



The International Association for Physical Therapists working with Older People

Newsletter 18

Website www.iptop.wcpt.org

January 2011

This newsletter is to update everyone on the association. It is sent direct to special interest groups as they become known. The idea for an association began in 1993 at an international course in Malta; was discussed at WCPT Washington in 1995 and at WCPT Yokohama in 1999 where a shadow committee and steering group were formed. The Foundation Meeting was held in Birmingham, UK, 2002. At WCPT Barcelona 2003, IPTOP was accepted as a WCPT subgroup. General meetings have been held in Barcelona 2003; Dublin 2004, Melbourne 2005, Istanbul 2006, WCPT Vancouver 2007 and Ankara 2009. Membership currently stands at 17 countries representing around 8,000 physical therapists in elderly care. The efforts of the association are directed towards member associations and their individual members working with older people through excellence, research, practice and clinical specialization. Officers traveling to international conferences are self-funded. This newsletter is published on our website six months after distribution to members. A summary is published in WCPT news.

Editorial

Dear Colleagues,

2011 will be a crucial one worldwide, especially for our members as we have the AGM in Amsterdam in June (P11) with the opportunity to influence the direction of IPTOP for the next 4 years; for our patients and their carers as the world economic situation will inevitably affect the most vulnerable; and for our managers and politicians as they grapple with getting best value from limited resources.

This latter situation is one that physiotherapists are well placed to contribute to---we all know that timely intervention is cost effective. What we are not so good at is proving it scientifically and promoting it politically. WCPT Amsterdam will be a good opportunity to keep up-to-date with the latest international research and share with each other how managers and politicians can be best influenced. Supporting each other is also a key objective of IPTOP and there will be several social functions to enjoy. For those unable to attend Amsterdam, we will provide a comprehensive report in the next Newsletter.

To ensure that our Chair is recognised as representing our 17 member countries at various events, Olwen is coordinating a ribbon to which each member can contribute their country badge . (Contact olwen.finlay@btinternet.com as soon as possible for information on how to contribute your national badge)

Yours sincerely,
Amanda Squires FCSP, PhD, MSc
IPTOP Editor, editor@iptop.wcpt.org

Contents

Page

Editorial	1
Main Feature--- Physiotherapy and the management of medications	2
Political feature--- Expert Committee on Geriatrics --Switzerland	7
World Roundup---Ireland, UK, Europe	8
<u>General information</u>	
--- IPTOP web site	9
---Research	10
---- Secretary's report	10
---- Treasurer's report	10
<u>Conferences</u>	
---WCPT 2011 Amsterdam	11
---Toronto Charter	12
---IPTOP conferences	13
CPD	14
IPTOP Objectives	15
IPTOP communication sheet	16



Main feature

Physiotherapy and the management of medications

Bhanu Ramaswamy MCSP, Independent Physiotherapy Consultant and Visiting Fellow at Sheffield Hallam University, UK. IPTOP UK and European representative. b.ramaswamy@shu.ac.uk

Introduction

Whilst physiotherapy intervention primarily addresses the physical components of a reported problem, there are other aspects of the person's lifestyle that influence the rehabilitation process. In addition to the condition related assessment, a physiotherapy assessment always includes questioning about past medical history, current medication and facets of social life to gain a fuller picture about the person. Knowledge of these can influence, whether directly or indirectly, management of the problem(s) the person presents with.

In this feature, I am going to discuss some clinical implications of Non-medical Prescribing (NMP) – a tool becoming more available to the profession. In the United Kingdom (UK), examples are emerging of how such practice can enhance both the clinical skills and the professional autonomy of the prescribing physiotherapist, as well as benefits to the services offered by such prescribers. I have presented examples of prescribing practice from personal experience, as well as a Case Study summarising the multi-faceted nature of NMP practice.

Background to Non-medical Prescribing

Since the late 1980's, the UK Department of Health (DH) have published policy papers proposing a more consistent approach to healthcare that make full use of the skills and experience of all healthcare professionals. The drive away from solely medically-led services allowed the extension of practice roles in a variety of nursing and allied health professions. In 1997, the '*Review of Prescribing, Supply & Administration of Medicines*' consultation was commissioned to review how service quality and accessibility to medicines for patients could be improved. The resulting report provided a policy framework that presented opportunities for non-medical professions to manage medicines as part of their clinical role where appropriate. Initially, (NMP) was undertaken by the nursing profession, and following a change to policy regulations in 2005 physiotherapists, chiropodists/podiatrists, radiographers and optometrists were also provided with a directive to qualify and register as NMPs.

Safeguarding of prescribing practice for physiotherapists is managed through legal 'Supplementary' prescribing regulations. This means that before any prescribing (assessing for, writing or changing existing drug prescriptions) can be done, a Clinical Management Plan has to be written. The document compares the medical history with medications prescribed, and must be agreed between a doctor and the person whose case you are to oversee. Although a long-winded approach, the process ensures that the NMP works within the clinical competence of the prescriber for that specific patient, and that the conditions being prescribed for fall within the clinician's area of expertise (1, 2). There is also a requirement to demonstrate on-going competence post-qualification with a suggested framework to follow (1, 3).

Acceptance of NMP in the health service across the UK

There has been a paradigm shift towards acceptance of health-assessment consultation by any appropriately trained professional over the past decade; doctors and patients are becoming increasingly used to seeking and taking advice from physiotherapists especially in the clinical specialities of women's health, neurology, respiratory and in musculoskeletal clinics.

By recording the medications people are prescribed during the initial assessment, physiotherapists have always had a basic knowledge of pharmacology. The ability to prescribe is a natural progression of this ability where it can be an adjunct to physiotherapy management. In its current form, the process of NMP assessment, the subsequent writing of the patient-specific plan, waiting for the doctor's signature and patient approval, has been recorded by physiotherapy prescribers as restrictive of practice, especially where the swift management of pain is an issue (4). Once the Clinical Management Plan is written and agreed however, the patient can be provided with quicker access to medicines utilising the skills of a trained physiotherapist, as well as the review of the effect of the prescribed medicines. In many instances, the therapist does not have to do the actual prescribing. Knowledge of the effects of medicines permits them to have direct conversations with a

doctor or nurse who can write the patient's prescription. Examples of this are seen in respiratory clinics where physiotherapists can discuss the type of bronchodilator or steroid that will best suit the patient's ability and temperament, or in chronic pain clinics, where physiotherapists regularly prescribe and alter analgesia in agreement with the multi-disciplinary team as pain resolves, requiring weaning off medications prescribed during the more acute pain phase.

Evidence of staff and patient satisfaction with NMP in both published work (5, 6) and in evaluation reports (7) have acknowledged the ability of non-medics to deal with minor ailments and medication issues in a timely manner. Given that they have more contact time with patients than the doctors, and nurses based in General Practice have been described as being more communicative during a consultation, made the patient feel more at ease and were able to provide more information than the practice doctors (6). To the managers who commission services that can be led by a non-medical professional safely and appropriately, NMP provides a calculable cost benefit by employing a nurse or therapist for such previously solely medical tasks.

A reflection on development of NMP practice

I qualified with a Post-graduate Certificate in NMP in 2006. As with any new skill, the first few months of prescribing practice produced a sharp learning curve whilst establishing basic patterns of prescribing e.g. the time medicine doses are better taken; which medications should not be discontinued abruptly; and which drugs interact adversely with others. Medical and pharmacy staff are usually amenable to answer questions and open to discussing cases to help develop clinical reasoning. This period clarified areas out with my physiotherapy remit to prescribe, as I feel strongly that NMP should not replace any of my physiotherapy skills, but be used to enhance the impact. An example of how my prescribing practice developed during the initial six month period (as competence and confidence improved) is recorded in Table 1 below. Prescribing here is from an audit / evaluation of practice on a rehabilitation ward where the people admitted were medically well, but as yet unfit to return home safely. At this time I was the ward's Consultant Physiotherapist, with medical cover provided by a visiting General Practitioner (7).

Over time, I dealt with increasing numbers of queries related to medication. The weekly interdisciplinary meeting discussion resulted in about 30% of the weeks work as it was during this meeting that different professional opinions were made about the condition of individual patients. For example, many of the analgesic and antibiotic reviews occurred after this point, and if a patient was reported to be improving or deteriorating, drugs were altered or added accordingly.

Table 1: An example of a week of prescribing practice when first qualified: June 2006 compared with six-months post qualification

	Item / description	June 2006	Dec 2006
*	Clinical Management Plan for new patients	3	5
*	Prescribe and review analgesia	0	5
	Bladder washout	2	0
	Creams, body washes and dressings	3	9
	Dietary supplements	1	2
	Laxative	1	1
	Drugs for ear, nose and throat e.g. cough, nasal spray	0	3
	Eye drops	0	1
*	Decisions re use of antibiotics e.g. when clinically ill, but laboratory investigation unresponsive of infection	0	4
*	Stop anti-coagulant when patient sufficiently mobile	0	1
*	Transcript of tablets to take home with copy to patient's doctor	0	3
	Correct card/alter (add drug time, sign, change drug time, stop date)	1	10
*	Rewrite treatment card when new one was required	4	3
	Sign a drug transcribed by the nurse during my absence	1	1
	Total prescribing interventions	16	48

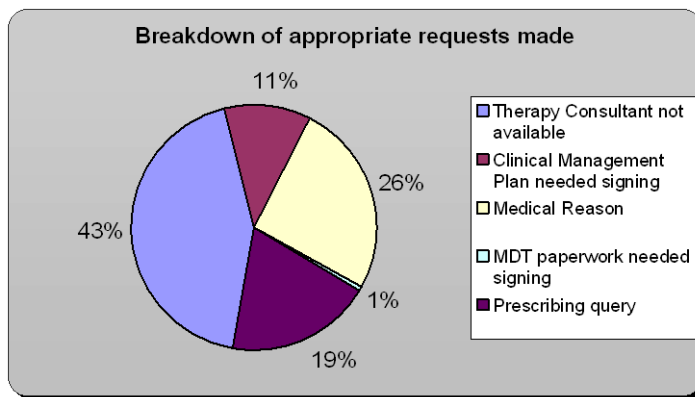
* = Self initiated, all others requested

As mentioned earlier, NMP is used as an adjunct to physiotherapy. The table above illustrates that the medication group I gained most confidence dealing with was analgesics, but I also developed practice in prescribing simple medications that

eased a person's discomfort (e.g. antibiotic use, cough syrups, ear and eye drops). I became more adept at correcting errors on cards transferred from another prescriber, making the process of dispensing a drug safer for the nursing staff. Not only did these practices save time for the doctor who could then deal with more serious medical issues, but lessening the individual's discomfort made them more amenable to participate in rehabilitation.

There was also a notable decrease in the use of medical staff by the ward. By December 2006, I was able to perform 40% of tasks previously asked of the doctor. Figure 1 below highlights the reasons medical staff were asked to see some of the patients. Bearing in mind that the majority of admitted patients were not clinically unwell but admitted for rehabilitation, it was inappropriate to call a doctor to the ward just because the prescriber was away for the day, yet this was the largest reason the medical staff were called to the ward (43%). By training staff to recognise the difference between an emergency, and also by my making sure I pre-empted reasons they might have been called, by the end of 2008, I was able to deal with nearly 70% of tasks related to prescribing. This allowed the managers to cut the number of visits the doctor provided from a five day, to a three times a week service – a large financial and time saving.

Figure 1. Reason requests were made by staff for review by the ward prescriber



As with any physiotherapy skill, it is essential that a practitioner understands their limits of knowledge and competence. A classic example of where I had need of medical expertise is given as follows. A patient was admitted for rehabilitation following a fall at home, possibly secondary to a urine infection. This person now presented with a resultant decrease in confidence to move and had gradually become immobile at home and unable to cope – quite a normal set of issues for a therapist to deal with. With regards to the prescribing element however, a beta-blocker that had been previously prescribed did not have sufficient dose strength to treat the angina noted in the medical history, and it was unclear if the dose was decreased because this was an elderly individual requiring less medication, or if the drug was actually prescribed for prophylaxis against arrhythmias from a long-standing anti-depressant the patient was also taking. There may also have been an element of postural drop from this anti-hypertensive causing the fall (the patient's blood pressure was low on admission). This example demonstrates my knowledge of what each individual medication could treat, yet insufficient understanding of the medication-dose-combination pattern of prescribing which I then discussed with a doctor to gain an understanding of *their* clinical reasoning in prescribing.

A Case Study example of the multi-faceted elements of prescribing practice

Mrs C was a 76-year-old woman admitted to the local Acute Hospital having fallen at home subsequent to a dizzy bout, and diagnosed with a urinary tract infection. She transferred to a rehabilitation bed for ongoing assessment and rehabilitation due to subsequent immobility from hip pain (no damage on X-ray) and loss of confidence.

As anticipated, Mrs C's mobility improved with combined management of analgesic review, interdisciplinary assessment of her needs, and commencement of rehabilitation to regain independence. After a couple of days however, Mrs C reported mild shortness of breath on exertion and gradual onset tenderness into both calves within a week of admission; bilateral lower limb oedema was also noted. Mrs C had a previous history of deep vein thrombosis (DVT) and subsequent pulmonary embolism (PE). At initial investigation she did not demonstrate classical clinical signs. A medical review was requested and a differential diagnosis of congestive cardiac failure was given following additional cardiac and respiratory examination.

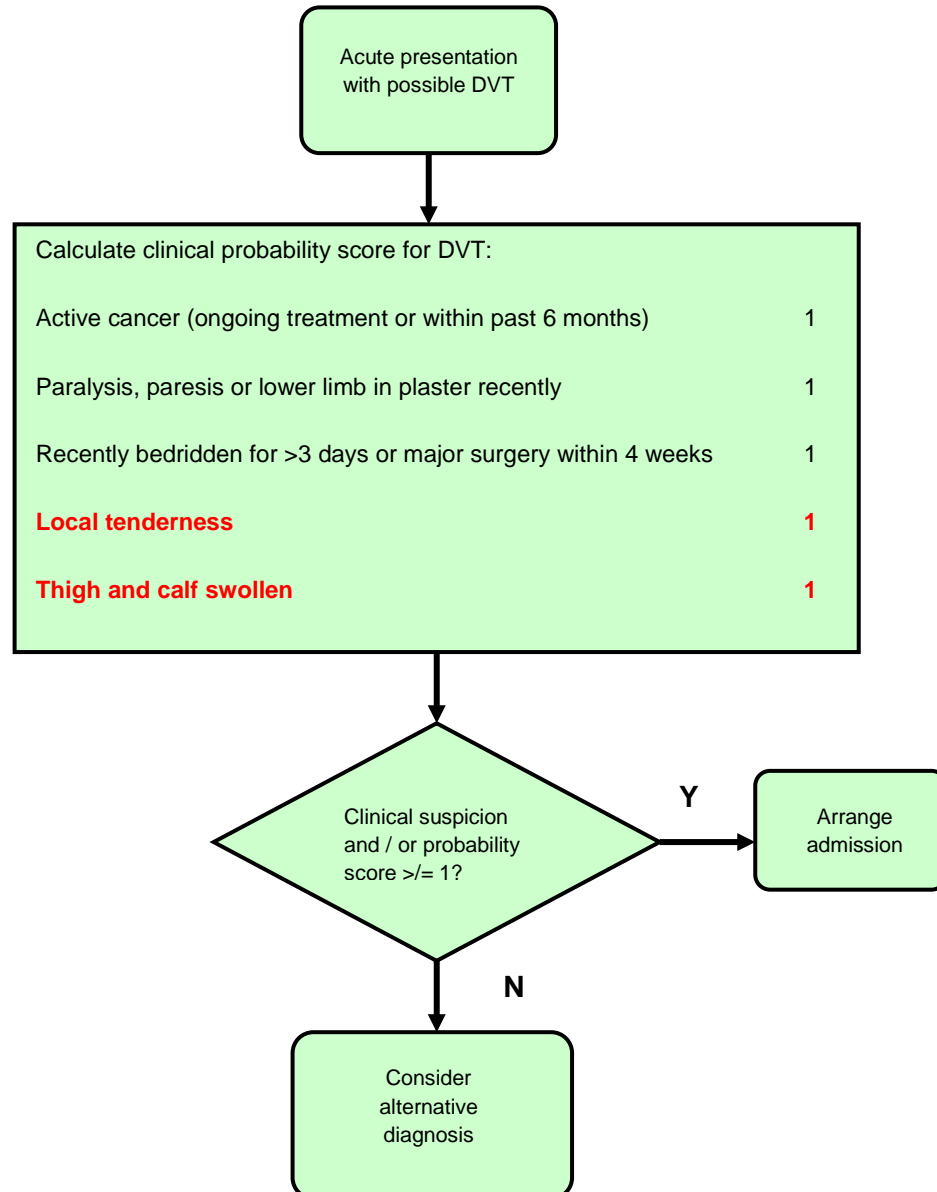
Diuretics were commenced and leg girths measured and her condition monitored closely. Three days later, the left leg had notably increased in local tenderness and raised temperature, and now demonstrated a positive Homan's sign. Following a telephone discussion of the developing scenario with the On-call medical cover, Mrs C was treated as having clinical signs of a DVT and commenced on the appropriate anticoagulant; a venous Doppler test performed at a later date did reveal a left femoral vein DVT.

Interpretation of Case management:

When she first complained of a problem, Mrs C’s risk factors included some of these aspects, but her initial presentation did not fit a classical presentation of DVT, plus she did not score high enough initially on the Algorithm provided by the hospital (Figure 2) aiding diagnosis of Venous Thromboembolism (VTE) to warrant initial treatment. According to these guidelines, the two suggested actions when suspecting a DVT are admission (Mrs C was already an in-patient) plus consideration of an alternative diagnosis – which occurred.

Mrs C’s symptoms persisted, raising further suspicion about the probable diagnosis. Discourse with Mrs C about her perception of the similarity in feeling of lower limb tenderness as when she previously had a DVT was taken into account throughout the process, but as the initial presentation was not typical of a DVT, her concerns were discussed along with the possible cardiac condition and she agreed to the treatment of the oedema in the first instance.

Figure 2: Algorithm to aid diagnosis of VTE.



The diagnostic and management process summarised in the Case Study demonstrated the available resources and interpretations that informed clinical decision-making. Although the assessment process and requested investigations were discussed in collaboration with medical and pharmacy staff, the issue about physiotherapy NMP here is that the subsequent management was initiated on the rehabilitation ward under my care and minimised delay in treatment. There was no transfer to a medical ward at another hospital, and no disruption to therapy intervention during this period and even with the new diagnosis of a DVT, Mrs C's discharge occurred well within the length of stay remit for the rehabilitation service. In addition to this, as the physiotherapist, I was able to monitor the different pain sensations (and improvements) affecting weight bearing, such as a stiffened and bruised post-fall hip as compared to the DVT tenderness and tautness. In addition to analgesia through medication, I had hands on skills of mobilisation, massage and exercise to draw on and even electrotherapy or acupuncture style modalities should I choose.

In summary:

I am biased, and cannot recommend the practice of NMP highly enough. My experience of prescribing has been quite different as a therapist compared to nursing colleagues, as medications management is not a core element of our undergraduate education. But:

1. NMP can provide the therapist with an empowering model of rehabilitation, with ongoing interactions between patient and staff – it allows a different reaction to the standard response previous to my advanced clinical training to medical queries of: *'I will ask the doctor'*. There is more open discussion with staff around the problems presented and agreed actions between staff patients.
2. It can assist by informing clinical diagnoses that expedite appropriate intervention. Ward staff and patients remark favourably on the rehabilitation journey – I interpret this to include the timelier remediation of potentially critical incidences.
3. It can save money – examples here were the decrease in medical staff input; NMP was a factor shown to (statistically) significantly decrease in length of stay on the rehabilitation ward; also, a review of medications pre-and post-discharge over the period of a year demonstrated a decrease in the medications prescribed people admitted to the rehabilitation ward, thus saving the pharmacology budget both in the short and long-term.

And finally, in 2009, the Department of Health published a scoping project reviewing prescribing and medicines supply mechanisms by the Allied Health Professions (4). They recommended that physiotherapists and podiatrists might be acceptable to progress from Supplementary to Independent Prescribing status. The Chartered Society of Physiotherapy is leading the campaign to progress this work and have called for evidence of the value of NMP to the public and the profession – I look forward to a positive outcome, and seek information from other countries that have a similar system. For those countries where NMP has not been considered, I urge therapists to take up this challenge.

References:

1. Crown J (1999). *A Review of Prescribing, Supply and Administrations of Medicines*. London, HMSO
2. Department of Health (2005). *Supplementary Prescribing by nurses, pharmacists, chiropodist / podiatrists, physiotherapists and radiographers within the NHS in England: A guide for Implementation*. London, HMSO
3. Granby T, Picton C (2004). *Maintaining competency in prescribing. An outline framework to help Allied Health Profession prescribing*. National Prescribing Centre, London
4. Department of Health (2009). *Allied health professions prescribing and medicines supply mechanisms scoping project report*. London, HMSO
5. Laurant M, Reeves D, Hermens R, et al (2004). Substitution of doctors by nurses in primary care; *Cochrane Database of Systematic Reviews*, Issue 4.
6. Redsell S, Jackson C, Stokes T et al (2007). Patient expectations of 'first-contact care' consultations with nurse and general practitioners in primary care. *Quality in Primary Care*; 15; 5–10
7. Ramaswamy B (2007 – 2010). Various annual reports on Non-Medical Prescribing and of the Service Evaluation of the Therapy Led Beds. Derbyshire County PCT, Derbyshire.

Political feature

Expert Committee on Geriatrics ---Switzerland

Catherine De Capitani, Switzerland@iptop.wcpt.org

In Switzerland the education system has been undergoing major changes, in part due to the Bologna Declaration of 1999. These changes have permanently affected the physical therapy education system. The earlier, practice-oriented physical therapy education (Diploma from a college of higher vocational education and training) has given way to a new, academic title - Bachelor of applied science (BSc) -from one of the four newly formed universities of applied sciences.

This development has led to a two-tiered educational background for practicing physiotherapists. As the last diplomas will be issued in 2010, these differences will still be felt for decades. To date, only a few cantons make a financial distinction between the different titles.

It is important for the Swiss Physiotherapy Association to assure that professional development opportunities continue to exist for those with a large clinical experience and less academic background. Working together with the Federal Office for Professional Education and Technology OPET, physiotherapists fulfilling set requirements can obtain a degree of equivalency in the new system. A BSc is the minimum requirement for acceptance into a Master of Applied Studies (MAS) or Master of Applied Science (MASc) program in the universities of applied sciences.

Further, the Education Committee of the Swiss Physiotherapy Association has called to life six Expert Committees in the following areas:

- Musculoskeletal
- Neuromuscular
- Internal organs and vessels (including cardiac and pulmonary topics)
- General practice
- Paediatrics
- Geriatrics

The main goals of the expert committees are

- Promoting continuing education and aiding career planning
- Defining the criteria for obtaining the title of "clinical specialist" in the specific field of practice (theoretical, clinical and practical experience)
- Promoting the development of evidence-based practice - applying relevant scientific evidence in everyday physiotherapy and initiating research necessary for the successful treatment in the specific field.
- Building and maintaining a national and international network of significant experts in the field
- Advising members with questions relating to the specific field
- Developing pamphlets pertaining to the specific field
- Supporting members in their work with specific services

The expert committees are facing new challenges:

Continuing education

At present, extremely varied and unregulated continuing education courses are being provided by individuals, education centres, special interest groups, hospitals and regional associations. Any quality management certification has been left up to the individual providers. Existing courses need to be evaluated and categorized in order to assure physiotherapist competency, qualified continued education and patient security. The Education Committee plans to define criteria for course providers wishing to be recognized as qualifying for educating clinical specialists.

Special interest groups and expert commissions

In addition to the six expert commissions, Switzerland has approximately twenty individual special interest groups, some of which are part of a larger international group, others operate independently. Although many active physiotherapists participate in these special interest groups, the groups are not an integral part of the Swiss Physiotherapy Association. This division can lead to conflicts of interest and double burdens. On the other hand, the special interest groups are an important source of very competent, committed people. Their networks have been built up over many years. The promotion of cooperation between the special interest groups and expert commissions could aid both parties.

The new kid on the block - geriatrics!

We are very proud and pleased that a new Expert Commission on Geriatrics has recently been formed. For us this represents an increasing interest in the work with older people, and respect for the work our association has been doing. We look forward to the possibility of becoming clinical specialists and hope this will lead to growing numbers of physiotherapists dedicated to working with older people.

Our special interest group now faces a new challenge - finding people to join the committee.

For further information on specialization: www.physio-europe.org>Education Issues>Specialization

World Roundup

***Ireland---* Chartered Physiotherapists in Neurology and Gerontology (CPNG). 190members.**

Siobhan Twomey Ireland@iptop.wcpt.org

CPNG is a clinical interest group representing physiotherapists who have an interest in neurology and/or gerontology. The role is to support continuing professional development in these areas through evening lectures, workshops, courses, research and education bursaries as well as the provision of a discussion forum and access to physiotherapists with expertise in the areas of neurology or gerontology.

CPNG had our annual planning day in November to organise courses and evening lectures for the coming year.

The recently established sub-group of the CPNG, for those with a specialist interest in vestibular rehabilitation, is currently planning a training course with an aim to develop this service for all patients' country wide.

Two members of the CPNG attended the APPDE AGM in October and are currently working with the group developing standardised European Parkinson's Disease Guidelines.

In response to the Irish National Stroke Audit a planning group with representatives from *OTs, SLTs, PTs, dieticians, Orthoptists* and *Podiatrists* was established to address the needs identified. The group has developed a training program which will run country wide in the coming months. The emphasis of the training is on developing stronger working relationships amongst health professionals involved with stroke care, to enhance the skills and knowledge of health professionals to work with clients post stroke and to enhance the integration of stroke services

Please email cpng@iscp.ie for details of upcoming meetings and our AGM

UK--- AGILE (Chartered physiotherapists working with older people) 614 members.

Ms Bhanu Ramaswamy b.ramaswamy@shu.ac.uk and Chair, Janet Thomas.

AGILE is a clinical interest group of the Chartered Society of Physiotherapy. As a representative body of physiotherapists, the group aims to assist members in delivering the highest possible practice with older people by:

- Promoting high standards through education, research and efficient service delivery
- Providing a supportive environment, facilitating the exchange of ideas and information
- Encouraging and co-coordinating relevant activities regionally and nationally

AGILE have held a very successful conference in Cardiff on 'Gait: Putting our best foot forward'.

An electronic survey was emailed to all members – the feedback from this has shaped AGILE position statements and work for the next year.

We are preparing to send the latest evidence based exercise supplement out on Amputee rehabilitation

We are preparing for a series of study days in 2011 by Bob Laventure, our President, on 'Motivate Me' – looking at how to engage the older person in Physical activity and exercise.

Our 2011 conference will be held in Belfast in October with a focus on Exercise and the Older Person.

Contact gail.mcmillan@belfasttrust.hscni.net for more information.

Europe---Ms Bhanu Ramaswamy, European representative. b.ramaswamy@shu.ac.uk

I continue to assist the Executive Committee in developing IPTOP's presence at WCPT Amsterdam this summer. Some of the information you can read in this Newsletter, and other aspects, will be available when you come to visit the IPTOP stand in Amsterdam in June.

With regards the project work I undertook to gauge which clinical interest groups have standards of practice specific to older people, I thank the Finnish group for their response, and hope to hear from those countries that have not responded at / by the time we meet at WCPT.

General Information

IPTOP web page

We now have our own web page within the WCPT website. It can be accessed direct through <http://www.iptop.wcpt.org> or via the WCPT website www.wcpt.org. Each officer (e.g. chair@iptop.wcpt.org) and each member organization representative (e.g. germany@iptop.wcpt.org) has an IPTOP address with mail automatically redirected to personal e-mails. These are all listed on the front page of the site. Our web page has 5 sections: contact details; about IPTOP (our leaflet); Newsletters---current and past; Meeting notes; and Conferences. Please encourage members to visit the IPTOP *and* WCPT websites.

Officers and member organization representatives are advised to install a Spam Catcher to block unwanted use of our IPTOP e-mail addresses.

IPTOP research (please send your comments on this item to Jennifer Bottomley vicechair@iptop.wcpt.org)

BEYOND GOOGLE, BEYOND WIKIPEDIA...

Jennifer M. Bottomley

When you're researching a topic online, it's easy to turn to Wikipedia or Google, do a quick search, and find a response. But have you thought about where the information that's posted on Wikipedia and Google actually comes from? When it comes to medical information, you want to make sure the material you use comes from a reliable, trustworthy source. Wikipedia may seem like a virtual version of the encyclopaedias that sit on library shelves, but did you realize that anyone can post information to the site? There is very little accountability on Wikipedia. Anyone from the guy down the street who has never opened a medical textbook in his life to the pharmaceutical sales rep who wants to show his product in a favourable light can add information to Wikipedia or edit what is already there. If you do a Google search, how do you know that the sites that come up on the first one or two pages are reliable? They are just ranked by popularity – how many people have visited the sites. Some of your search results may have even paid to get to the top of the list!

There are, however, some trustworthy places you can go to find up-to-date, accurate information.

If you're looking for medical articles **PubMed** – www.ncbi.nlm.gov/pubmed is the place to start. The PubMed database houses more than 19 million citations for biomedical articles. Just type in a few key words and you can find the latest published research on any topic.

If you are looking for comprehensive information on health and safety topics, the **Centres for Disease Control and Prevention** – www.cdc.gov provides a wealth of credible reliable information on diseases and conditions, international statistics, emergencies and disasters, global health trends, and so much more.

eMedicine – www.emedicine.com is a medical reference filled with evidence-based content, updated regularly by more than 8,000 physician or healthcare provider authors and editors.

No matter where you go online for the latest medical information, make sure the sites you visit are reputable and accurate.

Secretary's report (please send your comments on this item to Jill McClintock secretary@iptop.wcpt.org)

We are currently planning the IPTOP AGM to be held in Amsterdam on Wednesday 22nd June 2011 at 16.00-18.00 hrs in room G108 in the conference centre. There are a number of key issues that member countries should be considering---please note various actions and deadlines which have already been set to country reps:

- The agenda for the AGM meeting will be circulated no later than 1st May 2011. Suggested topics to Jill in advance
- One agenda item will be WCPT being the "the keeper" of IPTOP monies as it does with other sub groups.
- We are hoping to accommodate three representatives from each member country at this meeting with only **one** of the representatives having voting rights to represent the decision of the country. The numbers of those attending and the name of the attendee who will vote need to be forwarded to me no later than 30th April 2011.
- To have voting rights at this meeting the membership fees of the country must be fully paid up to date.
- Nomination Forms signed by the chair of the parent Association were due to be returned to me no later than 31st December 2010.

Treasurer's Report (please send your comments on this item to Nancy Prickett aspennp@voicenet.com)

I wish to thank all the member countries who have paid their IPTOP dues. The following countries have not responded to my emails regarding dues owed.

Bulgaria Germany Ireland Malta New Zealand Australia

I am asking some one from each of the listed countries to please contact me urgently at aspennp@voicenet.com

Conference ---contributions to editor@iptop.wcpt.org

IPTOP Conferences linked to Member Organization Conferences (offers please to

Filiz chair@iptop.wcpt.org). To date we have had excellent joint conferences with Irish, Australian and Turkish member associations) (see below “IPTOP conferences – links to Member Organization Conferences”). We are looking for a joint conference for 2012.

2011 WCPT Amsterdam (June 20-23) <http://www.wcpt.org/congress/>

Registration for WCPT Amsterdam commenced in September 2010. After registering you can access accommodation, the most economical and convenient being taken up very quickly---so advice is to register early. Some IPTOP members have already booked into Novotel---details are on the WCPT website. The website will also have various conference details including locations for our meetings, and on booking in at the Conference you will receive the full hard copy programme to plan you educational and social activities. It's a big document, so advice is to book in at the desk early.

Amsterdam IPTOP Update Jennifer Bottomley, IPTOP Vice Chair vicechair@iptop.wcpt.org

Preconference Course:

IPTOP will be a part of the preconference course on **Monday June 20, 2011**. Dr. Carole B. Lewis is presenting “Move It! Evidence Based Evaluation and Treatment for Back and Knee Pain in Older Persons” - an orthopaedic-based programme in geriatrics. We will have two specific time slots – one over lunch and the second at the end of the day. Over the lunch break, a member of the executive board will present IPTOP’s purpose, mission and goals. This will be followed by a round table discussion on active aging amongst course participants. We are in the process of developing *talking points* for these discussions and will look forward to any suggestions you may have. Bhanu Ramaswamy will access the Toronto Charter (see summary below---reprinted from last newsletter) through her involvement in the National Coalition of Active Ageing. This should provide some questions which will direct the basis of our round table discussions. At the end of the day, IPTOP will summarize the findings from the sessions. Book in via WCPT congress website.

Opening Ceremony and Reception

WCPT’s opening ceremony is scheduled for **Monday June 20, 2011** from **18:30 – 20:00**, with a reception following from **20:00 – 22:00**. This is an amazing event and very well worth attending.

Scientific Programme

Go to <http://www.wcpt.org> for review of the wealth of scientific program beginning on **Tuesday June 21, 2011 to Thursday June 23, 2011**. Focused symposia, discussion panels, platform abstracts, and poster presentations.

Satellite Program Education Sessions

Geriatric-based education is plentiful. Details are available at <http://www.wcpt.org> which is a great place to plan your days. There are so many incredible programs to choose from between **Monday June 20, 2011** and **Friday June 24, 2011**.

Networking Session

An IPTOP networking session has been scheduled on **Tuesday June 21, 2011** from **15:30-17:30**. The location is at the Amsterdam RAI Convention Centre. Check the WCPT conference programme for specific room location

Subgroups’ Chairs/Presidents Meeting (access to Chairs/Presidents only)

WCPT has established a chair, Laetitia Dekker Bakker, to head the meeting of subgroup chairs and presidents. This meeting has been scheduled for **Wednesday June 22, 2011** from **13:45-15:45**.

General IPTOP Business Meeting

IPTOP’s general meeting is on **Wednesday June 22, 2011** from **16:00-18:00** in room G108 in the conference centre.

Joint Subgroup Reception – Social Night A reception is being planned for the subgroups and will occur at the Novotel Hotel. Check the WCPT conference programme for specific time and room location.

An IPTOP social event is to be arranged for the evening of **21st June 2011** Olwen Finley has been working with the Dutch Charter to determine location and venue. Details of the venue and cost will be on our stand.

Social “Party Night” for WCPT attendees is scheduled for **Wednesday June 22, 2011** from **20:00 to Midnight**. Check the WCPT conference programme for specific location.

Shared Exhibition Space

WCPT will provide more detail regarding the incorporation of WCPT regions and subgroups into a shared exhibition booth. Check the WCPT website for details

---manning the stand--- IPTOP reps will be required to man our stand for a short time each day. Amanda will coordinate the timetable in Amsterdam once we have all seen the overall programme and identified our interests.

---member country leaflets--- any member country wishing to contribute leaflets to the stand should do so on day 1. These must be of good quality and in English. About 300 is adequate and not too heavy to carry.

---pop up banners--- A pair of pop up banners are also being produced for our stand, one will contain a brief text about IPTOP and one will have 2 or 3 pictures linked to the theme of active aging around the world. We received a number of photographs and members were asked to vote on them, the results were:

- No 7---man running up a hill---10 votes
- 2nd No 10---4 Turkish ladies round computer ---7 votes
- 3rd No 5---couple jumping on the sand---4 votes

We are now in discussion with the banner manufacturer and if the quality of the successful photographs is not adequate for large reproduction we will select/create a similar alternative.

Closing Ceremony and Awards

WCPT's closing ceremony is scheduled for **Thursday June 23, 2011** from **16:00 – 17:30**.

The Toronto Charter for Physical Activity: A Global Call for Action

The *Toronto Charter for Physical Activity: A Global Call for Action* was launched on Saturday 8 May 2010 at the 3rd International Congress for Physical Activity and Health in Toronto Canada.

The Toronto Charter is a call to all countries to help make physical activity a priority for all. The Charter provides a framework for action and partnerships across multiple sectors and with communities to build healthier, active, environmentally sustainable communities. It is a result of two years of international drafting and large scale global consultation. The global consultation received responses from over 400 individuals and organisations from 55 countries and provided over 1700 comments and suggestions.

The Toronto Charter was ratified by delegates at the 3rd International Congress for Physical Activity and Health with overwhelming support for its call to all countries to seek greater political commitment, resources and community action to support health enhancing physical activity for all. The Charter itself is an advocacy tool, designed for use with decision makers and to build partnerships towards achieving political commitment and resources with the aim of increasing participation in health-enhancing physical activity throughout the world.

There is then a request for support either from individuals or organisations with the address of the website to sign up to www.globalpa.org.uk

The six page Charter can be found as a pdf at:

http://www.cflri.ca/icpaph/en/documents/CharterDocument_ENG_May20_2010.pdf

This Charter for Physical Activity will form the basis of the lunchtime Older People education session being supported by IPTOP at the World Confederation for Physical Therapy (WCPT) Congress on June 2011 (See P 11 of this newsletter for more information)

IPTOP conferences – linked to Member Organisation Conferences

IPTOP as an International organisation of Physical Therapists working with Older People encourages collaboration between its member organisations. Member organisations come from each of the World Confederation of Physical Therapists Regions and represent member organisations at differing stages of development when working with older people. The constitution requires a four yearly meeting to be held in conjunction with the WCPT congress.

To facilitate business progress and ensure members organisations in all regions have an opportunity to cost effectively participate in the organisation, IPTOP seeks invitations from member organisations willing to collaborate with IPTOP to include a meeting within their programme so members can attend a local annual conference and an IPTOP meeting.

The Purpose of this briefing: To provide guidance to member Organisations interested in adding an international dimension to their congress by holding it in collaboration with IPTOP.

Collaboration means: Some IPTOP involvement in the programme planning; Time for an IPTOP delegate meeting; IPTOP assistance in promotion.

Organisation: The organisation, funding and profit from the national conference remain that of the organising country. However, IPTOP may be able to provide help with organisation and will negotiate in advance a pro rata share of any profit.

Benefits to Host Organisation; increased participation---international delegates attend on same basis and for the same fee as national delegates; international profile; possibility of increased national profile; opportunity for local members to expand international contacts. Members of the host country get a unique opportunity to hear international speakers / papers

Benefits to IPTOP: Expand awareness of, and increase participation in, IPTOP; facilitates progress of business; helps to build the financial resources of IPTOP; IPTOP members may be international experts. National members also have the unique opportunity to meet and share professional knowledge both formally and informally with international colleagues.

Financial issues: negotiate a pro rata organisation fee to IPTOP e.g. % of the delegate fee (or perhaps the international delegate fee); seek sources of funding to assist delegates from organisations that would not otherwise be represented. Any financial help that the national organisers can obtain to enable IPTOP members from organisations, which normally could not afford to sponsor a delegate within its region to attend the conference, would be much appreciated, and equitable allocation would be managed by IPTOP.

Contact Filiz Can chair@iptop.wcpt.org for more information.

International continuing professional development for physical therapists working with older people.

Collaboration between WCPT and the United Nations Institute on Ageing has resulted in a two week residential course curriculum with the following aims, objectives and themes:

- Aims:** 1. **To improve the healthcare of older persons by developing relevant PT attitudes, knowledge and skills**
2. To develop PT skills to influence policy both locally and nationally

- Objectives**
1. To increase awareness of and sensitivity to the process of ageing and its implications
 2. To adopt realistic and professional attitudes
 3. To highlight the need for
 - a. a comprehensive approach to the care of older persons
 - b. a multidisciplinary approach
 - c. community oriented health services
 4. To promote the value of physical therapy services for older persons.

Themes: Demography and epidemiology
Ageing---biological, psychological, social,
Health services, health promotion, illness prevention, community and government support
Physiotherapy specific including legal and ethical issues
Leadership, communication, negotiation, education and training skills.

The course is presented as formal lectures and facilitated learning followed by small group work. It is not a clinical practice course. Participants are encouraged to share their own areas of expertise formally and informally. Each course ends with each participant presenting their action plan for a work based project which is followed up by the tutors. Two courses have been held (1993 for physiotherapists, 1997 for physiotherapists and occupational therapists) both hosted by Malta. All students found it beneficial, especially to be with colleagues from the same specialty for an extended period. Students stated "*it was enriching, inspiring and confidence building*".

Further courses for can be arranged by IPTOP. Requesting countries should consider the following:

1. The programme is delivered in the country/region requesting it.
2. Allow 2 years set up time from IPTOP agreement to proceed. Consider pre/post WCPT/IPTOP conference.
3. **Presentations will be by an international core tutor group with local academic and physiotherapy specialist tutors**
4. Educational credits may be pursued locally by the requesting country/region
5. A local "clerk to the course" is required to liaise with the IPTOP course organiser
6. **Advertising is the responsibility of the requesting country**
7. Consider joining with another relevant profession (e.g. OT) to increase numbers, expertise and impact
8. The language is English in which participants must be fluent in both understanding and speaking (a comprehensive interpretation service to be included in costs might be considered)
9. A steering group (IPTOP course leader, course clerk and representative of joining profession if relevant) agree a course plan with dates, tasks and responsibilities; adapt the course length to meet local needs *although the full course is internationally recommended*; revise the curriculum; select tutors; manage the course.
10. A telephone conference call with core tutors and steering group will be needed at the early planning stage
11. Steering group will meet with core tutors preferably AT the facility 3 months prior to the event to finalise programme and participants.
12. The minimum 20/maximum 30 participants are chosen on level of experience, international (work/leisure experience, active participation, ability to cascade knowledge, ability to influence policy makers and/or teach other physical therapists, and geographical coverage.
13. The programme should include professional and cultural visits and opening/closing by a "high level" figure
14. Accommodation should have individual study bedrooms, restaurant, main conference room with full a/v facilities and 6 break out rooms (number dependent on course size), photocopy facilities, recreation facilities.
15. All costs (e.g. **bullets**) **are bon** by the requesting country. Costs to participants should cover their accommodation and all meals plus apportioned full conference overheads (i.e. administration, tutor travel/accommodation/meals etc).
16. Grants and bursaries may be sought by the requesting country/region from e.g. professional bodies, government departments, and charities.
17. The requesting country may wish to consider a feedback presentation at next WCPT/IPTOP conference.

Further information from IPTOP editor, Amanda Squires editor@iptop.wcpt.org

Summary of IPTOP objectives as at September 2010

Priority	Objective	Lead	Detail	Timescale	Progress updates
1	WCPT Link	Filiz	To continue links with WCPT	Ongoing	Teleconference Nov 09
2	Sponsorship	Jennifer	List potential sponsors. Act as liaison for these bodies regarding advertising	September 07	No progress to date
3	Website management	Amanda	New IPTOP officer to be appointed to keep all IPTOP information up to date on the website	Post to be included in 2011 elections	Job description completed
4	New member Organisations	Filiz	To encourage representation from all the WCPT regions. To encourage the setting up of new member countries.	Ongoing	No report received to date.
5	Promotion of IPTOP and the services it provides	Filiz	Upwards to WCPT, outward to member bodies and new members to promote the Newsletter & CPD opportunities	Ongoing	Work in progress
6	Other International disciplines	Jennie & Leah	To establish liaison with similar international bodies in nursing, OT and medicine	Ongoing	No report received to date.
7	EBP/Specialisation	Bhanu	To collate examples of Standards of Practice in member countries for PT with Older people	On hold due to insufficient response	Started Summer 2009. Interim short statement collated summer 2010, but still awaiting responses from several member countries
8	Carers & Elders	Filiz	Establish contact with International organisations representing Elders and Carers. UN has Standards so ensure IPTOP principles conform	Ongoing	No report received to date.
9	Annual Reports	Filiz & Jill	Timely production of the IPTOP annual report	Ongoing	Confirmation required that 2007/2008/2009 Reports have been sent to WCPT. Four yearly report needed prior to Amsterdam 2011
10	Annual Conferences	Feliz	To confirm IPTOP involvement in a member country conference for 2012.	Ongoing	Greece had to withdraw from hosting 2010 due to economic pressures.
11	WCPT Amsterdam 2011	Filiz	Planning all aspects of this conference	Ongoing	Started in Ankara 2009. Teleconferences with WCPT have taken place
12	Subgroup reconfirmation every four years	Filiz & Jill	Send to Brenda Myers	Before WCPT 2011	Due January 2011

The full version together with timescales and quarterly progress is available from secretary@iptop.wcpt.org

2010 communication sheet

Correct at December 2010. Please contact the secretary regarding any changes/problems.

Chair Filiz Can E-mail: chair@iptop.wcpt.org	WCPT Rep Filiz Can E-mail: chair@iptop.wcpt.org
Vice Chair Jennifer Bottomley E-mail: vicechair@iptop.wcpt.org	Europe Bhanu Ramaswamy Email: b.ramaswamy@shu.ac.uk
Secretary Jill Mc Clintock, E-mail secretary@iptop.wcpt.org	S W Pacific Shylie Mackintosh, Email: swpacific@iptop.wcpt.org
Treasurer Nancy Prickett E-mail: aspennp@voicemail.com	N America and Carribean Jennifer Bottomley E-mail : namericaandcarribean@iptop.wcpt.org
Newsletter Editor Amanda Squires , E-mail: editor@iptop.wcpt.org	South America No member in this region Africa No member in this region

National representatives (correct at December 2010)

Australia---Primary contact Shylie Mackintosh Email: Australia@iptop.wcpt.org	Netherlands ---Primary contact Judith Weyman Email: Netherlands@iptop.wcpt.org
Bulgaria---Primary contact Ludmila Venova Email: Bulgaria@iptop.wcpt.org	New Zealand ---Primary contact Ann Newsom Email: NewZealand@iptop.wcpt.org
Canada ---Primary contact Leah Weinberg E-mail: Canada@iptop.wcpt.org	Norway---Primary contact Huy Tien Dang E-mail: Norway@iprop.wcpt.org
Finland---Primary contact Karin Stahl Email: Finland@iptop.wcpt.org	Switzerland---Primary contact Catherine De Capitani Email: Switzerland@iptop.wcpt.org
Germany---Primary contact Christiane Roehling Email: Germany@iptop.wcpt.org	Sweden---Primary contact Gun-Britt Jarnlo Email: Sweden@iptop.wcpt.org
Greece---Primary contact Christos Kommissopoulos Email: Greece@iptop.wcpt.org	Turkey---Primary contact Nuray Kirdi Email: Turkey@iptop.wcpt.org
Iceland-- Primary contact Asalbjorg Iris Oskorsdottir Email: Iceland@iptop.wcpt.org	United Kingdom-- Primary contact: Bhanu Ramaswamy Email: b.ramaswamy@shu.ac.uk
Ireland-- Primary contact Siobhan Twomey Email: Ireland@iptop.wcpt.org	USA---Primary contact Jennifer Bottomley E-mail: @iptop.wcpt.org
Malta---Primary contact Maria Fenech Email: Malta@iptop.wcpt.org	

Editor---Professor Amanda Squires (UK) editor@iptop.wcpt.org

Next edition details Copy date for the next edition is **31 July 2011**. The editorial board retains editorial rights. Length for a “feature” article is 1,000 words. We welcome world news (200 words) from member countries, conference information and contributions from the Committee as relevant. Contributions should be in English language and WORD format with references in Harvard Style, any websites hyperlinked in and sent by e: mail to the editor

We are in the process of developing an advertisement protocol and rate. In the meantime suggestions from members of potential advertisers would be welcome to Jennifer Bottomley vicechair@iptop.wcpt.org