviews, to identify any areas of support or information they felt would help them in their role. The majority of those asked identified practical solutions, more space, better equipment, more staff and more time.

Bigger classrooms were suggested by several TAs *“facilities should fit the children not the children having to fit the facilities”* DES1TA1

More storage space came up as an issue for several *“storage is a huge issue for things in constant use”* MAIN1TA1

The schools that didn't have this facility identified the need for a 'quiet room' for the children *“somewhere quiet and safe”* where they could carry out their programmes or relax. MAIN1TA1, DES1TA2.

Better equipment, that didn't separate the children from others in the class so the child feels *“More included, not taken away from the others”* DES1TA2. The idea that equipment should be the right size and scale to fit into a classroom. DES2TA1

Others wanted an additional TA, a TA to cover *“times other than taught times”* such as playtime and PE and school trips, where cover was not always available. DES1T1, DES2T1, MAIN1TA1.

(2) Support from therapists

A few participants asked for more information and support from therapists. *“I was thrown in at the deep end”* MAIN2T1 and others wanted better sharing of information between *“health & education because schools don't get sufficient information”* DES1HT. Better information sharing included requests for information that made sense to teachers and TAs. *“Hospital letters have no meaning for us, full of gumpf”* DES1T.

Participants didn't identify additional training or knowledge. This may be because they feel they have sufficient knowledge and are managing well or that needs have not been identified. It is possible that they think in terms of 'doing' much more than 'knowing' and in that sense it is not surprising that their list of support needs focused on practical resources.

Opinion varied around the support received from therapy services to TAs and teachers. Some described their therapist as *“brilliant! “Always at the end of a phone if you need her”* MAIN1TA1.

In other schools visits from the therapist were more sporadic. *“It would be nice if they came in on a regular basis, their timing seems all wrong, its so quick its info, info and then they are gone and you don't see them for weeks and then you have forgotten”* DES1T1

Unplanned therapy visits to children were mentioned, and the impact on their school experience described. *“I used to get very frustrated – he would just have got his coat on and then they would turn up and he would hate this because he likes to go out at break time”* MAIN1T1

Therapists varied in the amount of time they were able to spend with staff and the extent of the advice and support they gave to school staff. Some suggested that the therapists were very good, always accessible and willing to answer any questions. For other schools they had had to “chase up’ input from the therapists in terms of reviewing equipment and providing information.

The TAs appeared to be the main point of contact for therapists and some teachers mentioned that they would appreciate more information and involvement from the therapists “*communication with the therapists so that we are part of things*” DES1T. Other teachers preferred the TA taking responsibility for liaison with the therapy team MAIN1T.

Head teachers and SENCOs suggested that the relationship between the schools and the therapists was very good “*Therapy staff visit regularly and have built up a good relationship with staff*” DES1HT. Although this view did not always correspond with how TAs and teachers perceived the relationship. Good systems were described as being in place for the child’s annual review and formal periods of transition appeared to be managed with health and education attending joint meetings.

The steering committee explored these findings and the possibility was raised about poor communication between administrative staff in the schools and teaching staff. One member suggested that therapists may attempt to pre plan their meetings but that information does not always filter down to the teachers and TAs.

Summary Findings and Recommendations

RQ1 Understandings of postural management in schools

1.1 A key finding from the research identified that ‘postural management’ is a health term and not widely used or understood by parents, teachers and TAs in schools. The steering group for the project suggested that ‘postural care’ or ‘postural awareness’ would be more appropriate terms to use in schools.

Recommendation: Develop a shared understanding and greater awareness of posture in mainstream schools between parents, therapists, teachers and TAs.
Recommendation: Make good posture a ‘whole school’ issue.

1.2 Teachers and TAs did have partial understanding of some principles of good posture, for example they could observe when children were sitting uncomfortably and when they were insufficiently supported. When carrying out therapy programmes with the children, they knew what to do but didn’t always understand why they were doing it, and this resulted in a rigid adherence to programmes, which may disadvantage children. Teachers and TAs lack an overall framework that would assist them in making sense of their observations and experiences. Information and advice about managing the postural care needs of the child comes from a variety of sources leading to an incomplete jigsaw of advice and ideas. Very few teachers or TAs had personal experience of the longer-term benefits of postural management with children. Currently there is no formal training available for Initial Teacher Trainers (ITT), or Continuing Professional Development (CPD) for teachers or TAs, focusing on the postural needs of the disabled child in a mainstream school.

Recommendation: Develop a postural care framework for schools, as a basis for providing knowledge, skills, resources and support. Communicate this through a variety of different media within schools.

Recommendation: Training in schools should be more than a 'one off' event and needs to encompass basic training at ITT stage, general training for the whole school, and specific 'bespoke' training with one to one support targeted at individual child needs.

RQ2 Barriers to postural management and examples of good practice

2.1 Teachers & TAs described the emotional impact of caring for a child with physical disabilities at school, and shared their anxieties about possibly causing the child pain or discomfort when using equipment, such as standing frames, or when implementing therapy programmes that included stretching exercises. This is not an issue currently acknowledged or addressed by schools or by health staff working in schools, there are no counselling or support services in place for teachers or TAs.

Recommendation: The emotional impact on teachers and TAs of delivering postural management programmes to children with physical disabilities needs to be acknowledged and support provided.

Recommendation: Regular meetings in addition to the annual review should be timetabled which allows difficult issues to be addressed and encourages an open and honest discussion between parents, TAs, teachers, therapists and where possible the child.

2.2 Teachers and TAs were critical of postural management equipment in schools and viewed it in largely negative ways. Equipment generally and standing frames particularly, were seen as too bulky. They were perceived as separating the child from their peers, and some items of equipment were viewed as uncomfortable for the child and restrictive. This compares with therapists and parents views of equipment. They viewed equipment more positively as enabling the child and having longer-term benefits. In some cases it seemed that equipment had been recommended and provided, without careful consideration of where or how it was to be used in the school. Children's own views on equipment and postural care programmes are unknown.

Recommendation: Therapists need to acknowledge negative perceptions of equipment and work closely with schools in order to promote the integration of postural management programmes. Careful consideration of the school environment, how and where equipment will be used, including storage should be carried out in consultation with teachers and TAs prior to issuing equipment.

Recommendation: Further research needs to be commissioned in order to identify children's views on their postural management and to inform a child centred approach.

2.3 There were many positive examples of where teachers and TAs had helped children who were initially reluctant to use equipment or engage in programmes. These teachers and TAs had made therapy sessions fun, involved other children and integrated therapy into the everyday routine of the class. For example, one teacher had used the child's stretching exercises as a basis for a warm up for the whole class PE session. Other strategies involved giving the child choice and control, for example over how long they stayed in equipment in order to gain their cooperation. Some teachers and TAs had found creative ways of integrating the programmes into the school routine so that they caused less disruption to the child's school routine.

Recommendation: Share good practice across schools and establish at local level a buddy system across schools, providing support and advice to those working with children with physical disability.

RQ3 Support & information

3.1 Teachers and TAs think in terms of 'doing' rather than 'knowing'. Most participants identified practical solutions when asked about the types of support they wanted. This included additional space to store equipment, additional TA support and additional space for the children to have what was described as a 'quiet area' for privacy and relaxation.

Recommendation: In planning school resources the views of TAs and teachers need to be taken into account. A knowledge transfer model of support needs to be developed focused on practical support for those managing children with physical disabilities on a daily basis.

3.2 Few teachers or TAs identified training as a specific need although most wanted more advice from therapists and closer working relationships between health and education to be established. Some teachers wanted to be more involved and understand more about postural management and wanted more input from therapists. Both teachers and TAs wanted planned regular visits from therapists and accessible advice. In some cases therapists were described as having built good working relationships with the school staff and providing an excellent level of support and advice when it was needed to the school, but this wasn't the case in all schools. In certain schools therapists visiting the school arrived without notice and at times that clashed with the child's break or lunch times. Therapy visits were described, in some instances as sporadic and teachers and TAs felt they were rushed and that they had insufficient time to ask questions.

Recommendation: Reasons for variation in therapy support provided to schools needs to be further explored. Insufficient numbers of therapists are available to provide a consistent service to schools, this gap needs to be addressed urgently in the light of the inclusion of increasing numbers of physically disabled children in mainstream schools.

Summary

Acknowledging the limits of this small-scale qualitative pilot study several key findings have emerged. These have led to the development of recommendations intended to bring about positive change in how postural management programmes for children with disabilities are implemented and supported in schools. Principle amongst these recommendations is the need to develop a postural awareness framework for schools. This framework would enable schools to develop greater awareness of the importance of good posture for all children across a wide spectrum, engaging all school staff in issues which currently are largely the responsibility of untrained TAs. The framework would address the individual needs of those working with children with more complex needs.

The study has provided greater insight into the experiences of teachers and TAs highlighting the emotional impact of this work. The study has also highlighted the dependence of schools for support from overstretched therapy services and the urgent need to address gaps in service if schools are to be adequately supported in this important role. In talking with teachers and TAs it became apparent that the child's own views on postural management were missing from our account. We currently lack insight and understanding of the child's perspective. Further research should be commissioned in order to explore their views and ensure future initiatives are child-centred.

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