POSTURE & MOBILITY GROUP

POSTURE & MOBILITY

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Editorial Team

Editor:
Phil Swann,
Delichon Ltd.
Kings Yard, Martin
Fordingbridge
Hampshire,
tel: 01923 673052
fax: 01923 673052
email: philswannptmy@aol.com

Assistant Editor:
Julia Cunningham,
Scarborough & NE Yorks
Wheelchair Service,
St Mary's Hospital,
Dean Road, Scarborough,
North Yorkshire, YO12 7SW.
tel: 01723 353 177

Assistant Editor:
Patsy Aldersea
tel: 0777 558 7354

Assistant Editor:
Dave Calder
RED Kings Healthcare,
c/o Special Seating,
Royal National Orthopaedic
Hospital, Brockley Hill,
Stanmore, Middx, HA7 4LP.
tel: 0181 954 9581
fax: 0181 954 1589
email: david.calder@

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www.Posture~Mobility.FSNET.co.uk

The PMG Committee, AGM stand down dates are given below in bold.

from left to right: Emma Parry **2003**, Robin Luff **2001**, Simon Fielden **2003**, Roy Nelham **2002**, Phil Swann **2001** (front), Rene Parison **2002**, Julia Cunningham **2001**, Patsy Aldersea **2001**, Christine Turner (front) **2001**, Barend ter Haar **2001** (hiding), Dave Calder Co-opted,.

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The next issue of Posture & Mobility will be in **July. 2001**. The deadline for this issue is the **4th of June**. The aim of the Posture & Mobility is to keep members in touch with current events in the world of posture and mobility and to provide the opportunity to share ideas and learn of new initiatives. Articles should be between 500 and 2000 words, photos and/or cartoons are welcome as are jokes and mindbenders etc. Please send contributions printed (Times New Roman bold 12pt) or on disk, alternatively email: philswannptmy@aol.com.

The Posture & Mobility is published by the Posture and Mobility Group. The views expressed are those of individuals and do not necessarily reflect those of the Group as a whole.

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Editorial

Welcome to another edition of Posture and Mobility. Later than intended because of various meetings in November which have been included in Feedback Forum. Big thank you to all those who have contributed to this issue.

Looking back on the workshop reports in the last issue, in particular links between services (inner and outer) and clinical issues, the concept of client diaries and key co-ordinators was referenced a number of times to improve communication. Expanding on this idea would be the creation of a new post, the primary responsibility of which, would be managing appropriate and timely service intervention. A key element would be the co-ordination of appointments within Health, Education, Social Services and other appropriate agencies. Advantages would include a logical progression through services with a reduction in inappropriate and missed appointments. Duplication of provision should be minimised and users would no longer be at risk from falling into a black hole once they leave education.

Any thoughts on this suggestion? Post bag is waiting to hear from you.

In the absence of any offers, see editorial volume 9, I've kicked off the equipment review slot, page 19. We've also added an education and training feature, page 21, so if you're running courses or have been on any and you would like to tell others about it then write in. Any volunteers to write a short article on CPD and how it works for you?

Look forward to seeing you all at York and receiving contributions to volume 13.

Phil Swann.

New email philswannptmy@aol.com

Letter from the Chairman

There seems to be another outbreak of reorganisation so it must be election time - or am I too cynical? On top of PCG's and PCT's we have the NHS Plan. Whilst we all know that reorganisation is a way of simulating progress and diverting minds from the underlying issues, the latest Plan does have some excellent potential benefits. The proposal for shared resources or joint working or seamless services or (add your own term) between health and social services can be used by us all to promote this principle within health! The Llandudno conference clearly stated the need for different parts of local services to work more closely and less defensively so if the drive is in place on this macro scale it must require refinement on the micro or local scale. I would urge you all to become conversant with the local implementation of the NHS Plan, which is now moving very quickly, and do what you can to raise the profile of your local needs for joined up working and thinking within and between the community health, wheelchair and rehab. eng. services, social services and even education which is not yet included.

More patient/client involvement in their own care is also proposed and further work on reducing waiting times can all be beneficial to our service users as well as us, the providers. We all know that our clients often have more clout than we do to effect change for their benefit and this Plan seems to give them more. Let's use it to get what our Cinderella services need and don't forget that Clinical Governance and the Audit Commission Report, "Fully Equipped" can be used in the argument for improved resources and joined up working. I wish you all success in the coming months as the Plan is put into place.

Although our services are not a current priority I did hear a rumour that sometime soon paediatrics may become an additional priority alongside cardiology, cancer and mental health. If this is so let's hope it goes beyond the acute services and even though the majority of posture and mobility clients are adults such a priority will help. There will be little point in developing and providing excellent services to our young clients if they fall off the pier into the turbulent services of the transition period to adulthood. Even more tools will thereby be available to us to promote a unified approach to excellence for all our clients. More on this theme at our March Conference in York and I would like you to encourage your colleagues in local services to also attend to explore the issues around "Children of today: Adults of tomorrow".

On the theme of joined up working the PMG and the Scottish Seating and Wheelchair Group (SSWG) have started talking about how we can work more closely together. A couple of PMG committee members will attend one of the SSWG committee meetings in 2001 for discussions and exploration of the potential for collaboration and joint meetings, etc. We will keep you posted on developments.

Our PMG Web Site is nearing its launch and may well be there by the time you read this. It will serve as a resource for members and an encouragement to others to join us in our quest for quality services with adequate resources and collaborative working to meet the needs for posture and mobility.

The work of the International Standards Organisation in developing standards for wheelchairs and seating is progressing quickly. I represent the PMG and Barend ter Haar is one of the BHTA representatives and we will be describing the relevance to and impact on clinical practice at the York conference around the time the draft standards will be available for comment. Whilst this is not the most riveting of subjects it is very important and your comments are taken into account for the final version of each standard. After that we are stuck with them for some time so we all have a responsibility to ensure they are clinically relevant and practical. The PMG web site may be a good place to share the drafts and collect comments without destroying too many forests.

Finally, I hope you all had an enjoyable Christmas and that 2001 brings us the improvements we are all working for. I look forward to seeing as many of you as are able to attend the next Conference, 20th to 21st March in York.

Roy Nelham
Chairman

A Custom Bed Positioning Wedge

Introduction

The Royal Hospital for Neuro-disability (RHN) is a national medical charity that provides rehabilitation and long-term care of people with severe and complex neurological disabilities resulting from damage to the brain and nervous system. Its clinical teams include the Brain Injury Unit, which specialises in the assessment of patients diagnosed as being in a vegetative or minimally aware state, a Behaviour Disorder Unit and a Huntingdon's Disease Unit.

The Biomedical Engineering Department (BED) at the hospital provides support to the clinical rehabilitation and disability management services of the hospital by supplying a variety of assistive technologies from the issue of appropriate wheelchairs and special seating to electronic switches and computer interfaces.

Postural Management

A significant role of the department is to provide equipment to support the postural management of the severely disabled clients at the hospital. Prevention of postural deformities before they occur, although highly problematic, is easier in the long term than trying to cure them afterwards. The maintenance of the individual in a posture of symmetry and balance that accommodates for the effects of gravity and abnormal muscle tone is of great importance in the overall care of the individual. In the long term, the client will be more comfortable and the nursing load will be made easier as it assists in manual handling and in the prevention of pressure injuries. Equally, a client that has been well maintained physically may well find that energy previously used to maintain their posture can enable independent function and mobility.

Many of the clients at the RHN exhibit signs of neurological release. These patterns of reflex movement and posture that we all possess are suppressed or modified as we grow and develop and may become disinhibited after injury. These reflexes can cause abnormal muscle tone, which along with the effects of gravity on a body unable to resist, can result in postural abnormalities such as 'wind-sweep' deformity, over abduction or adduction of the hips and associated abnormalities in the symmetry of the spine.

B.E.D Input

The Biomedical Engineering Department has for many years been manufacturing devices out of foam and fabric to assist in bed positioning and the Log Rolls and 'T'-Shaped Rolls originally developed and manufactured at the hospital have been commercially available for some years. However, there has always been a need for custom-made bed positioning wedges for those whose postural requirements were of a more complex nature and these devices were often time consuming and complicated to make. These bespoke items would differ to the 'T' Rolls and other commercially available equipment in that they would be custom made to the individual. Therefore, where there is contact with the device, weight would be evenly distributed in order to prevent pressure loading in one area.

The demand for custom 'bed wedges' (as they became known) has become greater over the years with the client-group within the hospital generally becoming more complex to manage and the increased need for a round-the-clock regime to physical management. It was therefore imperative that a streamlined method was found to improve the process of assessment and manufacture of these custom made items. The greater part of the background work on the finished article was carried out as part of my major project for the Design Research for Disability Master's Degree at London Guildhall University in nineteen ninety-seven. The project enabled me to carry out a thorough literature and product information search and formulate a design specification assisted by information gained from interviews with therapists carried out both at the RHN and at other centres in the UK.

The Custom Bed Positioning Wedge

The primary function of the Custom Bed Positioning Wedge is to support the lower limbs in a posture of symmetrical alignment with the shoulders, trunk and pelvis whilst in supine. In order to prevent adaptive shortening of soft tissue and eventual fixed deformity, the wedge should aim to prevent over abduction and adduction of the hip joints. The wedge should also prevent 'wind-sweep' deformity i.e., abduction and adduction of the hip joints with possible associated internal and/ or external rotation of the hips. In this regard, it is obvious that any device would need to have the ability to withstand the dynamic forces applied to it, and be

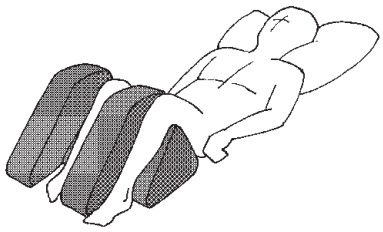
strong and stable in construction. If the Custom Bed Positioning Wedge is to be successful, it should also help to keep the pelvis in a neutral position. Other aims such as keeping the hips flexed in order to prevent extensor tone, the relieving of pressure from the sacrum where sores may be a problem and the use of the device to maintain a degree of stretch in tight flexors, whilst being worthy of consideration, are considered secondary.

Contraindications for the use of any bed positioning device may include existing pressure areas or excessive pressure loading. If the client is unable to vocalize: raised muscle tone, agitation, alteration in arousal levels, facial expression or perspiration may indicate discomfort. As a general principle however, it is desirable to ensure during assessment and fitting processes (as in special seating) that there is as much surface area of the lower limbs in contact with the wedge as possible. This may be found to contribute to lowering abnormal muscle tone and increasing a sense of proximal stability and security.

Other considerations in the design of the device were that it also has to be safe for the care staff to use, fairly simple to apply (or it will not get used) and comply with the relevant fire retardancy regulations. It also has to be hygienic to use in that it needs to be covered in a fabric that is breathable, able to withstand body fluids and be cleaned easily. Of equal importance in regard to client compliance, is the cosmetic appearance of the device.

The wedges can be assessed by the therapist supporting the client in the desired position and then taking measurements from the buttock to the knee crease, knee crease to heel and heel to buttock. A further measurement is taken from the knee crease to the supporting surface (usually the bed, but for more accurate measurement a plinth) to account for any fixed abduction at the hip.

The finished article is made from furniture quality medium density foam which is cut to shape by use of a band saw. Further minor modification can be made with a Bosch Foam Cutter. The central pommel is extended down the lower leg to divide the feet and can prevent over abduction of the hip with a lateral bolster acting as a counter-force applied to the knee. Once cut to shape, the wedges are bonded together in the correct configuration and covered in Dartex fabric, which is both waterproof and breathable and has a degree of stretch. The Custom Bed Positioning Wedge also has the optional feature of having the pommel or one or more of the bolsters detachable with the use of Velcro to ease fitting and removal. This feature is particularly useful if the individual has tight hip adductors, enabling the wedge to be slid in from the side and the medial/ lateral support being fitted afterwards.



It became obvious that in order to simplify the method of manufacture, it was necessary to modularize the configuration and shape of the wedge as much as possible. Through necessity, this limited the choice for the shape and size of the wedge. The method of assessment was reviewed and a prescription form devised using tick boxes which is easy for therapists to complete and contains the dimensional information the technicians require. The new form and new Custom Bed Positioning Wedges are now under trial at the RHN and results so far have proved very encouraging.

If you are interested to know more about Custom Bed Wedges, T- rolls or Log rolls, or would like an assessment/ order form please contact the Biomedical Engineering Department of the Royal Hospital for Neuro-disability, West Hill, Putney, SW15 3SW, telephone number 020 8780 4500 extension 5050.

Tim Sewell

MA Technical Development Manager

Royal Hospital for Neuro-disability Email: tjsewell@hotmail.com

Let the Earth Move

A common problem faced by wheelchair users who have problems of abnormal tone and patterns of movement is the tendency to push into mass extension when the soles of their feet come into contact with a supporting surface such as floor or foot plates (also known as extensor thrust). This causes enormous problems with stabilising their pelvis in the seat, resulting in poor seating posture of sacral sitting, kyphotic spine and poor head position. The continuous pushing down on the footsupports can also result in frequent problems with breaking of foot supports and it's mountings.

Carers for a person with extensor thrust find it very difficult to position them correctly in their wheelchair and the need to reposition frequently increases their care load markedly. The poor seating posture also effects the users quality of life in that their visual field is restricted and it adds to problems with feeding, poor swallowing, drooling etc.

In the past, a common solution used for such posture problems used to be to take the foot supports away and let the person sit with their feet unsupported. Although this reduced the wheelchair users extensor thrust problem, but it added other problems such as increased weight bearing under bottom and thighs as feet support approximately 20% of total body weight, which can add to pressure problems in high-risk patients. It also leads to increase in general tone of the body, which causes difficulties with care and users comfort in the seat.

When a person sits in a wheelchair with his feet unsupported for a considerable length of time, they can end up with hamstrings muscles shortening or contractures due to tendency to hook back their legs either under the seat or fixing against a kickboard to try and increase their feeling of stability. This pulls the pelvis into posterior tilt thereby exacerbating the poor sitting posture problems.

In wheelchair clinics, these problems are elicited time and again. The special seating team at DSC Harold Wood Hospital came up with a possible solution to them in the form of a dynamic footsupport. The footsupport is a footbox with, a gas spring attachment, which enables it to swing away when the user pushes down on it with his feet. When the user relaxes the footbox swings back into the resting position automatically due to the spring action. The principle behind the idea is that when the wheelchair user with an extensor thrust problem feels the support under their feet, they push down on it trying to elicit mass extension pattern, however the footsupport moves away and thus the force is transmitted away from the pelvis and the person does not get enough leverage to pull his pelvis into extension and out of the seat. The pelvis is stabilised using a good pelvic restraint correctly mounted.

Initially the team decided to trial the dynamic footsupport with three patients over a period of six months; the feedback from patient's carers and therapists was obtained over that period to evaluate the success of the dynamic footsupport.

Patient A young 20 years old female with CP was sitting in a matrix type seating with no footsupports and she had short hamstrings. She did not use the dynamic footsupport after a week due to poor compliance of her carers.

Patient B a 25 years old young male with CP had multiple fixed deformities Of spine, hips and knees was trailed with the dynamic footsupport as he had a very strong extensor thrust and had caused him to break footsupports in the past. He continues to use the system and carers have reported a reduction in his pushing down on the dynamic footsupport.

Patient C a young 17 year old male with CP had been using a CAPS 11 seating system in the past, but his extensor thrust were causing his pelvis and spine to rotate and his carers were finding it difficult to use his knee blocks. His trunk was already rotated and spine had developed scoliosis. His parents were very keen to try anything that might help the problem. The occupational therapist at school agreed to monitor the dynamic footsupport that was used in conjunction with a matrix seating system. The feedback from this carer's and the occupational therapist at school at school has been very positive. It appears C is able to maintain his seating posture much better and carers don't need to reposition him so frequently now.

The conclusions of this small trial are as follows:

- It is important to provide a suitable type of footsupport for all wheelchair users as it reduces the load on the seating base thereby preventing pressure problems. It also improves the overall sitting posture through reduced tone and improving stability.
- A suitable pelvic restraint that is correctly mounted also helps in stabilising pelvis.
- Dynamic footsupport is a helpful tool that should be considered for person with extensor thrust problem.
- If used at a young age it may help to reduce tone through provision of supporting base and help prevent shortening of hamstrings and contractures which result from person sitting in a poor seating posture over a period of time.
- Any additional benefits such as improved visual field, improved ability to communicate, safer feeding and swallowing due to better seating posture help in improving patient's overall quality of life.

At the time of submitting this article, a few more people had been issued with dynamic footsupports but it was much too soon to evaluate the success of the system. The initial results of this very small trial are very positive but there is need to trial it with larger sample to further evaluate its efficacy.

A. R. Kaul- Mead MCSP SRP

Supt. Physio therapist, Camden & Islington Wheelchair Service

Mindbenders

At midnight it is raining hard, how probable is it that it will be sunny in 72hrs time?

Answer age 10.

What gets wetter as it dries?

Answer page 15.

I have 25 hankies each equally divided into 5 different colours. If I was blindfolded, how many would I have to pick out to be sure of having one of each colour?

Answer page 19.

How many string quartets are there in a dozen?

Answer page 20.

RESNA 2000 (Rehabilitation Engineering Society of North America) Annual Conference 28/6 ~ 2/7/2000

The conference and exhibition was held in Orlando, Florida at the Omni Rosen Hotel, with excellent access for people with disabilities.

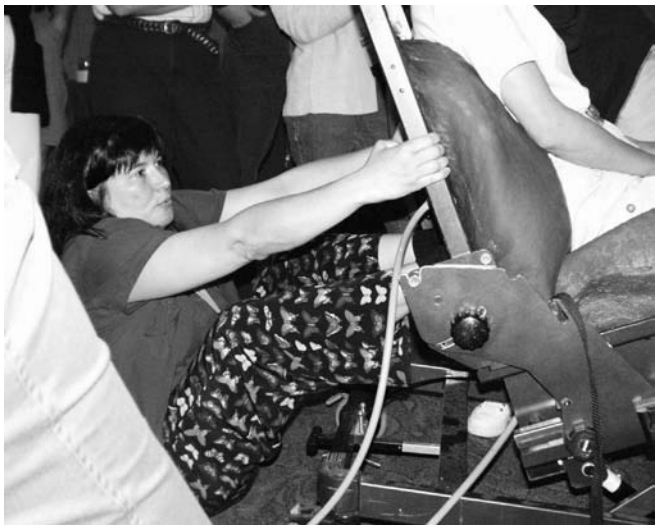
Although the organisation is based on Rehabilitation Engineering, all disciplines in the field of Assistive Technology were represented, Physio, OT, Speech & Language Therapy. The conference attracts between 700 - 1000 delegates form both the US and Canada as well as internationally

RESNA is involved in providing input in to US and International standards in Seating & Wheeled Mobility as well as accreditation for professionals working in this field.

There was a pre-conference program of 20 pre-instructional courses to select from depending on your interest the 2 days before the conference.

I attended the Intermediate Seating Course on the first day. This gave an interesting insight in to the types of systems used in the US. I noticed that the V-Trak system is just being launched over there, which was interesting as the Brits on the course almost ended up doing some of the teaching.

On the second day I attended the Advanced Moulding Skills course. This was fascinating as it gave an insight into how US services provide custom contoured seating (primarily this is CNC machined foam.)



An Unconventional Approach To Pelvic Positioning!

An awful lot of things are similar in principal to the way we do this in the UK but the kit is completely different, as are some of the techniques.

The seating simulators have similar adjustments to versions in the UK although there are systems, which have electrically operated adjustments for recline, tilt and seat depth. Bead Bags are much more durable and some organisations are using Rigid Polyurethane Foam (PUR Rigid) as an alternative casting medium to plaster, as it can be more robust and lighter therefore potentially reducing shipping costs.

The choice of paper presentations at the conference proper is even more is enormous, 190 scientific paper presentations crammed in to 3 days. Subjects ranging from Seating and Mobility, Alternative & Augmentative Communication, Computer Use & Access, Quantifying Function & Outcomes, Technology For Special Populations, Environment & Accommodation, Functional Control & Assistance, Service Delivery & Public Policy.

Each subject could be followed as a theme throughout the conference, but you could switch between topics and presentations as you wished.

The quality of the papers was excellent and varied from research to clinical practise. But you were always torn between more than one presentation set at each session. If you think the choice of workshops and paper presentations at Posture and Mobility is difficult, this was mind blowing.

The conference also has an excellent exhibition attached to it with 60 plus exhibitors, which had a variety of equipment, some of which was available in the UK, but some of the rest left you wishing you had the $$$'s in the budget.

Having said that I suspect that a lot of the equipment shown was aimed at the very complex end of the market as opposed to their equivalent our beloved Apollo's, see photos on page 10.

Whitmyer Biomechanix 3/7-8/7/2000 Tallahassee, Florida, USA

Some of you may be aware that this is the company who designed and manufactured the headrest imported by James Leckey Designs, with a revised version due to hit the streets soon.

I was fortunate to spend a week here seeing how provision in the US really works.

They were founded by Jody Whitmyer who initially was very hands, on and took custom made seating, both 3D and Planar to where people wanted it in his mobile workshop. The rear of the lorry has the materials store and the trailer has a very well equipped engineering workshop.

The company now has two sections, their Manufacturing Division which designs and manufactures the Headrest Products and other devices such Specialist Joystick Controls, Switch Devices and the other their Clinical Service is primarily involved in the assessment and provision of "Custom Fit Wheelchairs"

They manufacture their own Planar Seat Units purchasing neat brackets available in the US, they custom make all their own adaptations and do their own upholstery, the seat unit construction however was simple and mirrors the Freedom & Scott seat units now being used in the UK.

Truly Mobile Rehabilitation Engineering

The organisation of Whitmyer Biomechanix Clinical Services was very similar to a Special Seating Service in the UK, although with the US provision model they have to be very objective in their assessment and have to justify what is being prescribed to the insurance companies funding the equipment.

I'd recommend the trip to anybody interested in the field of Assistive Technology in its broadest sense. It's informative as well as inspiring to see so many people, who are so enthusiastic about what they do

The Mike Hall Travel Bursary is given annually to one of the Rehabilitation Engineers from King's College Hospital NHS Trust.

Paul Dryer

Senior Rehabilitation Engineering Manager, Rehabilitation Engineering Division, Medical Engineering & Physics Care Group King's College Hospital NHS Trust

Its not, because in 72hrs it will be midnight!

RARE 2000 Conference

The attractive surroundings of the Birmingham Botanical Gardens provided an ideal location for the RARE 2000 conference. The exhibition area, although small was of sufficient size to fit stands from most of the major suppliers of rehabilitation equipment in the UK.

Alan Lynch was able to overcome his jet lag to complete his presentation on 'The True Cost of Reconditioning'. As usual, he provided plenty of food for thought for most wheelchair services. While he recognised that reconditioning makes up an essential part of a cost effective supply of wheelchairs, Alan called into question whether wheelchairs of certain types and ages should be reconditioned. He also highlighted the fact that reconditioning without recording or questioning why the component has failed, or what parts needed replacing could cover up any trends of equipment failures.

An area that requires careful consideration for the industry is: to what levels should the traceability of equipment be extended. In case of a recall, is it necessary to be able to locate individual bolts in the event of failure? A worrying prospect as the majority of wheelchair services have enough trouble managing to locate entire wheelchairs.

An update (if you were present at the PMG conference 2000 and the IPEM Wheelchair Stability meeting!) was provided by **Simon Fielden** on the progress being made by the Oaktree Lane Centre with the development of a wheelchair stability test system. Unfortunately, it seems that due to problems with the merging of services in Birmingham, less work had been achieved on the project than was hoped. The system presented appears to have a number of advantages over other stability testing techniques available at present, namely increasing the speed of the test and obviating the need to tilt the client to the point of instability. However limitations of static stability testing have been well documented and the most interesting development would be, as Simon implied they could, if they are able to further develop the system to test the dynamic stability of wheelchairs.

A number of questions regarding what the term Clinical Technologist means and what plans are currently in place with regard to the training and examination of Rehabilitation Engineers were answered by **Jim Methven**. He indicated that the reason for creating the blanket term Clinical Technologist was to group together a number of smaller disciplines (of which Rehabilitation Engineering is one) together in order to gain government recognition.

A Clinical Technologist would normally be employed in the Medical Physics or Clinical Engineering Department of a Hospital, they are also usually educated to HNC, HND or Degree level in a science or engineering subject and perform a range of technical tasks supporting the treatment of patients and clients. It is planned that in the near future students will be able to carry out a three year vocational degree, followed by supervised tasks of increasing responsibility, with the eventual aim of working independently and becoming an incorporated member of IPEM. The importance of trying to create a national register for Clinical Technologists by getting all relevant staff to join the voluntary register was also stressed. As with the national register for Clinical Scientists it is hoped that the voluntary register will result in a government recognised national register. An important distinction was made by Jim to highlight the difference between Clinical Scientists and Clinical Technologists. He indicated that the main difference is that Clinical Scientists are generally educated to a higher level (masters or above) and have undergone the 'grade A' training scheme.

After lunch (if you didn't lose you meal ticket!) **Alan Turner-Smith** outlined the changes currently happening at CoRE with two new members of staff joining their team. He also outlined a funded Assistive Technology, two week long course in Finland. It is due to cover assistive technology in hearing and vision as well as environmental controllers and wheelchairs. Alan Turner-Smith was also able to confirm that the RARE conference will continue next year in a similar format, but it is also hoped that additional, more applied days will also be arranged.

The prospective Assistive Technology masters course is currently being validated by Kings College Hospital and is due to start in October 2001. There are currently ten bursaries available to students from a range of backgrounds. The students will be taught by a multi-disciplinary team and will be assessed individually and on how they interact in a team environment. It is hoped the course will produce students who can develop and

apply assistive technology while understanding the applications and limitations of the equipment.

Ros Ham gave a very interesting presentation on Whizz Kidz, the past, present and future. She recognised that there had been, and to some extent, still were a number of problems in the application process and generally how equipment had been selected and distributed. Ros also highlighted some exciting plans for the future. These included the setting up of a web site, advertising for a therapist in Northern Ireland, the possible funding of research projects and development of their user group.

FAST were represented at the conference by **Peter Field** and **Sue Quinton**. They helped to further define the meaning of the term Assistive Technology as any device or system allowing an individual to carry out a task. It can therefore cover anything from walking sticks to computers. They have set up a wish page on their web site (**www.fastuk.org**) for users, carers, GP's, RE's (basically anyone who is involved with assistive technology) who can think of something they need or that would be useful. They have already received over 50 requests and it has not yet even been put online! Sue Quinton outlined the assistive technology database which is based on the Access program. It includes a number of tables such as Organisations , Publications, Events, Services etc. which anyone can access in order to find out information on assistive technology.

Dave Calder gave an interesting presentation on the use of IT within the Rehabilitation Engineering Service. He brought to everyone's attention just how far IT has come in the last ten years. The Rehabilitation Engineering Department at King's College are now able to use mobile phones, lap tops, digital camera's, pressure maps and the internet. They now have standard report templates on computer, the National Health Service Purchasing and Supplies Agency database on CD and Computer Aided Design. It is these advances in IT which are helping the service pool their resources in order to become more efficient and provide a faster and more reliable service.

The Symmetrix back and the theory behind it was demonstrated by **Bart Van der Heyden**, from RoHo International. It appears to be a well thought out piece of modular seating equipment. Because the back is essentially separated into three independent parts, it is possible to accommodate most shapes and sizes. It is often useful, as in this case, to hear the manufacturer providing the biomechanical thinking and theory behind the design. As it helps provide anyone setting the system up, or a service considering whether they will provide it, with a better understanding of its possible applications and limitations.

he general consensus of the delegates seemed to be that it was a useful and informative day. The talks were attended by most of the delegates, limiting looking around the commercial exhibition to the structured breaks. Such a wide spread attendance in lectures was better than last year and a good indicator that the presentations were found to be relevant and interesting to all involved.

Russell Jewell
Bio-Engineer, Oxford Wheelchair Service

Mitchells Marvels

A recent leak reported that a new government department has been set-up to collate data on Uninteresting Research Into Necessary Equipment.

This new department is to be known as 'URINE'.

Thanks to Professor Heinz Wolf for this play on words.

Power to the Children

Whizz Kidz Conference, November 2000, Powered Mobility for Younger Children

For those of you who were unable to attend, or to those who work within the NHS and feel that powered mobility for the under fives is too far in the future to think about, read on for a quick summary. Material presented was both invigorating and thought provoking to all those working within the field of posture and mobility. The two-day conference was hosted by the charity Whizz Kidz at Regents College, London.

Dr Charles Fairhurst, Neuropaediatrician, Chailey Heritage and Guys Hospital, London, set the stage illustrating 'normal' development. Dr Fairhurst spoke of a fundamental link between a child's opportunity to be independently mobile and cognitive development within the first four years, "The Early Critical Period". If children are deprived of functional opportunities to develop cognitively and explore their environment, this in turn may lead to an inability to develop social skills.

With an informal approach, we heard from American OT **Karen Kangas**. Karen presented numerous case studies demonstrating that powered mobility should be an option to all children with physical disability. In Karen's experience many professionals working within the field of wheelchairs and mobility make the assumption that children cannot acquire the skills necessary to operate a powered wheelchair, rather than giving them the opportunity to try. By guiding children and their parents through purposely graded treatment programmes Karen has demonstrated how children previously thought to have limited functional abilities, do in fact develop in all areas once offered the guidance and training that they require. Children learn very quickly when something motivates them. As an Occupational Therapist with a wealth of experience, Karen is highly skilled at identifying what motivates the children that she meets. In most instances this is movement, whether it be directional and functional or play. Karen spoke enthusiastically of how offering children the opportunity to experience independent movement is the beginning of a whole new world for them. Karen believes that 'lack of independent experience is far more disabling than any mere disease or prognosis.' Karen is keen to inspire therapists to continue with the process of education and change. A very interesting voice to hear.

Jan Furumasu works as a physical therapist at the Rancho Los Amigos Medical Center in the USA. Jan conducted two presentations at the conference focusing on her involvement in evaluating functional and technological needs, primarily in the areas of seating and mobility. Jan has contributed towards clinical research projects and most recently been co-primary investigator of the study on 'Powered Mobility and Young Children,' determining the cognitive and coping factors that predict wheelchair skill level. Jan is developing an assessment tool to be used to identify powered mobility skills through exploratory play with children as young as 18 months. Jan demonstrated some innovative ideas such as teaching young children directional control of a joystick by playing with and following pigeons. Thoughts of therapists in the future conducting powered wheelchair assessments in Trafalgar Square spring to mind!

To many therapists working in the NHS coping with the increasing pressures being placed on wheelchair services, powered mobility to children under five years is an alien subject. After all wheelchair services are responsible for providing equipment to clients of all ages.

The benefits were clearly pointed out by parents of children who have been provided with independent mobility by the Whizz Kidz Charity. Integration within the family was a key point made by one family in particular, who have reaped the benefits of powered mobility for their child, both indoor and out. We saw some interesting footage of twin girls living in Alaska who's father endeavoured to involve his daughters in every aspect of play and outdoor activity that his other children enjoyed. This raised a few eyebrows with regard to stability, but the benefits were clearly displayed.

Common complaints were relating to parents feeling that the local wheelchair services had discriminated on the grounds of age. Some local wheelchair services had refused to discuss the possibility of a powered wheelchair assessment until children are over ten years. Clinical need did not appear to be an influencing factor in this, despite the fact that children will have surpassed the critical period of skill acquisition suggested by Dr Fairhurst earlier. In addition, the capacity for the child to operate a powered wheelchair safely is not investigated by many wheelchair services. Instead it was thought that lack of funding was the main driving force and that therapists hide behind criteria and hence lose

flexibility. One parent strongly felt that therapists should be making a stand to their Manager's regarding the benefits to be gained from offering children powered mobility at a young age. Lack of documented evidence and formal research in this area became the counter argument to the debate. Cost inevitably limits the options available to many NHS services, however without the therapists acting as advocates for the children there is little chance that budgets will include equipment such as this.

Professionals working within this area are urged by the parents to investigate the advantages and become involved in formal research. Parents felt very strongly that children of today can be empowered with mobility from an early age thanks to assistive technology. This ability for children to move independently within their environment offers them the strong foundations for learning that all other children are offered.

Those who missed out this time can further discussions at the pending 2001 Posture and Mobility Conference - 'Children of Today, Adults of the Future.'

See you there!

Tanya Syred
Head Occupational Therapist, Mid Surrey Wheelchair & Seating Service

FULLY EQUIPPED

The provision of equipment to older or disabled people
by the NHS and Social Services in England and Wales.
15th November 2000 ~ London.

Following the publication of-Fully Equipped - the Audit Commission held a conference to expand on their findings and provide opportunity for comment and discussion by those working in equipment services. Anyone reading the report will be aware that disability equipment services, in general, were found to be the 'Cinderella of the Cinderella services'. Under-resourced, poorly integrated and given a low priority by senior managers was the overall view of the commission who stated that the quality of service provided could 'make the difference between an enriched, independent life or an isolated, unproductive existence'.

Nick Mapstone, author of the report, expanded on the findings. Similar criticisms were stated in the Guthrie report in 1968 but there had been little change. Public Services, he commented, were good at policy and poor at implementation.

The audit commission recommended a 'hub and spoke' approach, with NHS, Social Services and others involved in equipment provision, working together to common standards.

On the positive side, the introduction of the National Plan offered hope for the future. Extra money had already been allocated to local authorities for community equipment and audiology service. Whilst not of direct benefit to wheelchair services, it could provide support to those already linked to their community services.

During the morning session **Julia Neuberger**, Chief Executive of the King's Fund stressed the importance of involving users in developing services and instigating change. What people want is speedy, timely assessment and appropriate equipment. Whilst working to reduce staff shortages, why not remove some access barriers, enabling users to carry out their own assessment, she suggested.

James Strachan from RNID gave a stimulating address on the plight of anyone needing a hearing aid, followed by **Kevin Curley** from Headway who criticized the unrealistic eligibility criteria found in some areas and mocked the distinction made between the social and medical need for a bath. Another point raised was the absence of 'training' for users. Anyone with brain damage requires repeated 'teaching' to benefit from equipment provision.

Picking up on the earlier comments made by Nick Mapstone, **Sheelagh Richards**, Therapy officer from the Department of Health, admitted that the report made uncomfortable reading for the government. The 'Department' would be keeping in touch with the Audit Commission as audits are carried out countrywide. Focussing on some of the improvements already made by the government, such as Voucher and EPIOC money and the Section 64 grant to examine ways of supporting local user groups she recommended a needs led approach with joint organisation. This was not necessarily joint stores.

Dr. Dipak Datta, representing the BSRM, took up the theme of 'hub and spoke', recommending closer links between clinical practice and universities to improve sharing of research for evidence based practice.

Other speakers were **Maggie Winchcombe**, Director of the Disabled Living Centres Council; **John Reed** Chairman of the National Association of Equipment Providers; **Ray Hodgkinson**, Director of British Healthcare Trades Association (BHTA) and finally **Duncan Eaton** Chief Executive, NHS Purchasing and Supply Agency. Speaking at the end of a packed day is not easy, but this contribution was disappointing. Although he he said he was 'pleased that his service is closely involved in this area of care', there was little to indicate any understanding of the way they should work with the service providers.

In summing up, the Chairman, **David Browning**, Audit Commission Associate Director, pointed out that 'intermediate care is shooting up the political agenda' as people recognise the importance of appropriate prescription and provision in reducing hospital admissions and increasing individual independence.

There is no easy 'quick-fix' that will solve problems being experienced by equipment providers. The report offers 'fodder' for discussion with senior managers, but a great deal still needs to be done to change attitudes at this level.

Patsy Aldersea
Occupational Therapist

Who is this man?

A towel

IPEM Conference
Risk Management in Vehicle Transportation for People in Wheelchairs

Transport. Transport. Transport. So what do you know? Enough? Too much?

The conference 'Risk Management in Vehicle Transport for People in Wheelchairs' organised by IPEM was probably the most important conference covering transport and risk assessment for some time. If your responsibility does or could cover this area, you should have been there. If you weren't, you should at least track down a copy of the two key developing documents that were presented at the conference (amongst others). The draft guidelines that were published by the MDA 'Guidance on the safe transportation of wheelchair users seated in their wheelchairs', and the 'Good Practice Guidelines' draft document to be issued by PMG et al, are both documents that we should be actively contributing to and helping develop.

A range of speakers from industry, government and the NHS presented a range of viewpoints in the transportation and risk assessment theme.

Alan Lynch (MDA) started the proceedings and delivered one of the key statements that **'We should allow people who travel in vehicles to travel in a manner that is AS SAFE AS PRACTICABLE'.**

Alan presented some findings from the MDA:

There have been 6610 reports on medical devices. Of those, 1154 have involved wheelchairs or seating.

There have been 64 deaths. Of those, 8 involved a wheelchair or special seat, 5 were transport related, none occurred during a crash.

Of the 5 that were transport related, 3 involved tail-lifts and 2 involved inadequate restraint during normal travel.

These figures help put the risk of crashing in perspective. It seems a wheelchair user is at higher risk of being injured whilst getting onto the bus than during the journey. We should, however, all be striving to maintain or increase this level of safety.

A key theme here was communication. There must be communication between service boundaries, with clear pathways for information and data.

Ed Stait (Unwin Safety Systems) put forward four risk variables to be considered during a risk assessment. These are the User, the Mode, the Wheelchair and Competence.

We have a 'common goal' suggested **Julian Cobbledick** (RJ Mobility). We should keep the transport issues in perspective and be realistic. The chain of responsibility includes the Manufacturer, the Prescriber, the User/Carer and the Transporter.

'Does a crash test pass or fail actually matter?' was one point Julian raised. You shouldn't need to ask a company how it got its CE mark, but should be able to assume its products are safe for the conditions specified in user documentation. But is this always the case? We do need to ask manufacturers the right questions. Have you? May I? How?

There is obviously overlap between the disciplines, but where do specific responsibilities lie and how much overlap is there? These are issues that should be addressed by the two documents mentioned above.

Murray Seacombe (Community Transport Association) has looked at risk assessment within the association and found five specific solutions that were right for the CTA:

Communication and research
Risk management procedures
Training
Vehicle and equipment maintenance
A culture of SAFETY.

He stressed that often, information is not always passed onto the transport provider and that risk assessment should be a cyclical process with a feedback loop.

How many people have carried out a risk assessment? That was the question **Colin Gibson** (Rookwood Hospital) posed to the conference delegates. Not everyone had. Why? This should be part of our everyday lives. In terms of risk assessment, we need to ask ourselves three questions:

Why?
How?
Who?

Two types of risk were identified, 'Clinical Risk' and 'Health and Safety Risk'. The former should be reduced to a level to which the potential benefit substantially outweighs the risk. The latter should be reduced to an acceptable level. Information gathering is very important and can help judgements of hazards and severity and probability. But should we actually be doing Risk/Benefit assessments when assessing for and prescribing equipment?

Martin Seabrook (Active Design) presented a broad overview of transportation including special seating, in the real world. A range of issues was discussed including statistics, national and international standards and other relevant documents. Crash testing and the use of **ISO 7176 Part 19** in the UK was considered and how this represents real life, day-to-day practice. Virtually none of the wheelchairs on the market today fully complies with this draft standard (it does in fact contain much more than just criteria for crash testing products). Crash testing is designed to ensure consistent measurement of wheelchair and seating performance is achieved, and that specific criteria contained within the standard are met. But how realistic are the standards? Martin stated 'they are a comparative measure of safety and no more'. For example, the occupant is restrained in the wheelchair during the test with a lap and diagonal belt that uses a top mounting rail. However, very few of the buses used in this country have them fitted. Why is this? Cost? Barry Taylor (below) had them fitted to ALL Treloar vehicles at very small cost. Why are they not in use elsewhere? Martin concluded by stating that we are only managing risk and not removing it. **An individual's right to quality of life should be respected during the prescription and risk assessment process.'**

A problem identified by **Karen Gibson** was that there is not a single source of information. She also stated that during transport we need to assess what is essential, and remove any non-essential items. A question from Jill Kendrick was interesting, 'Who pays for a transport only headrest?' Karen's answer was the 'the transport provider'. But who does the risk assessment that that states that the headrest is only suitable for transport? And who does the risk assessment that considers it to be unsuitable for day-to-day use?

Barry Taylor (Treloar Trust) suggested that all transportable wheelchairs should be crash tested. Should they? Why? Risk assessment should involve all parties and it is important to work together to create policy. We must follow the guidelines and the best available knowledge.

Jacqui Romer (Roehampton Special Seating Service) suggested that all equipment prescribers need to accept some responsibility for transport. The prescription should be communicated to the transport provider and any problems we come across need to be circulated to the relevant people. Focused procedures ensure people are aware of their responsibilities and are correctly informed and educated. She suggested that an area directory of special schools and transport providers could be a useful tool to ensure issues can be communicated effectively. Manufacturers should provide a uniform way of saying where straps should go. Better guidelines and accessibility to information is important.

I have tried to summarize the content of the speakers' presentations to give a feel for their presentations. I have also asked a number of questions during the text. What are the answers to these? Who should be answering them? We all should.

As professionals, we all have a responsibility to ensure the equipment we manufacture, prescribe or transport is used in such a way that the user is transported as safe as practicable. ISO 7176 Part 19 states:

Failure to comply with the provisions of the standard should not limit access to, and availability of, motor vehicle transportation for wheelchair users.

We hear so much about crash testing and perhaps accept too readily the usefulness of a crash test 'pass', it is only a small part of the picture. A range of considerations should be taken into account when carrying out a risk assessment that references the best available knowledge (including, but by no means restricted to, the result of a crash test whether it is a pass or fail). We all have a responsibility to produce and pass on information about the decisions we have taken in our specific area of expertise as they relate to transport. These should be passed on to the next point of contact. Clear routes of communication should be constructed and followed.

I felt a key theme of the conference was that transport issues should be kept in perspective and consideration should be given to day-to-day transport activity and normal travel rather than focussing purely on a crash test result (be it a pass or fail).

There is a huge range of information available from different sources. Perhaps this should be collated and pre-

sented in an easily accessible format. An accessible web site or distributed CD resource could provide a central 'hub' site from which information could be obtained.

There was a sense of 'get it into perspective'. This is not an issue to run from. Make use of current resources available in a sensible way to ensure wheelchair and special seating users are as informed as they can be, and each professional they come into contact with is informed as they can be.

We must all ensure the risks are minimised, and the benefit maximised.

Paul Hewett
paul@activedesign.co.uk

PMG News; Visit the web site at: www.Posture~Mobility.FSNET.co.uk

All paid up members of the PMG attending the conference will once again be eligible for their **FREE** **Book voucher**

This years conference at York looks to be the best yet. **Children of Today - Adults of Tomorrow** kicks in on the Tuesday the 20th of March. Key presentations on the Tuesday include Postural Management by E. Green (Chailey) and Surgery by M. Gough (Guys Hospital) covering the general topics of Objectives, Expectations, Reality and Impossibilities. Free papers follow and in the afternoon parallel sessions offer training at preliminary and advanced levels of postural management.

The formal dinner on Tuesday evening should not be missed: good food, wine, dance and entertainment combining to create the perfect ambiance for networking!

Wake up sessions on Wednesday morning offer a variety of training opertunities depending on experience. These are followed by clinical case studies and The Aldersea lecture, commemorating Patsy Aldersea's energetic service to Posture and Mobility through her work within the NHS. After lunch the clinical impact of international developments and the transition of young adults from school to college, employment and beyond will set a challenge to everyone for the coming year.

If you're interested in **patient support surfaces** and **pressure management** then get in touch with **Dr Alistair McLeod tel. 01582 413104** who will organise a session covering these issues on on **Monday the 19th of March** at the York PMG Conference venue

The exhibition is showing throughout the conference and **presents the latest in Posture and Mobility technology**. Don't forget to enter the exhibition trail competition.

Note on conference booking form under Registration: Conference rates section should read Tuesday 20th and Day rates section should read Tuesday 20th and Wednesday 21st.

York Factoids

The ninth roman legion established it's headquarters on the site of York Minster in AD71 for a campaign against the Brigantes tribe. This settlement became known as Eboracum.

During the Viking era Eboracum was renamed Jorvik from which the name York is derived. During the Norman period York became a vital centre of government, commerce and religion for the north.

York Minster

York Minster was completed in the Tudor period and took 250 years to build. The 18th century saw York develop into a fashionable resort and centre. Its growth was secured with the links provided by the rail network.

Note: If you're keen on rail transport, the York rail museum is the largest in the world.

Post Bag

Dear Phil

I'd like to see more results from audit projects featured in Posture and Mobility. They wouldn't have to be long, just snappy, to the point with conclusions.

Great newsletter, keep up the good work, looking forward to the next issue already

Phil Swann

Editor.

This issues bonanza prize for best letter is awarded to Phil Swann.

Notice Board

Date	Venue	Title	Contact
March 2001			
20 - 21	**York**	**PMG National Conference**	**tel. 01223 882105**
2002 DATES FOR PMG CONFERENCE ARE 15th and 16th OF APRIL			
April 2001			
25 - 27	Evry, France	Rehabilitation Robotics	tel. Mounir Mokhtari, 331-6076-4755
25	London	Managing spasticity and severe disability in adults - the state of the art	tel. 020 7935 1174 www.rcplondon.ac.uk
May 2001			
15 - 17	NEC	NAIDEX 2001	tel. 020 8332 0044
June 2001			
6 - 8	Cardiff	CIGOPW Annual Conference	tel. 0114 256 1571 (Viv Ibbotson)
22 - 26	Nevada	RESNA 2001	tel. +1 703-524-6686 email:info@resna.org
July 2001			
1 - 6	Glasgow	ISPO	tel. 0115 962 8044

Equipment Review

Supporting posturally challenging feet

Feet that are inverted, everted, valgus, pronated, however you wish to describe them, are difficult to support. A lack of comfort and potentially high-pressure areas may exist because the foot shape is inadequately supported. Casting individual support would be expensive and often inappropriate because of foot movement.

An effective solution has been to use Dartex bags filled with either loose polystyrene beads or loose foam chunks, the amount of filling depending on the force and asymmetry to be supported. The main difference between foam and bead fillings, is the level of stability provided because of their different dynamic properties. The ease with which beads move relative to each other results in more rapid shape changes than loose foam, which holds its shape and tends to be more effective when supporting larger forces. Both foam and bead supports require 'fluffing up,' usually done prior to transferring the client into the seat to prevent the filling 'bottoming out' as a result of contact pressures.

The bag supports may be interfaced in a variety of ways depending on the intended use. One method allowing removal for transfers is to use a clip on ABS interface, which locates on the footplates. A separate board is fitted to this and adjusted front to back to ensure that the bag supports under the foot. The bag is attached to the board using Velcro. A calf strap may be required to ensure that feet can't get stuck behind the footplates.

For further details and a prescription form contact Delichon Ltd on tel. 01725 519405 or fax 01725 519406.

Phil Swann

You need to pick 21 hankies.

LITERATURE REVIEWS

ADAPTATIONS MANUAL

Philippa Harpin

Muscular Dystrophy Campaign 2000.

Based on the specialist knowledge and experience gained by the author, who has worked for over 22 years with people with muscular dystrophy and allied neuromuscular disorders, this is a comprehensive guide in loose-leaf format, packed with easy to follow and essential information and advice for disabled people, their families, therapists, architectural designers, carers. In fact anyone working with physically disabled people in their home situation.

The aim of the manual is to provide practical information which will enable all concerned to work their way step by step through the many complex issues that have to be addressed when endeavouring to remain independent at home, whilst coping with a progressive disability.

Providing the reader with sufficient information to consider the choices and alternatives available clearly eases the decision making process and enables the professional and client to work together in reaching a satisfactory and appropriate conclusion in a rational manner.

The manual is divided into 20 sections which fall under 5 main headings. These are: Introduction, Assessment, Funding, Drawing the Plans and Index. This last section provides references, addresses of manufacturers, suppliers, and various sources of advice, together with equipment literature.

The length of the sections vary and whilst some contain a simple check list, others provide extensive and often complex information presented in a clear, easy to follow format. The user is guided through everything from how to obtain a grant, to who should be involved in assessment, whilst comparing the range of equipment available, including wheelchairs. The restrictions associated with funding are fully recognised and there is an interesting section which looks solely at justification for funding.

'Be your own Keyworker' is a 10 point plan which advises families how to understand the process and contribute to decision making. It includes two useful forms. One for recording details of contact names including the best time to make contact. The second is structured as a diary to record all actions agreed, taken, when and by whom. These can be easily photocopied for use with all clients as can the many other forms and guidelines found throughout the manual.

'Assessment of Need' includes a discussion on the advantages of looking at the long term as opposed to short term needs. An important issue for anyone with a deteriorating disorder. Options are offered and discussed and equal consideration is given to financial and practical implications

Equipment sections include Lifts vs Extensions, Baths vs Showers, and Hoisting problems. Wheelchairs are referred to throughout and there is a specific chapter which identifies models and features of particular value to this group of user. Space requirements are considered in the sections looking at housing, planning and design issues and contact details are given of the 69 specialist architectural designers available to advise on adaptations or building issues.

The information provided will be of use to experienced practitioners and students alike as well as architectural designers, users and their families. This is an informative, well presented reference book for all involved in the provision of services and equipment to people with physical disabilities.

Available from: Muscular Dystrophy Campaign, 7-11 Prescott Place, London. SW4 6BS. (www.muscular-dystrophy.org) 407pp. £25. ISBN 0 903561 03 4

Patsy Aldersea

Occupational Therapist

There are 12 string quartets in a dozen!

Education and Training

SUCCESS FOR 18 PRACTITIONERS.

Ideally this column should have been written by one of the 18, but not only are they too modest to proclaim their achievements, but they are all recovering from their efforts which resulted in completion of the Core Module of the Wheelchair Prescription and Provision Programme, credit rated by the University of Greenwich.

The purpose of the Core Module is to enable practitioners to consolidate, extend and widen their experience and knowledge in this area. The credit rating provides recognition for clinical skills and knowledge. The credits acquired can be recognized as a stand-alone achievement and part of CPD or can be used to access further modules and a higher award.

This is a nine month, distance learning module with three residential study blocks. The study time required by the student, to reach the standard set by the university, is demanding and stretches those already in full time employment. In spite of this, it seems that all 19 students (one has had to delay her final assignment) not only enjoyed their nine months of study, but also felt the benefits for themselves and for their future practice. The benefits went beyond the expected sharing of clinical experiences and the group quickly formed their own e-mail network support group - sharing ideas, solving problems and exchanging jokes to lighten the load. The fact that a number of final presentations were competently given using power-point, by students who were previously computer illiterate, was an unexpected bonus.

One of the assignments which we hope students may share with other colleagues, is the information collected for their Resource Files. The range of topics included: head supports, pressure cushions, air travel for wheelchair users and terminology. The standard of all assignments was generally high and it is hoped that some students may feel able to share relevant work through publishing and presentations. PMG members attending the last conference at Llandudno will have already seen two of the posters (one the prize winner) produced by these students. Once students have given their agreement, we would like to publish a list of material available.

The next course is ready for take-off in February. We hope the new students will acquire the same level of success and enjoyment as the previous group.

CPD is now an essential part of clinical governance. Your trust should be willing to support you in undertaking a recognised course related to your area of work. There are other sources for funding should you not be fully funded. Information on all modules credit rated within this programme can be obtained by phoning 020 8942 0488.

Patsy Aldersea
Occupational Therapist

Guess the product?

Delichon Ltd. would like to introduce two of it's latest special needs paediatric products to the readers of PMG.

The **Recaro Start Plus** car seat and the **Ranger**, all-terrain buggy, have both generated significant interest amongst professionals during exhibitions throughout 2000.

THE RECARO START PLUS

Based on the hugely successful Recaro Start, the Start Plus has been adapted specifically for children with special needs. (aged 1 –12)
This unique seat has been fully crash tested, includes a 5-point harness and optional swivel base which, enables safe handling of the child and minimises back strain for the carer.
The Recaro Start Plus is able to grow with the child and is available with a range of accessories to aid the child's comfort and postural needs.

Recaro Start Plus with optional headrest and lightweight footrest

Ranger ATB with raised footplate and large hammock

THE RANGER ALL-TERRAIN BUGGY (ATB)

Designed jointly by Delichon Ltd. and Mountain Buggy, the Ranger is a lightweight 3-wheeled ATB that can accommodate special needs children from 6 months, to 11yrs old (or 45 KG). The exclusively designed Ranger allows two different hammocks and three footplates to be interchanged on the one frame, giving maximum flexibility to suit individuals postural requirements.

Both products are exclusive to Delichon and come with a clinical assessment service, allowing our experienced staff to assess the needs of each and every child.