Progressing Disability Services (PDS) Interdisciplinary Learning Resource

Children's Disability Network Team

UNIVERSITY OF LIMERICK OLLSCOIL LUIMNIGH | Education and Health Sciences

HSE

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Contents

Welcome

Dear Student and Learner,

Welcome to the Midwest Children's Disability Network Teams Services. We hope that this resource will provide you with useful information that will support your understanding of PDS.

This interactive learning resource was developed in partnership between the School of Allied Health in the University of Limerick, The Midwest Children's Disability Services & the Health Science Academy. It relates to practice learning within a Children's Disability Network Team (CDNT), which provides services to children who present with complex needs arising from a disability.

We invite you to be curious and ask questions. A family centred approach to assessments and interventions requires active engagement and critical thinking in order to respond to the complex requirements and various health presentations of children and families.

We wish you a learning experience full of discoveries and a great start into your professional lives.

The Project Team

VIDEO **CDNT Placement Video**

Introduction

This resource is intended to support students when engaging with clinical placements on Children's Disability Network Teams (CDNTs). The resource is designed to be used by allied health professionals and students, to enhance your learning and challenge your understanding and assumptions about working with children and families.

It will help orientate you towards the Progressing Disability Services (PDS) Framework, including the core principles underpinning it. It encourages you to consider critical concepts within the framework such as family centred care, a partnership model and a collaborative strength-based view of service delivery.

This resource can be used in advance of, and throughout the placement experience. In addition, take the opportunity to draw on content that has previously been covered in your academic modules to support your engagement in this resource.

The authors recognise the demands placed on students to understand and implement their own disciplines' core competencies and scope of practice, while also engaging in an interdisciplinary model of practice. Allow yourself the time and space to navigate this journey, knowing that it is a challenging but rewarding experience. It is intended that this resource will support this process.

How to use this resource

This resource provides a narrative on PDS and its evolution. It explores three of the principles that underpin PDS in depth: **Evaluation of Outcomes**, **Family Centred Practice** and **Interdisciplinary Team Working**. These three principles are highlighted as they have been explored in depth by the HSE in relation to their application to PDS.

- This resource provides carefully considered learning opportunities that are designed to optimise engagement with the content and support knowledge translation. These opportunities promote reflection, discussion, integration of knowledge and a deeper understanding of the background and evolution of PDS.
- The learning opportunities are placed at the end of each section providing options for the student to engage with. It is not intended that students engage in all activities but rather select a range to support their own learning.
- It is recommended that students work with other disciplines when interacting with the learning opportunities in order to optimise interdisciplinary learning.
- The University of Limerick Practice Education Teams can provide advice and consultation as needed.

What is Progressing Disability Services (PDS)?

Progressing Disability Services for Children and Young People (PDS) seeks to develop a standardised and integrative disability service which responds to the needs of the child and family (Bradley et. al, 2020). PDS aligns with the ambitions of Slaintecare in relation to providing community based services and to encourage team members to provide an integrated service by working collaboratively with families.

The 'Roadmap for Service Improvement 2023–2026' sets out the overall aim for Children's Disability Services.

LINK **Roadmap for Service Improvement 2023 – 2026 (HSE.ie)**

The supplementary document and video were prepared to give a brief overview of the Roadmap for children and families. The video and document give a summary of some of the main points in the Roadmap. They explain what children's disability network teams are, what the Roadmap is about and what the key actions are between 2023 and 2026.

LINK **Roadmap for Service Improvement (HSE.ie)**

VIDEO **HSE Roadmap for service improvement: Disability services for Children and Young People 2023 (youtube.com)**

The following document shows the results of a national reference group of stakeholders who reviewed services for 5–18-year-olds and made recommendations for changes to service delivery. This was the initial step towards developing the PDS Framework. This report was completed in 2009.

LINK **Report of the National Reference Group on Multidisciplinary Disability Services for Children aged 5-18**

The key objectives of PDS are to:

- Provide a clear pathway and fair access to services for all children with disabilities.
- Make the best use of available resources.
- Ensure a partnership approach between teams and families.

DIAGRAM 1

The Core Principles of PDS

PDS is guided by 12 core principles which inform the service delivery model for Children's Disability Network Teams (CDNT).

1) Accessibility

- → This refers to the environment & information
- → Services & supports will be physically accessible to family
- → Information provided will be clear & jargon free

2) Accountability & Governance

- → There will be accountability, fairness & transparency in all relationships & interaction

3) Bio-psychosocial model

- → Service delivery will be holistic taking consideration of biological factors, psychological factors & social factors

4) Clinical Governance & Evidence based practice

- → The application of research & Evidence Based practice will inform service delivery

5) Cultural competence

- → Sensitivity to cultural differences is entwined in service delivery systems

6) Early Detection & Referral

- → Early identification of needs is recognised as key in ensure an optimal outcome for the child & family
- → This will be coupled with a clear pathway of services

7) Equity of Access

→ Access is based on the child's needs

8) Inclusion

→ CDNTs support the inclusion of the child in their community & seek to optimise each child's independence & participation

9) Interdisciplinary Team working

→ An Interdisciplinary team will work collaboratively to support the child & family in sharing information, decision making & goal setting

10) Evaluation of Outcomes

→ Outcomes are measured through the Individual Family Supports Plan. This involves agreeing goals based on the family's needs & priorities.

11) Family Centred Practice

→ Family Centred practice ensures that supports provided are determined from family priorities & requires full consider of each child & families, strengths, needs & opportunities in the context of their own roles, values structures, beliefs & coping styles

12) Staff are valued & respected

→ The efforts of staff to provide the best possible service must be acknowledged, valued & supported, promoting a culture of respect amongst staff & between families & staff

Information on the National Access Policy can be found at this hyperlink. This document includes details on how families are referred into services for children and the decision-making process around which service suits their needs best.

LINK **National Policy on Access to Services for Children & Young People with Disability & Developmental Delay**

The following online seminar is helpful in understanding the Progressing Disability Services Framework and how it has evolved in Ireland in relation to reconfiguration of existing services.

Duration: 1 hour 10 minutes

ONLINE SEMINAR **HSE PDS Webinar**

LEARNING OPPORTUNITY

REFLECTION

Reflect on the 12 Core Principles of PDS (diagram 1). Choose one principle and consider how it will influence your practice as a health professional (what does it mean to you, how will it impact on your engagement with families and your colleagues, what does it mean in relation to accountability & governance).

How would you explain this principle to a colleague?

PRESENTATION / DISCUSSION

Prepare a brief presentation on the 12 Core Principles of PDS

CASE STUDY

Dan is an 8-year-old boy. Dan & his family's priority for this service is support with accessibility of the school environment. Your team is meeting with Dan's family for the first time.

How are you going to explain the Core principles of PDS in a way that makes it relate to how services will be provided to address this priority?

Children's Disability Network Team

The Children's Disability Network Team is the team families and young people will attend if they meet the threshold based on their needs as identified by their parents or themselves. The threshold is defined by a scoring system outlined in the national access policy.

There are ninety-one Children's Disability Network Teams (CDNTs), aligned to 96 Community Healthcare Networks (CHNs) across the country. Each CDNT covers a defined geographical area within a Community Health Organisation (CHO).

Children's Disability Network Teams (CDNTs) comprise of health and social care professionals and administrative support who provide interdisciplinary, child and family centred services and supports for children from birth to 18 with complex needs arising from their disability. CDNTs are delivered and managed by a range of service providers including the HSE, Section 38 and Section 39 agencies. Each CDNT operates under a Lead Agency model where the Lead Agency has responsibility for the service provision in an assigned area in line with the National Policy on the Lead Agency Model. The role of the HSE, Section 38 and 39 Agencies is critical in the development and sustainability of CDNT services in line with the Progressing Disability Services model. (HSE, 2021)

The CDNT supports a child's development, wellbeing and participation in family and community life. The CDNT is expected to ensure everyone, family members and health professionals, work together as a team focusing on the child and families' identified needs at that time.

Children's Disability Network Teams can include the following professions:

- Children's Disability Network Manager (CDNM): manages the interdisciplinary team and ensures clinical governance (see below) and the delivery of services based on principles of progressing disability services framework.
- Dietician
- Early Intervention Specialist: provide therapeutic supports to younger children, play based interventions and supports around their early education.
- Nurse
- Occupational Therapist (OT)
- Paediatric Link worker: varying role, supporting younger children attending the service.
- Physiotherapist
- Psychologist
- Social Worker (SW)
- Speech and Language Therapist (SLT)
- Therapy Assistants

Team members in partnership with the family share their knowledge, information, and skills to support and optimise the child's participation. This approach supports children and young people to develop, learn, and take part in everyday activities and those activities that are most meaningful to them and their family.

A detailed description of the team and the policy framework for service delivery within CDNTs is available here:

LINK **Policy Framework for Service Delivery of Children's Disability Network Teams**

CDNTs are encouraged through the facilitation of their manager to audit their services based on the 12 PDS principles. This self-audit tool ensures accountability and alignment of services with the PDS framework. This self-audit tool is accessible through the link above.

LEARNING OPPORTUNITY

REFLECTION

Have you worked with all the professionals listed above previously? Consider their role on the team.

Consider how they compliment your own profession.

PRESENTATION / DISCUSSION

Families will be referred to your team with no experience of interdisciplinary working and therefore may never have sat in a room with a group of professionals from different backgrounds. Consider how you would prepare them for this initial meeting through a presentation or discussion format.

CASE STUDY

You are partnering with a parent to support their child with transitioning into their car seat in the morning to safely travel to school. You become aware that although you can provide supports and strategies to the parent and child, you need another colleague to become involved, i.e., SLT for communication supports, Psychologist for behavioural supports or OT with support in relation to appropriate equipment etc.

How will you explain to the parent and child why this is needed and what that professional will do?

Evaluation of Outcomes

As part of the move towards PDS the HSE, in collaboration with stakeholders, developed a reporting system for PDS programme accountability of CDNTs. The system developed is known as the '**Outcomes for Children and their Families' Framework.**

The framework can be seen in full at the following link:

LINK **Report on Outcomes for Children and Their Families**

Framework Statements

The Framework sets out **11 outcome statements for the child, young person and family**. Interventions and supports are tailored to achieve these outcomes.

Services should **support children and young people** to achieve the following outcomes:

- Children and young people have a voice in matters which affect them, and their views will be given due weight in accordance with their age and maturity.
- Children and young people enjoy the best possible health.
- Children and young people are safe.
- Children and young people have friends and get on well with other people in their lives.
- Children and young people learn skills to help them to be independent.
- Children and young people take part in home life, school life and community life.

While recognising the lived experience of families, disability services should aim to **support families** to achieve the following outcomes:

- Families understand their child or young person's needs, what they are able to do well and what they find difficult as they are growing up.
- Families look after, take care of and support their child or young person.
- Families are supported to ensure that their rights and the rights of their child or young person are respected.
- Families take part in community services and supports.
- Families feel supported by family, friends and neighbours in their local community.

LEARNING OPPORTUNITY

REFLECTION

Reflect on the 11 outcome statements.

Choose one child statement and one family statement and consider its impact on service delivery within CDNTs.

PRESENTATION / DISCUSSION

Prepare a brief presentation for an introductory meeting with families that have been recently referred to the CDNT. Explain the outcomes framework, its purpose and how families will be engaged by the team in service delivery.

CASE STUDY

A new referral to your service is a family with a young child who is starting preschool in the coming months. The family priorities include ensuring their child, who uses a wheelchair for independent mobility, can access the whole space both indoor and outdoor. This preschool has not previously enrolled a child who uses a wheelchair for mobility.

Identify one child outcome & one family outcome that is particularly relevant to this family. Explain your clinical reasoning behind your choice.

Family Centred Practice

What is Family-Centred Practice (FCP)?

- FCP is a model of child disability health care which acknowledges and prioritises the strengths and abilities of the family unit through recognising the family as central in the delivery of services (Bradley et al, 2020; Dunst, 2002; MacKean, Thurston and Scott 2005).
- It is both a model of practice and a theoretical concept. As part of this model, service delivery emphasizes a partnership approach moving away from expert-led care (Bradley et al 2020; Dunst, 2002).
- FCP practices do not replace other types of intervention but instead provide a framework for how interventions are provided or used. (Eurlyaid, 2019).
- As part of PDS and the outcomes focused commitment of the framework, the integrated family centred model of support ensures that children and their families, regardless of nature of disability, will receive appropriate support in their local community.
- CDNTs are expected to be responsive to the family's needs and requests. Family centred practices treat families with dignity and respect, and endeavour to provide families with information to facilitate informed, empowered decision making. Collaboratively, families and teams focus on the strengths and abilities of the child and emphasise what the child can do.
- Within CDNTs, the Individual Family Support Plan (IFSP) frames the picture of how CDNTs will engage with families.
- FCP is designed as a whole family approach, seeking to empower the child, the family and the community.

DIAGRAM 2

Continuum of Family-Centred Models in Disability Care (Dunst et al., 1991) adapted from Espe-Sherwindt (2008)

Professionally-Centred

- → Professional is the expert in determining child's and family's needs
- → Professional guides the intervention and is the key decision-maker

Family-Allied

- → Professional determines the needs of the child and family and directs clinical intervention
- → The family is a partner in implementing intervention

Family-Focused

- → Family is viewed as a consumer who can make informed decisions regarding intervention and care practices, with clinical guidance

Family-Centred

- → Professional and family are equal stakeholders
- → Intervention is flexible and responsive to the family's needs
- → Intervention is strengths-based and focuses on positive family outcomes
- → Families are the key decision makers

Bradley et al (2020) describe how FCP has evolved since its early development. Diagram 2 above illustrates how disability care models of service delivery have evolved.

FCP promotes a collaborative caregiving style where families and service providers work in partnership to determine service provision and how these services are delivered to the child and family (Gao, 2023). The research acknowledges significant challenges with this model, including gaps in implementing theoretical ideas into service delivery. (Gao, 2023 and Pozniak et al, 2023).

The model is underpinned by an interdisciplinary approach to service delivery where team members work in partnership with parents to problem solve and develop intervention programmes that are based on the family's self-identified priorities. This can be challenging for professionals as they may feel that their unique skill set is being eroded away and that they are to become more generalist in their approach and their specialist skills are diluted or no longer required (Eurlyaid, 2019).

An example of how parents experience a family-centred approach from their interdisciplinary team in relation to service delivery can be seen in the example of honouring a child's priorities highlighted in Pozniak et al (2023). The professional noted that: 'We recognize the kid is not feeding himself and chokes all the time, but climbing on the playground is important to him so that is what we will focus on'.

This model of care recognises that families operate as an integrated whole. To work in partnership, it is essential that the team are aware of and honour the family's interests, needs and values. FCP recognises families as experts on the needs of their child and family and that the well-being of the child is largely dependent on the well-being of the family unit (Bradley et al, 2020). This is a dynamic model of engagement in which the clinician is as active a partner in the process as the children and families.

This process is designed to provide opportunities for families to feel empowered and increase their self confidence in facing challenges. It enables children with disabilities and their families to participate in and lead the services that they receive. It ensures that therapeutic support is tailored to the specific needs and requirements of the child and family at that given moment (Bradley et al., 2020).

The following resource reports on NICE guidelines for supporting children with complex disabilities and is a useful reference in relation to how standardised recommendations have been provided to guide service delivery.

Recommendations on support for all disabled children and young people with severe complex needs

LEARNING OPPORTUNITY

REFLECTION

Consider the following assumptions relating to FCP in practice

- Services listen to the family and child and strive to achieve the best possible outcomes for that child or young person.
- Families are, in the main, fully capable of making informed choices and acting on their choices.
- Parents/carers have the ultimate responsibility for the care of and decisions regarding their children.
- Services exist to support children and families to attain the best possible outcomes related to their identified priorities.
- Interventions are appropriate to the needs of the child and family. They emphasise capacity- building, strengthening existing skill sets, promoting the acquisition of new skills and other supports.
- Children, families and service providers all benefit most when services are based on true collaborative partnerships between families and professionals (HSE, 2013).

Reflect on previous placements/experiences of working/volunteering in services providing support to families and their children/young person. Identify which of the above you have observed and the impact it has had on service delivery?

LEARNING OPPORTUNITY

PRESENTATION / DISCUSSION

Discuss 5 benefits and 5 challenges of this model of practice from a clinician, parent and child's perspective?

CASE STUDY

A family has been referred to your service from Primary Care. How would you explain the family centred outcomes focused approach they will be receiving from your CDNT?

In this discussion use some of the information you gained from the second learning opportunity above to provide evidence of your explanations.

Interdisciplinary Team Working

A core principle of PDS is an interdisciplinary approach to care. Interprofessional Education Collaborative (IPEC) (2016) defines interprofessional teamwork as “the levels of cooperation, coordination and collaboration characterizing the relationships between professions in delivering patient-centred care” while Gilbert et al, 2010) defines interprofessional collaborative practice as; “when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care”. In an increasingly complex healthcare environment, the benefits of effective and efficient teamwork are evident. Collaborative practice is a cornerstone in many areas of health care provision.

IPEC (2016) identifies 4 core competencies for interprofessional collaborative practice:

1. Work with individuals of other professions to maintain a climate of mutual respect and shared values.

2. Use the knowledge of one's own role and those of other professions to appropriately assess and address health care needs and to promote and advance the health of populations.

3. Communicate within all stakeholder communities in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.

4. Apply relationship building values and the principles of team dynamics to perform effectively in different team roles to plan delivering population centred care and population health programs and policies that are safe, timely, efficient, effective and equitable.

One of the challenges for students and professionals alike is in developing and establishing their professional identity in their chosen profession while simultaneously developing and establishing their identity as a member of an interdisciplinary team. Khalili et al (2019) describes this as dual professional and interprofessional identity development. This is described as the development of a robust sense of belonging to both your own profession (In-profession Favouritism) and to the interprofessional community (Interprofessional Favouritism) in which individuals view themselves simultaneously as a member of their profession and the interprofessional team/community (Khalili, 2019; Khalili et al, 2014).

This is no easy task, but it is important to understand that this is not a sequential process, the formation of both identities is occurring simultaneously, and both take time to develop. The challenges that may be experienced by a student are challenges experienced by all professionals working within an interdisciplinary framework.

Within the context of PDS and using a family centred outcomes focused approach, interdisciplinary professionals report FCP as a distinct approach to providing intervention to families (Foster et al, 2020). They see their role as supporting families to be teachers, and advocates to and for their children. Their role is helping families identify their concerns and priorities.

Core Participatory and Relational Skills

Research indicates that there are core participatory and relational skills required across disciplines for working within a family-centred model of practice (Dunst et al, 2006, Eurylaid, 2019, Bruder et al, 2019 and Foster et al, 2020).

Relational clinical skills include active listening, empathy, showing respect and being non-critical/impartial. It also includes professionals' attitudes towards families 'abilities and skills' (Bradley et al, 2020).

Participatory help-giving methods are described as being dynamic, responsive to family's needs and supportive of their engagement in the process e.g. collaboration, flexibility, joint decision-making, family action (Bradley et al, 2020).

The European Association for Early Childhood Intervention (Eurlyaid, 2019) highlights technical knowledge (professionals' knowledge, skill set, experience, and specialisation) as another essential factor in care provision.

DIAGRAM 3

Supporting Family Centred practice (Moran et al, 2020; Dunst 1998)

PARTICIPATORY PRACTICES

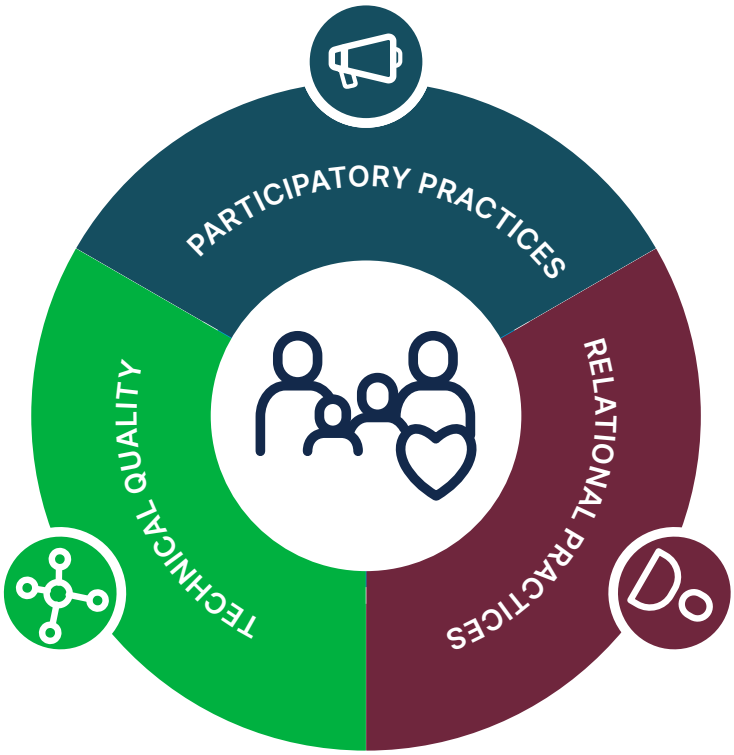
- Flexibility
- Responsiveness
- Joint decision making
- Family action
- Collaboration with families

RELATIONAL PRACTICES

- Active listening
- Empathy
- Authenticity
- Respect
- Information sharing
- Beliefs around family competencies

TECHNICAL QUALITY

- Professional experience
- Training
- Skills
- Knowledge of clinical practice



Professionals who participated in the Foster et al (2020) study noted skills that are essential when using an FCP approach:

- **Active/reflective listening which encourages open discussion.**
- **The relationship is based on a peer support relationship/ partnership as opposed to an expert-led relationship.**
- **Professionals need to adopt a non-judgemental approach where consideration of all family circumstances are reflected in conversation.**
- **Flexibility is key where the professional can adapt relative to the changing needs/circumstances of the family.**

Ongoing research is looking at which of the two components, participatory practices or relational practices are the most impactful in relation to parent involvement in services. (Mas et al, 2022; Movahedazarhouligh, 2019)

Within PDS team members are being asked to change their way of working in relation to how they have traditionally provided services to families and their children. Bradley et al (2020) explored the evolution of these changes within Midwest Community Healthcare. This project facilitated team members to reflect on the transition that was required when their services were reconfigured from multidisciplinary diagnostic led service provision to the PDS model of interdisciplinary teams moving towards a partnership, needs based method of service delivery. This shift is reflected in the figure below where the evolution of services continuum (Diagram 4 Continuum of Models in Disability Care) of this document was adapted to reflect the changes in Midwest Community Healthcare.

DIAGRAM 4

Continuum of family-centred Models in Disability Care (Dunst et al., 1991) adapted from Espe-Sherwindt (2008)

Professionally-Centred

Initially teams often provided their service in a professionally-centred model where access to team supports was often based off a discipline specific assessment. This assessment would then be used to formulate goals based on individual deficits rather than direct family needs and in turn, the voice of the family was often not properly accorded into the process of writing goals.

Family-Allied

As teams became more used to working through IFSPs, some were challenged by meeting families and setting goals without first "seeing the child" to ascertain if the desired outcomes were "realistic". Owing to this, teams spent a large period oscillating between a professionally-centred model and a family-allied model.

Family-Focused

As teams became more experienced and committed, they tended to move towards a family- focused model, feeling that they could implement interventions if directed. However, these interventions were still often linked to the team's perception of what was most important and was immediately and easily available at that time (rather than family direction)

Family-Centred

As time went on there were more instances of teams seeing families as champions of their own supports but there was sometimes little flexibility afforded to these decisions.

There were some positive indications from more experienced where families were viewed as equals in decision making and goal creation. Interventions in these instances were individualised, flexible and responsive to the family- identified needs of each child and family and focused on strengthening and supporting family functioning.

LEARNING OPPORTUNITY

REFLECTION

Reflect on each of the effective help-giving practices above.

What area do you feel that you have the most strength in?

What area would you like to develop?

PRESENTATION / DISCUSSION

Together with a colleague consider service delivery practices that illustrate the difference between practices that encourage family empowerment and practices that foster family dependence on services.

CASE STUDY

Think about a family that has been attending a primary care service within their community. Changes in their child's needs and the family circumstances now warrants that they are referred to a CDNT.

Think about the differences that this family and young person will experience when they attend the CDNT. How can you smoothen this transition, what practices could the team put in place for these families and young people?

Stages of Service Engagement

The next section of this resource will look at how services for children and their families are now configured under the PDS framework.

RECOMMENDED RESOURCES

To explore this more the following link takes you to the documents that support the implementation of the PDS framework for CHOs.

LINK **HSE PDS Key National Documents**

National Access Policy

The national access policy is the procedure by which families and young children and their CHOs manage new referrals to services.

The National Access Policy document and referral forms can be found here:

LINK **National Policy on Access to Services for Children & Young People with Disability & Developmental Delay**

Once a child and their family have met the referral criteria and have been accepted by their local CDNT, their journey through the services begins.

LEARNING OPPORTUNITY

REFLECTION

Whilst on placement request to look at a completed referral form. Score it and reflect on your findings. Your experience will be more in line with CDNT experiences if you could score it with a colleague.

- → What challenges did you find in scoring the referral form?
- → Considering the 10-point scoring scale, was it clear which service was the most appropriate for the completed referral?
- → If not, familiarise yourself with the processes CDNTs must go through for referrals that require further discussion, eg the integrated Children's Services Forum.

Information on this is available on this link:

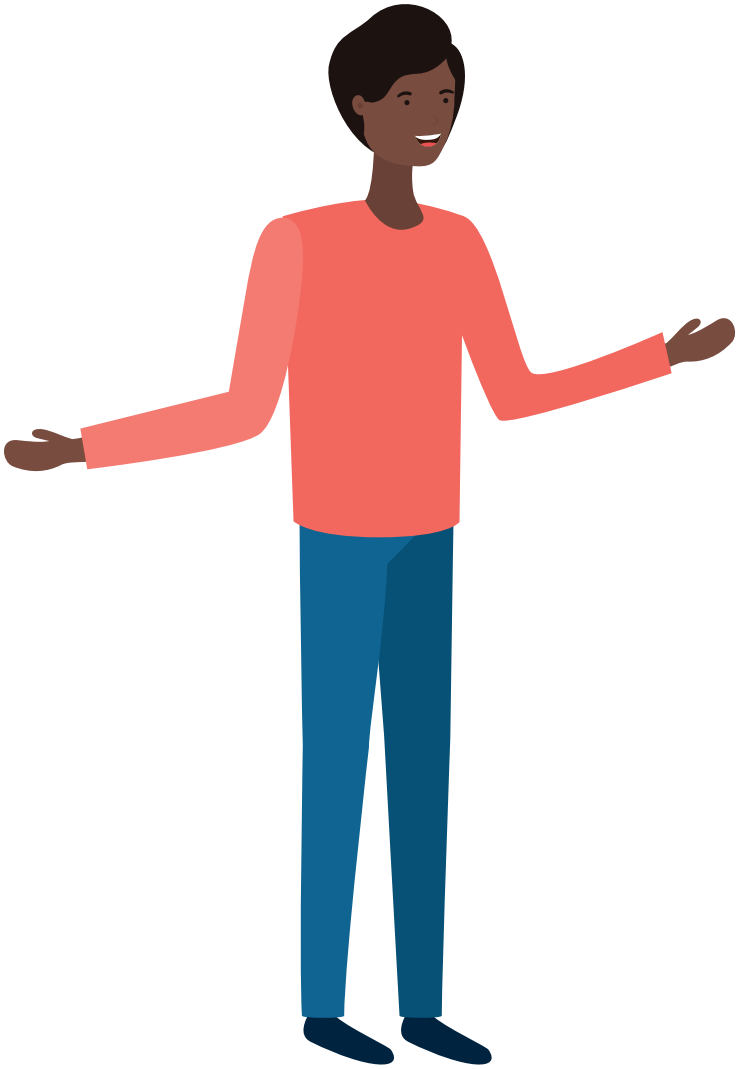
LINK **National Policy on Access to Services for Children & Young People with Disability & Developmental Delay**

PRESENTATION / DISCUSSION

Whilst on placement take the opportunity to discuss with families the process of referral and filling out the referral form. Take time to note any challenges they may have had and any recommendations they would make to policy makers.

CASE STUDY

You have been invited to the Integrated Children's Services Forum to represent your team in relation to the scoring of a referral form. In this case, a definitive decision was difficult to make in relation to where a child and their family's needs would be best met. What information do you need to prepare in advance of this meeting?



Governance

How do services and families feel reassured that service delivery is aligned with the PDS principles? Governance is an essential consideration in PDS and is one of the core principles. Governance is described as the framework of rules, practices, and policies by which an organisation can ensure accountability, fairness and transparency in the organisation's relationship with its stakeholders.

Further information on governance within CDNTs is available here:

LINK **CHO Governance of Children's Disability Network Services**

How will a team prioritise and manage waitlists following referral acceptance? The National Policy on Prioritisation of Referrals to Children's Disability Network Teams guides teams in relation to how they can prioritise referrals once accepted.

The National Policy on Prioritisation of Referrals to Children's Disability Network Teams

Some teams will implement waitlist initiatives where they will offer generic programmes to families and children who have been referred into the service with similar concerns. This can include signposting families and young people to community supports and resources in their local area. It may also include groups focusing on skills like study skills groups, learning to cycle groups, groups on managing anxiety etc.

Initial contact following a time on a waitlist involves meeting with families and their children and starting the IFSP process. At this time a key contact may be allocated to the family.

Information on guidance in relation to this is available in the document:

Interim National Guidance for Children's Disability Network Teams on the Key Contact Role

The following part of the resource takes you through the service of engagement in more detail with a specific focus on the Individual Family Support Plan (IFSP). The IFSP is the tool used to map services for families and their children.

Firstly, the child and family referral has been accepted and the child and family will be attending a CDNT for services.

What is an Individual Family Support Plan (IFSP)?

An IFSP is a plan made by the child (as appropriate to their age), their family and the CDNT in partnership. The plan brings together the child's and family's needs, priorities and desired outcomes with the team's knowledge and expertise, in order to agree what they will focus on next. Everyone then knows who is doing what, where and when.

One of the core objectives in developing the plan is for members of the team to actively listen to the child and their family, gather information, develop an understanding of their values and culture and how the team can support them in a meaningful way. A written plan of this is created and this can be updated at any time to reflect changes in priorities and goals, supports and strategies.

When considering development of the IFSP within services, it is useful to frame all interactions and service delivery models around the International Classification of Functioning, Disability and Health.

Within the IFSP there are certain conditions that must be met before the IFSP meets the expectations of the PDS framework. See the document below for detailed information on this.

National guidance on IFSPs for CDNTs is available at:

National Guidance for Children's Disability Network Teams on Individual Family Support Plans

Family priorities: *what is important now*. This needs to be written in the present tense. The more specific the **priority** the easier it is to move through goals, baseline and then strategies and supports. The more specific, the more measurable change is.

An example of this would be:

The family identifies that they are concerned that John will not sit at the table for breakfast. Following collaborative discussion the priority for support is: *'That John can finish his breakfast in one sitting' as opposed to 'John will not sit at the table for prolonged periods of time'.*

Goal: this is the opportunity for the family and team to collaboratively set targets that are objective, measurable, clear & concise.

For the example above the goal could be 'John will eat his breakfast in one sitting'. This is concise and complete, but you need to ensure that you have all the information you need to set strategies to support the attainment of this goal. If not, the goal may be too broad.

For example, if you have not completed a comprehensive interview with the family in relation to what is currently happening then John sitting at the table to eat his breakfast in one sitting might not be achievable.

Supporting this investigative work will be establishing a **baseline** of what the child can currently do in relation to the priority and goal. In this case the baseline could be that *'John currently has good seating and enjoys the food. He is sometimes distracted by the dog wandering around the kitchen'.*

Now through an in-depth interview with the family there is increased clarity around the goal. In partnership with the family, the team can work on what the family will do and what the team will do to support goal achievement.

In the IFSP, the **strategies/what the family will do** section details what the family and child will do to achieve the goal. These strategies are written with the family and are clearly linked to the goal, baseline skills and circumstances.

For the goal above, considering the baseline, it may be that *'Mum and Dad will look at where the dog is during breakfast and create a consistent routine around breakfast time for the whole family'*. This may require layers of strategies for the family where they may need to spend periods of time supporting the rest of the family in setting consistent routines around breakfast. This further adds weight to the requirement that the goal is based on a family priority so that the family has ongoing motivation to implement the strategies.

The team supports or what the team will do section may be linking in with family around communicative and behavioural supports to trial during breakfast. Some examples are:

- **Sequencing breakfast eating with visuals.**
- **Ensuring that John knows that when he leaves the table breakfast is over and tidy up begins to happen where John might realise 'Oops, I am not finished, and I am still hungry'**

The team supports can include individual appointments with a team member, standardised assessments or group sessions as deemed appropriate.

DIAGRAM 5

IFSP elements

Partnership

The IFSP is a plan written/completed in partnership with the family.

Interdisciplinary

It is compiled with identified team members and the family and then shared with the team.

Specific

It relates to the child needs and the child and family's priorities in detail and throughout.

Family Focused

It is completed with families.

Within the IFSP, goal setting is the critical element that will support the success or failure of the plan. Goals that are too broad and not linked to priorities will hold little value to families. For example, it may seem relevant to the team that a child starting in secondary school would benefit from attending a group looking at how to orientate to a new environment, planning your locker and also study skills. If the family is more concerned about solving the problem of getting appropriate transport for their child to go to school then there may be non- attendance at the group or little engagement with the content if the child does attend. The responsibility of the team is to consider the family priorities first, in the example above the group could include a session for parents only where options are explored, and advice given on how to access transport services to the school.

S.M.A.R.T. Goals Worksheet

When writing S.M.A.R.T. goals use concrete language, but relevant information. Goals are designed to help families succeed, so try to be positive when answering the questions.

Initial Goal	Write the goal you have in mind:
SPECIFIC	What does the family want to accomplish? Who needs to be included in this? When does the family want to do this? Why is this a goal for them?
MEASURABLE	How can the family measure progress and know if they have successfully met the goal?
ACHIEVABLE	Does the family currently have the skills required to achieve the goal? If not, how do they obtain these? What is their motivation for this goal? Is the amount of effort required on par with what the goal will achieve?
RELEVANT	Why is the family setting this goal now? Is it in line with the overall priorities for the family?
TIME-BOUND	What is the deadline? Is it realistic?

What does the initial goal now look like?

The goal needs to include a way of measuring the success or not of it. The measurement could include a time frame, a completed skill or component of a skill. For example, lifting the spoon to their mouth as opposed to feeding themselves or alternatively a satisfaction measurement. It can be difficult for team members to acknowledge a goal is met if it is only met 50% of the time like 'John will eat his breakfast and lunch in one sitting and during dinner he can take 3 breaks'. A family may feel that when this is achieved, they can move onto another priority, but a team member may wonder why the family is not looking for all meals to be eaten in one sitting. This is a critical element of a family centred service, writing plans in partnership with families.

Tools for Goal Setting

Tools that can be used to support outcome measurement and add an element of standardisation to the process include the Canadian Occupational Performance Measure and Goal Attainment Scaling. Having the addition of outcome measurement tools supports acknowledging goal attainment and adds a time bound aspect to goal setting. This aspect of goal setting is critical when the team is reviewing the IFSP with the family and young person. The IFSP guidance document recommends that the IFSP is a living document where the goals are reviewed on an ongoing basis as agreed with the family. If this is not possible, the document is reviewed at least once every 12 months.

Canadian Occupational Performance Measure

LEARNING OPPORTUNITY

The following link takes the reader to an activity where they can engage in the process of auditing goals to ensure they align with a family centred, outcomes-focused service delivery approach.

LINK **Enhancing Recognition of High Quality, Functional IFSP Outcomes**

Using the awareness following completion of this exercise, go to the examples at the back of this document and review the goals and the amendments made to the goals to increase their functionality and relevance.

LINK **https://www.hse.ie/eng/services/list/4/disability/progressing-disability/pds-programme/documents/national-guidance-for-cdnts-on-individual-family-support-plans-revised-june-2023.docx**

Now consider these goals:

- Mary will go up and down the steps of the therapy room.
- Alex will increase his sitting time.
- Aoife will obey her mother's instructions.
- Jack will eat his dinner.

Asking these questions, audit the goals in relation to their SMARTness.

Interdisciplinary Assessments

Within a family centred practice model of service, the assessment phase takes on a different format than in traditional expert led services. The initial focus is to identify concerns and priorities with the family. This informs how intervention is delivered.

The assessment focuses on:

- identifying the family priorities.
- considering current strengths and resources that the family and child have in relation to supporting targeting the priorities.
- identifying the functional skills the child has that support setting goals, baseline skills and building strategies.

Examples of assessments that can be used by the interdisciplinary team include:

Routines Based Interview

The Routines-Based Interview™ (RBI) is a semi-structured clinical interview designed to help families decide on outcomes / goals for their individualised plans, to provide a rich and thick description of child and family functioning, and to establish an immediately positive relationship between the family and the professional. This tool can be used from the beginning of the process (i.e., planning) through to the family's putting goals they have selected into priority order.

Routine Based Interview report forms can be found at:

LINK Routine (illinois.edu)

Another example of an interdisciplinary assessment is the SAFER assessment. Information on this assessment can be found at this hyperlink:

LINK Scale for Assessment of Family Enjoyment within Routines (SAFER)

This is not an exhaustive list of assessments, and these may not be used by the CDNT you are on placement with, therefore, please engage with your practice educator for information related to interdisciplinary assessment in the setting you are in.

IFSP Review

Following completion of the IFSP there are recommendations in the guidance document.

LINK **Progressing Towards Outcomes-Focused Family-Centred Practice**

Specialist Supports within the PDS Framework

There will be times when some family's circumstances will change in relation to the level of support they require. This support may relate to more specialised input following surgery or acute medical episodes.

The following document provides information on this in the context of PDS and the ability of families to access specialist services including gait analysis, postural management services and feeding, eating, drinking and swallowing specialist services:

LINK **Guidance on Specialist Supports**

Discharge and Transfer

As families and their children come to the end of their time with their team due to not requiring support any longer, moving address or becoming an adult, the HSE have the following document to support discharge or transfer of these families.

LINK **National Policy on Discharge and Transfer from CDNTs**

Professional Roles with the CDNT

Physiotherapist

Role of the Paediatric Physiotherapist

Children may experience disruption in their development or function due to multiple factors. Paediatric physiotherapists may work with these children and their caregivers/families to improve function. Typically, paediatric physiotherapists will address motor issues, but their service users may also present with other impairments that affect cognition, language, and psychosocial issues (Pagliarulo 2021).

When working with children with physical impairments or different abilities, the overall goal of the paediatric physiotherapist is to promote independence. Physiotherapists aim to help their service users achieve developmentally appropriate functional skills, decrease the impact of an impairment, impart adaptive strategies, and educate the family and caregiver to ensure carryover (Long, 2018).

Goals during paediatric physiotherapy sessions include:

- Promote independence.
- Increase participation.
- Facilitate motor development and function.
- Improve strength and endurance.
- Enhance learning opportunities.
- Ease challenges associated with daily caregiving (Long, 2018).

Paediatric Physiotherapy Assessment Process

LINK **Category: Paediatrics – Assessment and Examination – Physiopedia (physio-pedia.com)**

LINK **Category: Paediatrics – Guidelines – Physiopedia (physio-pedia.com)**

Useful Outcome Measures

LINK **Category: Paediatrics – Outcome Measures – Physiopedia (physio-pedia.com)**

- Goniometry
- Oxford Scale
- Peabody Developmental Motor Scales (PDMS-2)
- Bayley Scales of Infant and Toddler Development
- AIMS (Alberta Infant Motor Scale)
- Gross Motor Function Classification Scale (GMFCS)
- Visual Analogue Scale, Faces Pain Scale
- Movement ABC
- Observational Gait Scale
- BOT
- TUG
- 6-Minute Walk Test
- Modified Ashworth Scale + Tardieu Scale
- Beighton Score

Examples of CDNT Assessment Pathways

- Cerebral Palsy Integrated Pathway Scotland (CPIPS) (See Appendix)
- SOP Physical Disability Support Pathway (See Appendix)
- Physical Disability Pathway (currently under review)
- Motor management pathway (currently under review)
- Postural management pathway (currently under review)

Paediatric Physiotherapy Intervention Approaches

LINK **Category: Paediatrics – Interventions – Physiopedia (physio-pedia.com)**

LINK **Clinical Guidelines: Paediatrics – Physiopedia (physio-pedia.com)**

LINK

- → Motor control/learning
- → Physical Activity/Wellness Promotion: **Physical Activity Guidelines – HSE.ie**
- → Play-based therapy
- → MDT approach
- → Family-centred care
- → Neuromuscular Relaxation/Inhibition/Facilitation (Neurodevelopmental Therapy-NDT)
- → Sensory Integration Training
- → Balance and Coordination Training
- → Breathing exercises and ventilatory muscle training
- → Functional Mobility Training
- → Manual Therapy/Massage
- → Prescription, application and, as appropriate, fabrication of devices and equipment
- → Airway clearance techniques
- → Electrotherapeutic modalities
- → Pathway for accessing orthotics/casting
- → Postural management
- → Body mechanics
- → Hydrotherapy
- → Community-based (home, school, LSP)
- → Hippotherapy
- → FMS training

Physiotherapists' Competencies on the CDNT

Discipline specific:

- Examine and diagnose the service user's physical condition, drawing up and implementing treatment programmes as appropriate to the professional standards of a physiotherapist.
- Monitor and assess the service users' progress and adjust as necessary to the treatment programmes.
- Maintain comprehensive records of service user's assessment, interventions carried out, communications relating to service users etc.
- Maintain detailed records and submit reports or other statistical information relating to physiotherapy or service users as may be required.
- Participate in quality assurance as may be required to ensure quality service provision.
- Liaise with parents and caregivers, assisting and advising them on physiotherapy programmes which are to be undertaken with their children.
- Advise on footwear and appliances which are most suitable for service users where appropriate.
- Advise, seek competitive quotations, and order equipment and special appliances as may be required and approved from time to time.
- Strive to improve the mobility of the service user and ensure that each person has every opportunity to achieve his/her full physical potential.
- Treating the service user after injury or surgery and if necessary, liaising with employees from other agencies/ hospitals or acute services.

- Assessment and treatment of service users with respiratory needs, as appropriate and linking with specialist services and acute services around the same.
- Participate in in-service training as may be required.
- Monitoring and keeping up to date with new developments in physiotherapy.
- To attend supervision with the nominated Senior Professional within your profession.
- Be aware of and follow all Service and departmental policies and procedures.
- Ensure that the health and safety policy of the Service is fully complied with.
- Reporting any accidents and complaints immediately and providing follow up forms and information as may be required.
- Ensure that all equipment is checked on a regular basis and if defective reported immediately to the manager.
- Maintain good working relationships with colleagues.
- Maintain a high standard of work performance, attendance, appearance, and punctuality always.
- Ensure that the highest standards of confidentiality are maintained in relation to all areas of work at all times.

LEARNING OPPORTUNITY

REFLECTION

1. How would you explain your discipline role to your team?
2. How would you explain your discipline to a parent?
3. How would you explain your discipline role to a child?

DISCUSSION

How does your explanation of your discipline role change when communicating with a child?

Speech and Language Therapist

Role of the Paediatric Speech and Language Therapist (SLT)

The SLT's role is to assess, diagnose and provide a broad range of interventions and supports to children and their families, with a variety of disorders and /or concerns regarding communication, voice, feeding, eating, drinking, and swallowing (FEDS) that co-occur with other difficulties. This may be done as part of a team and/or as a uni-disciplinary role within the team. SLTs on the CDNT may work with children and their families with regards to:

- Assessing speech, language, and communication skills.
- Supporting diagnostic assessments.
- Providing intervention for a range of communication difficulties.
- Providing intervention via direct therapy, consultation, training for parents and teachers, advocacy and as part of a team approach or specific intervention.
- Assessing and supporting drinking and swallowing difficulties.
- This work is carried out in the clinic, online, at home, schools and in the community.

Speech and Language Therapy: Commonly Used Assessments

Below is a list of commonly used assessments, it is not an exhaustive list. Assessments used will vary across CDNT sites, in response to client needs and as advised by your Practice Educator.

During spontaneous conversation and play observe:

- → Spontaneous language
- → Speech sounds
- → Play skills
- → Pragmatic skills and purpose of communication

Speech

- → Observations
- → Stimulability
- → Diagnostic Evaluation of Articulation and Phonology (DEAP)
- → South Tyneside Assessment of Phonology (STAP)
- → Nuffield

Language

- → Clinical Observations
- → Children's Communication Checklist
- → Down Syndrome Checklists
- → Receptive-Expressive Emergent Language Test 4th Ed.
- → Test of Abstract Language Comprehension
- → Derbyshire Language Scheme
- → Clinical Evaluation of Language Fundamentals Preschool 2nd Ed.
- → Clinical Evaluation of Language Fundamentals 4th UK Ed.
- → Clinical Evaluation of Language Fundamentals 5th UK Ed.
- → Assessment of Comprehension and Expression (ACE) 6-11
- → Bracken Test of Basic Concepts
- → Renfrew Action Picture Test
- → Renfrew Bus Story
- → Renfrew Word Finding

Pragmatics

- → Clinical Evaluation of Language Fundamentals 5 META
- → Test of Pragmatic Language – 2
- → Test of Problem Solving

Speech and Language Therapy Intervention Approaches

Below is a list of commonly used intervention approaches, it is not an exhaustive list. Intervention approaches will vary across CDNT sites, in response to client needs and as advised by your Practice Educator.

Parent Training

- → Hanen More than Words
- → Hanen It Takes Two to Talk
- → Hanen Talkability
- → DIR Floortime
- → Intensive Interaction
- → Gestalt Language Processing (GLP)

Language Intervention

- → **Colourful Semantics**

- → **ELKLAN**
- → Shape coding

Social Interaction

- → Social Stories
- → Visuals
- → Lego Therapy
- → PEERs
- → Youth Clubs/Social Clubs

- → **Communication Passports**
- → Comic Strip Conversations

Speech

- → Auditory Bombardment
- → Auditory Discrimination
- → Articulation Therapy
- → Minimal Pairs
- → Core Vocabulary

Visual Supports

- → TEACCH
- → Visual Timetables

Augmentative and Alternative Communication (AAC)

- → High tech devices
- → Objects of Reference
- → CoreBoard
- → Lámh
- → Picture Exchange Communication System (PECS)

- → **Liberator**

- → **Safe Care Technologies**
- → Family Service Plans
- → Assessment of Need (assessment under Disability act)
- → NAS Early Bird Parenting Training
- → Cygnet
- → Transition to Primary School
- → Transition to Secondary School

Speech and Language Therapists' Competencies on CDNT

Discipline specific:

- Be responsible for assessment, diagnosis, planning, implementation, and evaluation of treatment / intervention programmes for service users according to professional standards.
- Arrange and carry out assessment and treatment / intervention programmes in appropriate settings in line with local policy / guidelines and professional standards.
- Communicate results of assessments and recommendations to the service user and relevant others as appropriate.
- Document all assessment, diagnosis, treatment / intervention plans, clinical notes, relevant contacts, and summaries in accordance with department and professional standards.
- Collaborate with service user, family, carers and other staff in goal setting and treatment / intervention planning.
- Foster close working relationships with colleagues and other relevant professionals in maximising the service users' potential.
- Provide support and information in relation to communication and / or feeding, eating, drinking, and swallowing disorders etc. to service users and relevant others.
- Attend clinics and participate in meetings, case conferences, ward rounds etc. as agreed with the Speech and Language Therapist Manager.
- Participate in teams as appropriate, communicating and working in collaboration with the service user and relevant others as part of an integrated package of care.
- Maintain professional standards of practice.

- Represent the department / profession / team at meetings and conferences as designated.
- In conjunction with the CDNT Manager, contribute to the development and implementation of procedures, policies and guidelines while adhering to existing standards and protocols.
- Actively engage in team-based performance management, where appropriate.
- Maintain professional standards in relation to confidentiality, ethics, and legislation.
- Seek advice and assistance from the CDNT Manager with any assigned cases or issues that prove to be beyond the scope of his / her professional competence in line with principles of best practice and clinical governance.
- Operate within the scope of Speech and Language Therapy practice as set out by the Irish Association of Speech and Language Therapists.
- Participate in and develop activities which support Health Promotion.
- Carry out other duties as assigned by the CDNT Manager.

- Participate in mandatory and recommended training programmes in accordance with departmental / organisational guidelines.
- Maintain continuing professional development e.g., by attending in-service events, training courses, conferences, and involvement in research.
- Engage in reflective practice, support / supervision with designated supervisor(s) / manager.
- Participate in the practice education of student therapists and provide teaching / training / supervision to others (e.g., to staff, service users, carers) as appropriate.
- Attend practice educator courses as required.
- Engage in planning and performance reviews as required with the CDNT Manager.
- Comply with the policies, procedures, and safe professional practice of the Irish Healthcare System by adhering to relevant legislation, regulations, and standards.
- Assist in the development, implementation and review of the department's Health and Safety statement, as appropriate.
- Document appropriately and report any near misses, hazards and accidents and bring them to the attention of the relevant person(s).
- Work in a safe manner with due care and attention to the safety of self and others.
- Be aware of risk management issues, identify risks and take appropriate action.
- Comply with department procedures regarding assessment, recommendation and / or manufacturing of all assistive devices.
- Support a culture that values diversity and respect.
- Keep up-to-date administrative records, reports and statistics as required by the Speech and Language Therapist Manager.

- Be responsible for organisation and maintenance of own clinical equipment and identification of equipment needs as appropriate.
- Participate in the planning and development of the Speech and Language Therapy Service.
- Represent the department at meetings and conferences as designated.
- Participate in the review, evaluation and audit of Speech and Language Therapy services, identifying changing needs and opportunities to improve services.
- Assist in ensuring that the Speech and Language Therapy Service makes the most efficient and effective use of developments in Information Technology.
- Keep up to date with organisational developments within the Irish Health Service.
- To support, promote and actively participate in sustainable energy, water, and waste initiatives to create a more sustainable, low carbon and efficient health service.

LEARNING OPPORTUNITY

REFLECTION

1. How would you explain your discipline role to your team?
2. How would you explain your discipline to a parent?
3. How would you explain your discipline role to a child?

DISCUSSION

How does your explanation of your discipline role change when communicating with a child?

Occupational Therapist

Role of the Occupational Therapist

Occupational Therapy is a client-centred health profession concerned with promoting health and well-being through meaningful occupation (WFOT, 2010). Paediatric Occupational therapists seek to improve children's engagement and participation in life roles (Novak and Honan, 2019). These roles include developing personal independence, becoming productive and taking part in play and leisure pursuits (Hanna & Rodger, 2002). When working with children, there is an added complexity as one must consider the family's values, the child's values, and the developmental and educational expectations. One must also take a life course approach, children are dynamic beings, constantly changing and evolving and moving toward their adulthood. Although not the focus of intervention, it is important to keep an eye on the future. How can your interaction with the child and family now support their independence and engagement in their chosen activities as they progress through life? Swann et al. (2023) prompts us to consider the concepts of being, belonging and becoming with a view to supporting occupational engagement. Understanding the developmental trajectory of tasks and activities supports the therapist in guiding the child and family as to where they can go next in skill development. This is called anticipatory guidance.

OTs work with children in a variety of settings including clinical settings, school environments and the home. OTs use tools such as assessments and activity analysis to support decision making and clinical reasoning. We collaborate with the child and family to help the child grow, learn and thrive.

A systematic review of the effectiveness of OT for children with disabilities completed by Novac and Honan in (2019) highlights that OTs working with children and their families have several evidence-based interventions to choose from. The evidence suggests that parent-delivered intervention is equally effective to therapist-delivered intervention (Baker et al, 2012). Working to empower parents and families supports them in developing a skill set that they can draw from to support the development of their child. Basak (2002) provided an excellent diagram that considers how OT promotes participation in Occupation.

DIAGRAM 6

Occupational Therapy: Promoting Participation in Occupation (Basak, 2022)

Assessment

The first step is to collaboratively compile an **Occupational Profile**. This captures the child and family's current concerns around their engagement in meaningful occupations and activities of Daily Living. The family is encouraged to consider their values and interests, to reflect on their personal and occupational history and the impact of this on their current functioning. In addition, contexts are investigated to see if they support or inhibit engagement. Barriers to successful participation are identified by the family. This process is completed in partnership between the therapist and the family and aligns closely with family centred practice.

Occupational Performance is then analysed with a summary of the occupational profile used as a basis to identify the priorities of the child and family. An **Activity or Occupational analysis** is completed to assess the demands the occupation will have on the child and family.

Specific assessments related to the occupation may then be completed with the child where performance skills and patterns are identified. Assessments will also look at client factors and context factors. This aligns with the team support aspect on the IFSP framework document.

Specific Assessments include:

- → Detailed Assessment of Speed of Handwriting (DASH)
- → Beery-Buktenica Developmental Test of Visual-Motor Integration, Sixth Edition, The (BEERY™ VMI)
- → Movement Assessment Battery for Children – Second Edition (Movement ABC-2)
- → Perceived Efficacy and Goal Setting System (PEGS)
- → Motivational Interviewing
- → Occupational Performance Coaching
- → Scale for Assessment of Family Enjoyment within Routines (SAFER)
- → Canadian Occupational Performance Measure (COPM)
- → Sensory Processing Measure
- → Sensory Profile

Planning

The evaluation process is then synthesised to ascertain skills and supports required for engagement in priority occupations. This feeds into the identification of universal strategies to support the child and family.

Goals are collaboratively set with families including outcome measures for each Goal. This feeds into the child and family's Individual Family Support Plan (IFSP).

Intervention plans detailing timelines are compiled based on the goals set. This includes universal strategies and team supports.

Intervention

While delivering OT services, the following are also critical factors in an Occupational Therapist's practice:

Therapeutic Use of Self

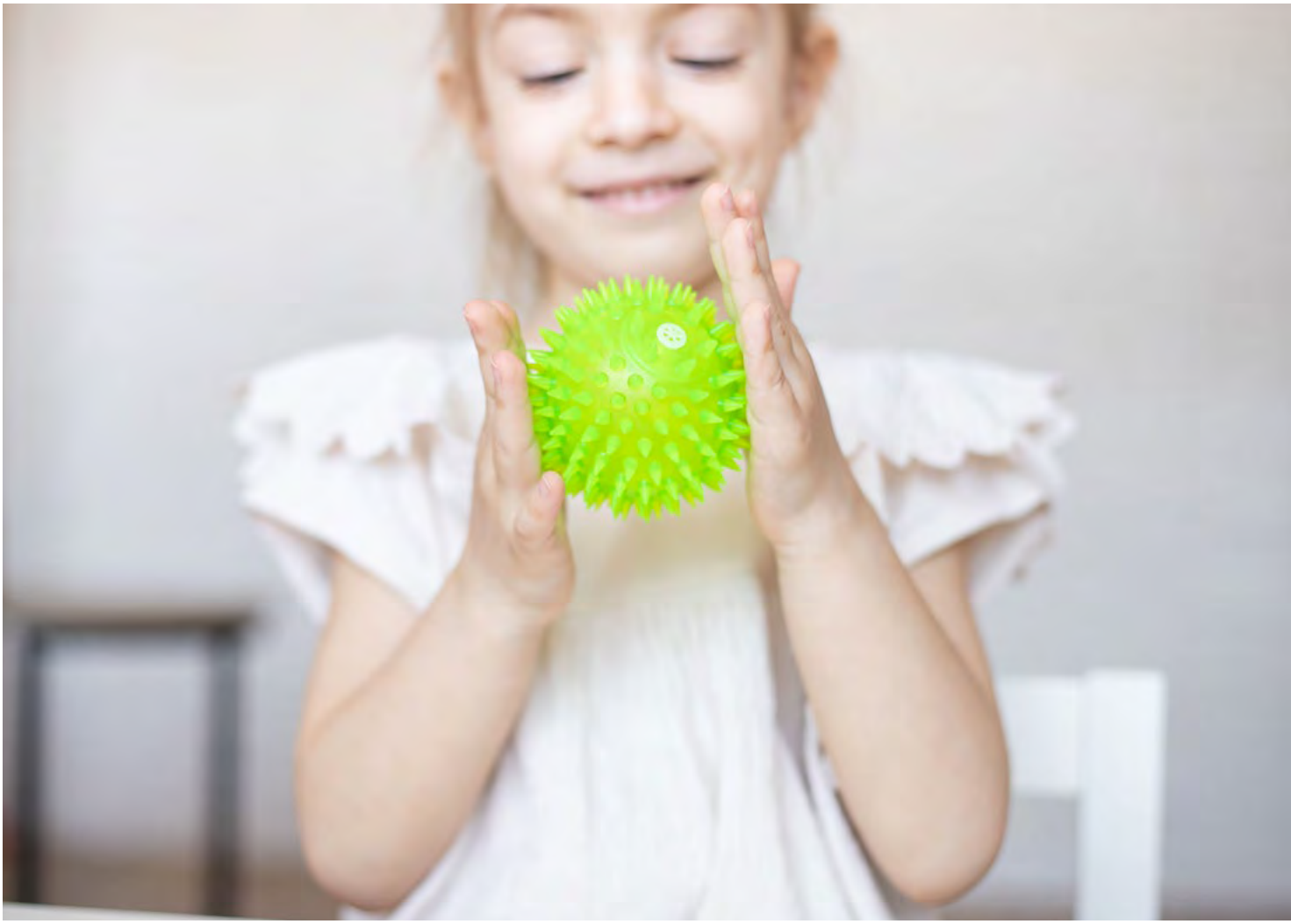
The therapeutic use of self is described as a cornerstone of Occupational Therapy practice (AOTA, 2020). This is widely recognized in literature and clinical practice. AJOT (2020) advises that OTs must create an inclusive, supportive environment to enable clients to feel safe in expressing themselves authentically' (AJOT, 2020 p20).

This aligns with PDS and FCP in that the role of the team member is to engage in Relational Help-Giving Practices and Participatory Help-Giving Practices.

Occupational Performance

Occupational performance is the client's ability to engage in the occupation they want to up to a standard they are satisfied with. 'Accomplishment of the selected occupation resulting from the dynamic transaction among the client, their contexts, and the occupation' (AOTA, 2020 p22). A client's measure of success in engaging in occupations is a vital part of outcome assessment.

In understanding the impact of Occupational Therapy, it is essential to understand that the goals and identified outcome measures must be meaningful to the client. The change that is being measured must also hold meaning for the client. When reviewing occupational performance, challenges may be evident in certain areas. It is essential that the focus of goals and outcomes is not on those challenges but rather on what is meaningful to the family and child at that time.



Occupational Therapy Competencies on the CDNT

Occupational therapy aims to help each child to reach his or her optimum level of functional independence when performing daily activities.

Assessment

- Child's functional strengths and areas of difficulty across different performance areas including ADLs, school, play and leisure.
- Performance components including motor, sensory, cognitive, perceptual, and psychosocial.
- Comprehensive assessment and recommendations for the provision of appropriate assistive equipment in areas including seating/positioning, transport, manual handling, pressure relieving and bathing.
- Assessment for and provision of upper limb splinting.
- Comprehensive home environmental assessments including making recommendations regarding housing modifications.

- Comprehensive school environmental assessment including
  - Accessibility of the physical environment: recommendations about access to the internal and external environment including classroom, toilet and changing facilities, circulation areas and play areas.
  - Assessment of classroom furniture - making specific recommendations for special chairs and tables and seating position in the classroom.
  - Accessibility of curriculum material: recommendations of assistive technology from low tech (pencil grips, slanted board) to high tech (special keyboards, software).
  - Alternative methods of presenting material (on paper rather than blackboard, orally rather than visually, using multi-sensory approach). Exams: recommendations regarding special arrangements required such as using scribe, keyboard, or increased time allowance.
  - Recommendations to assist resource teachers or special needs assistants. Intervention.
  - Individual or group intervention in clinic, school or home as appropriate to meet the needs of the individual child.
  - Home or school programmes to meet the needs of the individual and training in use of these to parents, carers, teachers, and classroom assistants.
  - Providing appropriate training and health promotion within the community to include training for other health, school, and educational professionals. General education courses for parents in target groups. Promotional activities including the production of handbooks, meetings with GPs, schools etc.
  - Provision of relevant information on resources and related services.

Occupational therapists use many different models of practice and frames of reference in their work. This helps to guide their clinical reasoning, planning and intervention.

LEARNING OPPORTUNITY

REFLECTION

1. How would you explain your discipline role to your team?
2. How would you explain your discipline to a parent?
3. How would you explain your discipline role to a child?

DISCUSSION

How does your explanation of your discipline role change when communicating with a child?

LEARNING OPPORTUNITY

REFLECTION

How have you observed an interprofessional team provide family-centred care during the assessment process?

What specific role did each discipline assume?

DISCUSSION

What benefits or challenges did you note?

CASE STUDY

Present a case study based upon a client of your choice that includes the presenting complaint, reason for referral, key assessment findings, prioritised problem list and evidence-based intervention plan. Include the IFSP.

References

Baker, T., Haines, S., Yost, J., DiClaudio, S., Braun, C. and Holt, S., 2012. The role of family-centered therapy when used with physical or occupational therapy in children with congenital or acquired disorders. Physical Therapy Reviews, 17(1), pp.29-36.

Bradley, S., Byrne, M., Ffrench, C., Hayes, D., Hughes-Kazibwe, A., and McCarthy, E (2020). Progressing Towards Outcomes - Focused Family Centred Practice. An Operational Framework. [Online]. HSE. Available at: **https://www.hse.ie/eng/services/list/4/disability/progressing-disability/pds-programme/documents/progressing-towards-outcomes-focused-family-centred-practice.pdf**

Bruder, M. B., Catalino, T., Chiarello, L. A., Mitchell, M. C., Deppe, J., Gundler, D., ... & Prelock, P. (2019). Finding a common lens: Competencies across professional disciplines providing early childhood intervention. Infants and Young Children, 32(4), 280-293. doi: 10.1097/IYC.0000000000000153

Canadian Occupational Performance Measure Website: (**https://www.thecopm.ca/**)

Dunst, C. J. (2002). Family-centered practices: Birth through high school. The Journal of Special Education, 36(3), 141-149. Doi.org/10.1177/00224669020360030401

Dunst, C. J., Trivette, C. M., & Hamby, D. W. (2006). Family Support Program Quality and Parent, Family and Child Benefits. Winterberry Press Monograph Series. Asheville, NC: Winterberry Press.

Eurylaid (2019). Recommended Practices in Early Childhood Intervention: A Guidebook for Professionals.

Foster TD, Decker KB, Vaterlaus JM, Belleville, (2020) A How early intervention practitioners describe family-centred practice: a collective broadening of the definition. Childcare Health Development. 2020;46(3):268-274. Doi: 10.1111/cch.12749

Gilbert, John HV, Jean Yan, and Steven J. Hoffman, (2010) "A WHO report: framework for action on interprofessional education and collaborative practice." *Journal of allied health* 39, no. 3 (2010): 196-197.

Hanna, K. and Rodger, S., 2002. Towards family-centred practice in paediatric occupational therapy: A review of the literature on parent–therapist collaboration. *Australian Occupational Therapy Journal*, 49(1), pp.14-24.

Health Service Executive (2020) Progressing Disability Services for Children and Young People Programme. Dublin

Health Service Executive (2009). Report of Reference Group on Multidisciplinary Services for Children aged 5-18 years. Dublin

Health Service Executive (2019). National Policy on Access to Services for Children and Young People with Disability and Developmental Delay. Dublin.

Health Services Executive (2013) Outcomes for Children and Their Families. Dublin

Health Service Executive (revised version 2022) Policy Framework for Children's Disability Network Teams. Dublin

Health Service Executive (2021) Community Healthcare Organisation Governance of Children's Disability Network Service. Dublin

Health Service Executive (2016) National Policy on Prioritisation of Referrals to Children's Disability Network Teams. Dublin

Health Service Executive (2022) Interim Guidance for Children's Disability Network Teams on the Key Contact Role. Dublin.

Health Service Executive (Revised 2021) National Guidance for Children's Disability Network Teams on Individual Family Support Plans. Dublin

Health Service Executive (2016) Guidance on Specialist Supports. Dublin.

Health Service Executive (2017) National Policy on Discharge and Transfer from Children's Disability Network Teams. Dublin

Interprofessional Education Collaborative. (2016). Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative.

Khalili, H., Hall, J. and DeLuca, S., 2014. Historical analysis of professionalism in western societies: implications for interprofessional education and collaborative practice. *Journal of Interprofessional Care*, 28(2), pp.92-97.

Kahlili, H., Thistlethwaite, J., El-Awaisi, A., Pfeifle, A., Gilbert, J., Lising, D. and Ward, H. (2019). Guidance on global interprofessional education and collaborative practice research: Discussion paper.

Kokorelias KM, Gignac MA, Naglie G, Cameron JI. **Towards a universal model of family centered care: a scoping review.** BMC health services research. 2019 Dec;19(1):1-1.

Long T.(2018) **Handbook of pediatric physical therapy.** Lippincott Williams and Wilkins; 2018 May 17.

Longo E, de Campos AC, Palisano RJ. **Let's make pediatric physical therapy a true evidence-based field! Can we count on you?.** Brazilian journal of physical therapy. 2019 May;23(3):187.

Lucas, A., Gillaspy, K., Peters, M. L., & Hurth, J. (2014). Enhancing recognition of high quality, functional IFSP outcomes. Retrieved from **https://ectacenter.org/~pdfs/pubs/rating-ifsp.pdf**

Mas, J.A., Dunst, C.J., Hamby, D.W., Balcells-Balcells, A., García-Ventura, S., Baqués, N., and Giné, C. (2022) Relationships between family centred practices and parent involvement in early childhood intervention, European Journal of Special Needs Education, 37:1, 1-13, DOI: 10.1080/08856257.2020.1823165

References

McCarthy, E, Guerin S. Family-centred care in early intervention: a systematic review of the processes and outcomes of family-centred care and impacting factors. Child Care Health Dev. 2022;48(1):1-32. Doi: 10.1111/cch.12901.

MacKean, G. L., Thurston, W. E., and Scott, C. M. (2005). Bridging the divide between families and health professionals' perspectives on family-centred care. Health Expectations, 8(1), 74-85. Doi: 10.1111/j.1369-7625.2005. 00319.

McWilliam, R.A., 2009. Protocol for the routines-based interview. Chattanooga: Siskin Children's Institute.

Movahedazarhouligh, S. (2021) Parent-implemented interventions and family-centered service delivery approaches in early intervention and early childhood special education, Early Child Development and Care, 191:1, 1-12, DOI: 10.1080/03004430.2019.1603148

https://www.nice.org.uk/guidance/ng213/chapter/Recommendations-on-support-for-all-disabled-children-and-young-people-with-severe-complex-needs#principles-for-working-with children-young-people-and-their-families

Novak, I. and Honan, I., 2019. Effectiveness of paediatric occupational therapy for children with disabilities: A systematic review. *Australian occupational therapy journal*, 66(3), pp.258-273..

O'Connor M, Clinical Psychologist. (2021). *Family Centred Practice*. [Online]. HSE. Available at: **https://www.hse.ie/eng/services/list/4/disability/progressing-disability/pds-programme/family-centred-practice** [Accessed 21 November 2022]

Pagliarulo MA. **Introduction to Physical Therapy-E-Book.** Elsevier Health Sciences; 2021 Jan 12.

Pozniak, K., King, G., Chambers, E., Martens, R., Earl, S., Kraus de Camargo, O., McCauley, D., Teplicky, R. and Rosenbaum, D. (2023): What do parents want from healthcare services? Reports of parents' experiences with pediatric service delivery for their children with disabilities, Disability and Rehabilitation, 7, 1-14. DOI: 10.1080/09638288.2023.2229733

Rosenbaum, Peter. (2022). The F-words for child development: functioning, family, fitness, fun, friends, and future. Developmental Medicine & Child Neurology. 64. 141-142. 10.1111/dmcn.15021.

Swann, C., Jackman, P.C., Lawrence, A., Hawkins, R.M., Goddard, S.G., Williamson, O., Schweickle, M.J., Vella, S.A., Rosenbaum, S. and Ekkekakis, P., 2023. The (over) use of SMART goals for physical activity promotion: A narrative review and critique. *Health psychology review*, 17(2), pp.211-226.

World Federation of Occupational Therapists, 2010. WFOT. *Position statement on human rights*.

Yu-Sin Gao (2023) Service Providers' Perception of Providing Family-Centered Care for Children with Developmental Disabilities: A Meta-Analysis, International Journal of Disability, Development and Education, 70:5, 722-734, DOI: 10.1080/1034912X.2021.192112

References

Appendices

Appendix 1: Project Team

This resource was developed by the following project team members. We wish to acknowledge the funding support received from the National Health and Social Care Professions Office in undertaking this work.

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Eileen O'Donnell	Senior Speech & Language Therapist
Suzanne Bradley	Consultant Occupational Therapist & Content Specialist

Appendix 2: Abbreviations

AON Officer:	Assessment of Need Officer
AON:	Assessment of Need
CAMHS:	Child and Adolescent Mental Health Services
CDNM:	Children's Disability Network Manager
CDNT:	Children's Disability Network Team
CDNTIMS:	Children's Disability Network Team Information Management System (Formerly known as MIS)
CHN:	Community Healthcare Network
CHO:	Community Healthcare Organisation
DC:	Domiciliary Care Allowance
EI:	Early Intervention (0-9) also known as SPRAOI
IA/IC:	Initial Appointment/ Initial Contact
IFSP:	Individual Family Support/Service Plan
KPI:	Key performance indicator
PCCC:	Primary Community and Continuing Care
PDS:	Progressing Disabilities Services
SA:	Teams are not called school age or early intervention team anymore, we have sub teams: 0-9 Team and 9-18 team in the CHO 3 region; however, we operate as 0-18 service as per PDS model School Age (9-18) also known as SONAS

Appendix 3: IFSP Example

INDIVIDUAL FAMILY SERVICE PLAN (IFSP)

AUGUST 2023

DATE OF MEETING: Sam
DATE OF Birth: ____, _____ 2017

DATE OF MEETING: DATE OF BIRTH: 2017

PEOPLE PRESENT

Parents	John and Maggie
Mary	Physiotherapist
Sarah	Occupational Therapist
Jen	Speech and Language Therapist
Carol	Early Intervention Educator

PURPOSE OF MEETING

The purpose of this meeting was to provide an opportunity for Sam's parents and therapists from the Early Intervention Team to meet together to produce an IFSP that will form the basis of services and supports from the Early Intervention Team offered to Sam and his family over the next six months.

SUMMARY OF WHAT IS WORKING WELL FOR SAM AND HIS FAMILY

Maggie and John describe Sam as a 'happy little man' who is content playing by himself. He sleeps well and is able to feed himself using his fingers. Sam is able to quickly crawl to move around/ explore rooms and can pull himself to standing and side step along furniture and walls easily. He has taken some independent steps. He enjoys 'electrical' toys that are musical and have lights; he likes singing and enjoys books.

Sam is due to start at preschool in his local preschool on the 31st August, with support from an AIMS worker.

Sam Jones DOB: 2017 IFSP August 2023

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KEY FAMILY PRIORITIES

1. Mobility: Maggie and John report that whilst Sam has taken some independent steps his balance and co-ordination was poor. They find family outings with Tom, Sam's brother, difficult as Sam doesn't like to stay in his buggy- he wants to move/ walk but cannot do so safely in places like playgrounds with sand or busy environments like shopping centres. Sam's current walker no longer meets his needs.

2. Communication: Maggie and John would like Sam to have a communication system that enables him to communicate his needs/ emotions with others. At present Sam enjoys vocalising (especially when the sound echoes back); he smiles and laughs during familiar games and has started to understand some key words and Lámh signs. Maggie and John have introduced PECS and are currently using 'objects of reference' with Sam. They both find it difficult on days when Sam 'whinges' because he cannot communicate his needs.

3. Play and Social Interaction: Maggie and John are happy that Sam is content playing by himself but would like him to be more 'socially aware'. They would like him to be more interested in other children and to enjoy playing/ interacting with them. They are working on turn taking and find that this works well with activities like eating porridge in the morning but find it difficult to find activities that interest/ motivate Sam and Tom so that the boys can play together. They are also concerned that Sam's sensory seeking behaviour limits his ability to develop his play skills- they both report that Sam constantly mouths/chews objects and repetitively bangs doors because he enjoys the sensory feedback.

4. Self Care Skills/ Activities of Daily Living: Maggie and John report that their over-arching priority for Sam is to help him to become more independent. Sam is able to drink from a Dodi cup that has been held for him by an adult, Maggie and John would like to focus on helping him hold and drink from a cup and feed himself with a spoon. In the longer term they would like him to be toilet trained and dress himself.

5. Services and Supports from Clare Children's Services: Maggie and John feel they need more supports for Sam than are available to them at the moment. They report that they are accessing a number of private therapies (SLT, PT and OT). They would like baseline assessments and updated programmes from Physiotherapy, Occupational Therapy and Speech and

Language Therapy to make sure that they are meeting Sam's needs. The family are awaiting information from genetic testing for Sam.

INDIVIDUAL FAMILY SERVICE PLAN

PRIORITY AREA	GOAL	SUMMARY OF STRATEGIES TO HELP
WALKING	• That Sam will be able to independently walk the length of his hallway with supervision. • That Sam has a mobility aid that enables him to walk during family outings.	• Sam is on the waiting list for a DMO lycra garment to help provide core stability. • Sam will be reviewed by the orthotist to ensure that he has the optimum orthotic combination to provide stability at his foot/ ankle (stable base) without impacting his mobility (crawling, ability to pull to stand etc). • Sam has recently received a Rifton Pacer Gait Trainer which has been set up as a rollator frame. This, less supportive walking aid will help Sam to develop his muscle strength/ balance reactions when walking. • Sam should continue to practice pulling to standing; cruising (walking along walls and furniture) side to side and around corners; and stepping between supports.
COMMUNICATION	• That Sam has a communication strategy that enables him to communicate his needs to others and be understood by people within and outside the family.	• Sam is currently using a range of communication strategies including: ✓ 'Say it, sign it and show it' using single words and (grammatically correct) short sentences to name things in his everyday environment; using Lámh signs to support his understanding of key words; and using objects to consolidate his understanding of key words. ✓ Objects of reference will continue to be used to show Sam what is going to happen next and to enable him to ask for some things. ✓ BIGMack will be used with tactile support to engage with structured activities at preschool.

PLAY AND SOCIAL INTERACTION	• That Sam will reduce the frequency with which he 'mouths/chews' objects/ toys. • That Sam will be able to join in with a simple game with his brother, Tom.	<u>Sensory</u> • Sarah discussed the need to give Sam opportunities (ideally every 20 minutes) for oral sensory input in a safe way. This can include sensory stimulating foods (iced drinks/ smoothies, sour foods), chewy tubes, vibration around mouth/ jaw. Maggie and John to keep a diary of how often they give Sam sensory input during the day and what sensory input they give him so that Sarah can gather further information. • Sam will continue to work on the activities in the 'Preparation for Pre-School' pack developed by Carol, in particular: ➢ Take out toys that interest both boys and put the others away. Let them spend time playing next to each other. When doing so comment on what each boy is doing, "Oh! That's a really tall tower Tom" or "look how fast the spinning top is going Sam". ➢ Continue to practice turn taking with adults, for example when eating porridge in the morning. ➢ Continue to explore toys, like the microphone, that interest/ motivate Sam and Tom. When you identify toys encourage them to take turns set up a 'turn taking moment' giving Sam a turn and then Tom. Name the turn "Sam's turn" now "Toms turn" and keep them simple and short acknowledging good turn taking. ➢ When the boys play well and achieve something together, give them high fives and then encourage Tom to give Sam a high five (Tom could place his hand against Sam's).
SELF CARE SKILLS	That Sam will be able to hold and drink from a cup.	Sam will continue to develop his shoulder strength through: ➢ Crawling ➢ Reaching up high (above shoulder level) ➢ Playing with his hands at shoulder level (sensory play on a vertical surface)

		Sam will continue to develop his hand dexterity through: ➢ Play doh: squeezing, pinching, pulling, finding toys ➢ Play with textures: rice, pasta, jelly water putting his hands in and feeling the textures as well as practicing scooping and pouring using different kitchen utensils (spoons, empty yoghurt cartons). For the textures that Sam doesn't like, put the items (like jelly) in a bag that he can squeeze and squish. ➢ Squeezing water out of a wet sponge (a big one with two hands or smaller ones with one hand or between fingers) ➢ Ripping paper ➢ Picking up small objects/ food (blueberries, cheerios) ➢ Using tools to play- stick to play a xylophone or bang a drum (Sam will need hand over hand assistance to start with)

DATE OF NEXT MEETING:

- The IFSP will be reviewed formally in February 2024.

August 2023

Mary Browne

On Behalf of the Early Intervention Team

Sam Jones DOB: 2017 IFSP August 2023

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Appendix 4: S.M.A.R.T. Goal Setting

When writing S.M.A.R.T. goals use concrete language, but relevant information. Goals are designed to help families succeed, so try to be positive when answering the questions.

Initial Goal	Write the goal you have in mind:
SPECIFIC	What does the family want to accomplish? Who needs to be included in this? When does the family want to do this? Why is this a goal for them?
MEASURABLE	How can the family measure progress and know if they have successfully met the goal?
ACHIEVABLE	Does the family currently have the skills required to achieve the goal? If not, how do they obtain these? What is their motivation for this goal? Is the amount of effort required on par with what the goal will achieve?
RELEVANT	Why is the family setting this goal now? Is it in line with the overall priorities for the family?
TIME-BOUND	What is the deadline? Is it realistic?

What does the initial goal now look like?

Appendix 5: Family, Fun, Function

(Rosenbaum and Gorter 2022)

- **Function:** refers to what people do – how things are done is not what is important; synonyms include 'role,' 'job,' 'task,' etc. (for children, 'play' is their 'work')
- **Family:** represents the essential 'environment' of all children
- **Fitness:** refers to how children stay physically active, including exercise and other recreational opportunities
- **Fun:** includes activities children are involved in or enjoy participating in
- **Friends:** refers to the friendships established with peers; social development is an essential aspect of personhood
- **Future:** is what child development is all about; it refers to caregivers' and children's expectations and dreams for their future

An F-words foundation course can be accessed at the link below:

F-Words (CanChild)

This course is designed to help learners:

- Identify and describe the F-words for Child Development
- Share what families and health care providers think about the F-words
- Understand how to use the F-words Tools
- Apply the F-words in visioning and goal-setting activities

When completing the IFSP there is an option to consider the use of the F-words tool available here:

LINK **F-words Tools (CanChild)**

Further information on this can be found at:

LINK **F-Words in Childhood Disability (CanChild)**

This is a tool that would be especially useful when supporting young people with identifying what is important for them.

Appendix 6: CPIPS Assessment

Children's Disability Network Team

CPIPS ASSESSMENT GMFCS Levels I-III

PERSONAL DETAILS

Name		**Date of Birth**	
Diagnosis If cerebral palsy include dominant type and pattern of distribution		**GMFCS Level**	
Date of Most Recent CPIPS Ax Recommendations: Every 6/12 to age 6 Every year to age 16		**Date of Assessment**	
Date of Most Recent Hip X-Ray Recommendations: L I-II at age 2, 6 and 16 L III-V every year to age 8, every two years to 16		**Date of Most Recent Physical Disability Pathway Assessment of Function**	

ASSESSMENT

	Right	Left	Right	Left
HIP - supine				
Thomas Test/Hip flexion deformity **GMFCS I- III any FFD**				
Abduction: R2, slow – Bilateral knees flexed over corner of plinth **GMFCS I-III <30° 30°- 40° >40°**				
Abduction: R1, fast - Hip neutral, knee extended				
Abduction: R2, slow –Opp hip and knee flexed on plinth (unilateral) **GMFCS I-III <30° 30°- 40° >40°**				
Popliteal angle: R2, slow passive **GMFCS I-III >50° 40°- 50° <40°**				
Popliteal angle: R1, fast movement				
Pain on Hip ROM: yes/no				
KNEE- supine				
Extension (Fixed Flexion) **GMFCS I-III any FFD 180°/0°**				
Knee hyperextension				

ANKLE/FOOT-supine				
Dorsiflexion-knee flexed **GMFCS I-III <10° 10°- 20° > 20°**				
Dorsiflexion-knee extended: R2, slow **GMFCS I-III < 0° 0°- 10° >10°**				
Dorsiflexion knee extended: R1, fast				
Leg Length mm				
HIP - prone				
Duncan Ely: R2, slow **GMFCS I-III <100° 100°- 120° >120°**				
Duncan Ely: R1, fast				
Hip Extension **GMFCS I-III < 10° >10°**				
Internal rotation - Hip extended **GMFCS I-III <30° 30°- 40° >40°**				
External rotation - Hip extended **GMFCS I-III <30° 30°- 40° >40°**				
HINDFOOT - weight bearing Valgus/norm/varus				
MIDFOOT BREAK - weight bearing Yes/No				
SPINE- Observations				
	Yes	No		
Scoliosis sitting				
Scoliosis standing				
Thoracic kyphosis excessive				
Lumbar lordosis excessive				
Functional Mobility Scale				
5 metres				
50 metres				
500 metres				

Red: Value requires referral to orthopaedics for further assessment

Amber: Value should prompt a review of the child's management strategy

Green: Normal, or almost normal, value

Traffic Lights Apply to Slow Passive Movements Only

Priorities for Follow Up	

Therapist Name		**Therapist Signature**	
Therapists Role		**Date Report Completed**	

CPIPS ASSESSMENT GMFCS Levels IV-V

PERSONAL DETAILS

Name		**Date of Birth**	
Diagnosis If cerebral palsy include dominant type and pattern of distribution		**GMFCS Level**	
Date of Most Recent CPIPS Ax <u>Recommendations:</u> Every 6/12 to age 6 Every year to age 16		**Date of Assessment**	
Date of Most Recent Hip X-Ray <u>Recommendations:</u> L I-II at age 2, 6 and 16 L III-V every year to age 8, every two years to 16		**Date of Most Recent Physical Disability Pathway Assessment of Function**	

ASSESSMENT

	Right	**Left**	**Right**	**Left**
HIP - supine				
Thomas Test/Hip flexion deformity **GMFCS LIV-V <-10° -10-0° >0°**				
Abduction: R2, slow – Bilateral knees flexed over corner of plinth **GMFCS IV-VI <20° 20°- 30° >30°** **Abduction: R1, fast** - Knee extended				
Abduction: R2, slow				

–Opp hip and knee flexed on plinth (unilateral) **GMFCS IV-V <20° 20°- 30° >30°**				
Hip Abduction: R1, Fast - Knee extended				
Hip adduction contracture				
Abduction -Both hip and knees flexed to 90° (optional)				
Internal Rotation -Hip in 90° flexion **GMFCS L IV-V: <30° 30°-40° >40°**				
External Rotation - Hip in 90° **flexion** **GMFCS L IV-V: <30° 30°-40° >40°**				
Popliteal angle: R2, slow passive **GMFCS L IV-V: >60° 40°-60° <40°**				
Popliteal angle: R1, fast movement				
Pain on Hip ROM: Yes/ No				
KNEE- supine				
Extension (Fixed Flexion Deformity) **GMFCS IV-V: >10°FFD 1-10°FFD 180°/0°**				
Knee hyperextension				
ANKLE/FOOT-supine				
Dorsiflexion-knee flexed **GMFCS IV-V: <0° 0°- 10° >10°**				
Dorsiflexion-knee extended: R2, slow **GMFCS IV-V: <-10° -10°- 0° >0°**				
Dorsiflexion knee extended: R1, fast				

Leg Length cm				
HIP - prone				
Duncan Ely: R2, slow **GMFCS IV-V: <90° 90°-110° >110°**				
Duncan Ely: R1, fast				
Hip Extension **GMFCS IV-V: <-10° -10°-0° >0°**				
SPINE- Observations				
	Yes	No		
Scoliosis in sitting				
Thoracic kyphosis excessive				
Lumbar lordosis excessive				
Functional Mobility Scale				
5 metres				
50 metres				
500 metres				

Red: Value requires referral to orthopaedics for further assessment

Amber: Value should prompt a review of the child's management strategy

Green: Normal, or almost normal, value

Traffic Lights Apply to Slow Passive Movements Only

Priorities for Follow Up	

Therapist Name		**Therapist Signature**	
Therapists Role		**Date Report Completed**	

Appendix 7: Commonly Seen Conditions

Under the National Access Policy service provision is needs based rather than diagnosis led. It is helpful to be aware of some of the diagnoses that you may encounter while always being clear that the needs and priorities of the child and family define the therapeutic supports.

CDNTs work with children with a range of physical and medical complex presentations. Some of the common conditions that may be encountered are listed below.

Condition	Recommended Resources
Autism Spectrum Disorder	→ Starting-the-Autism-Journey.pdf (asiam.ie) → Autism Spectrum Disorder | CanChild → Autism Spectrum Disorder - Physiopedia (physio-pedia.com) → Physiotherapy for Autism Spectrum Disorder Children With Motor Control Disabilities - Physiopedia (physio-pedia.com)
Intellectual Disability	→ Developmental Disabilities in Early and Middle Childhood - Physiopedia (physio-pedia.com)
Cerebral Palsy	→ Cerebral Palsy Introduction - Physiopedia (physio-pedia.com) → Cerebral Palsy | CanChild → Developmental condition – Cerebral Palsy – IAACD (International Alliance of Academies of Childhood Disability)
Chromosomal Abnormalities	→ Down Syndrome (Trisomy 21) - Physiopedia (physio-pedia.com)
Neuromuscular and Genetic Disorders	→ Congenital and Acquired Neuromuscular and Genetic Disorders - Physiopedia (physio-pedia.com)

Appendix 8: Additional Resources

CAIPE is the leading organisation in the UK for Interprofessional Education and Collaborative Practice (IPECP). This website has valuable resources in relation to Interprofessional working.

LINK **Resources – CAIPE**

Eurlyaid has this document on competencies for professionals on Early Childhood teams. It leans very heavily on a FCP lens in relation to service delivery. It talks about the relational, participatory, and technical skills/ professional knowledge required.

LINK **Competency Framework for Early Childhood Intervention Practitioners**