National Protocol for Physiotherapy Practices

Ministry of Social and Family Development

Ministry of Health

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1. INTRODUCTION

"Physiotherapy is a primary care, autonomous, client-focused health profession dedicated to providing services that develop, maintain and restore clients' maximum movement and functional ability. Physiotherapists can help people at any stage of life, when movement and function are threatened by ageing, injury, diseases, disorders, conditions or environmental factors.

Physiotherapists help people maximize their quality of life, looking at physical, psychological, emotional and social wellbeing. They work in the health spheres of promotion, prevention, treatment/intervention, and rehabilitation.

Physiotherapists are qualified and professionally required to:

- Undertake a comprehensive examination/assessment of the patient/client or needs of a client group
- Evaluate the findings from the examination/assessment to make clinical judgments regarding patients/clients
- Formulate a diagnosis, prognosis and plan
- Provide consultation within their expertise and determine when patients/clients need to be referred to another healthcare professional
- Implement a physiotherapist intervention/treatment programme
- Determine the outcomes of any interventions/treatments
- Make recommendations for self-management" (https://world.physio/resources/what-is-physiotherapy, n.d)

Physiotherapy services are provided by licensed physiotherapists. Assessments, evaluations, and interventions unless performed by a physiotherapist, are not physiotherapy and should not be represented or funded by public insurance or any social protection schemes. Protection of title and the clarity of professional activities are essential for the protection of the public.

2. SCOPE OF PRACTICE OF PHYSIOTHERAPIST TREATING CHILDREN

Paediatric physiotherapy is a dynamic and rewarding field that plays a crucial role in supporting the health and development of children from infancy to adolescence (Sudhir & Sharath, 2023). These Physiotherapists assess, identify, diagnose, and treat disorders of movement and physiological issues of children in the areas of orthopedics, congenital malformations, neurology, neuropsychiatry, cardiopulmonary and prematurity, including developmental delay and neuromotor issues (Harniess & Nikopoulou-Smyrni, 2015). In addition, they are involved in providing specialised interventions such as sensory integration, recommending adaptive equipment, providing behavioural and psychological support, managing chronic conditions and pain management, school-based therapy and interdisciplinary collaboration with other members of the multidisciplinary team (Sudhir & Sharath, 2023). Although the scope generally involves direct patient care, paediatric physiotherapy also embraces strategies that go beyond to include health promotion, wellness, fitness, prevention and education as well as advocacy and research (Rowland et al. 2015; Schlessman et al. 2011).

While paediatric physiotherapists use many of the generic skills of physiotherapy, they possess specialised knowledge and training related to child development and childhood conditions through higher education or acquired via hands-on practice and continued professional development (Burslem et al. 2016; Paediatric Physiotherapy, 2021).

3. INFRASTRUCTURE

Health Service facilities should be registered as per the requirements of the Maldives Health Service Act 29/2025 and the guidelines published as per the act. The healthcare facility should also be compliant with the Maldives Healthcare Quality Standards (MHQS) published by the Ministry of Health (2018). The theme “Structure” specifies the infrastructure criteria and standards required for the health facilities to abide by according to MHQS, the following is a list of standards as per the document

- Standard 1.1 The Health facility has adequate space as per prevalent norm and case-load of the facility
- Standard 1.2 The Health facility has adequate infrastructure for the offered services

- Standard 1.3 Layout out of the health facility is conducive for undertaking Intended Processes
- Standard 1.4 The Health facility provides adequate amenities for Patients and Staff.
- Standard 1.5 Infrastructure at the Health facility is safe and maintained well.

Although a therapeutic setup to provide rehabilitation services should be compliant with additional guidelines published by the Ministry of Health, Republic of Maldives, such a guideline is yet to be published. Therefore, a minimum infrastructure requirement for a paediatric facility is suggested below:

Minimum infrastructure requirement

- Universal accessible health facility
- Reception, waiting area and washroom with accessibility for PWDs
- Ancillary area for storage of records, equipment / toys, consumables, stationary etc. including pantry and restroom for staff.
- Minimum one treatment chamber of 10ft x 7ft with couch, and electric fitting of required load.
- Exercise area with space enough for parallel bars, gait training and mat exercises and a treatment cabin and wash basin (Guidelines for physiotherapy center design, 2022).

4. COMPETENCY FOR PHYSIOTHERAPIST/CLINICS

Licensed rehabilitation professionals should follow the Maldives Healthcare Professionals Act (Law 13/2015) and abide by the guidelines published by the regulatory bodies.

A Practicing Physiotherapist should meet the following:

- Minimum educational qualification as per the most recent “List of Allied Health Professional titles” registered by the Maldives Allied Health Council (2024).
- Be registered to practice as a Physiotherapist at Maldives Allied Health Council and have a valid license.

Clinic Management:

Registered clinics should be compliant with the guidelines set by the Ministry of Health to operate therapeutic services in Maldives. However, no specific guideline for physiotherapy services has been established yet.

- Supervising Physiotherapist at the clinic should have a bachelor's degree in physiotherapy AND a minimum of 4 years of relevant clinical experience (Senior Physiotherapist as per the job matrix published by the National Pay Commission of Maldives, 2022) to be able to oversee the physiotherapy services and other physiotherapists working at the clinic.
- Desirable to have a master's degree holder in the relevant specialty to supervise the specialty services.

5. ENTRY POINT / REFERRALS

- Self / parental referral
- School teachers / health nurse
- Medical practitioners
- Allied health professionals

6. ASSESSMENTS

Consent

- Informed consent should be obtained from the parent or legal guardian prior to the assessment and intervention.
- Follow Health Service Act 29/2015, section 29 & 30 for further information.

History (Working with Children-Guidance on Good Practice; Guidance for Paediatric Physiotherapy, 2016)

- **Personal Information (**name, age, gender, education/schooling, hobbies and interests, behavioral history)

- **Medical History** (review the child's prenatal, perinatal, and postnatal history, including any significant illnesses, hospitalization, surgeries and ongoing medical issues and current concerns)
- **Developmental History** (assess milestones, including motor, cognitive, language, and social development)
- **Family and social history** (gather information on the child's home environment, support systems, and any social and familial factors that may impact their care)

Assessment components (Working with Children-Guidance on Good Practice; Guidance for Paediatric Physiotherapy, 2016; Package of intervention for Rehabilitation)

- **Observation** (general observation of the child's posture, movements, and interaction with the environment)
- **Physical examination**
    - **Assessment of pain**
    - **Assessment of respiratory function**
    - **Motor functions and mobility**
        - **Assessment of joint mobility**
        - **Assessment of muscle function**
        - **Assessment of muscle tone functions**
        - **Assessment of movement functions**
        - **Assessment of gait pattern and walking**
        - **Assessment of mobility**
        - **Assessment of hand and arm use**
    - **Assessment of exercise capacity**
    - **Assessment of activities of daily living (ADL)**
    - **Assessment for secondary complications**
        - **Screening for osteoporosis**
        - **Education**

- **Assessment of school environment/workplace environment**
- **Assessment of participation in community and social life**
- **Standardized outcome measure**
    - Use validated tools such as Peabody Development Motor Scales (PDMS-2), Gross Motor Function Measure (GMFM), Pediatric Evaluation of Disability Inventory (PEDI) or Modified Ashworth Scale (MAS)
    - Physiotherapists must ensure that the outcome measures are applied promptly and effectively, allowing for accurate evaluation of any changes in the child's health status.
    - Refer to Pediatric Outcome Measure Database by The Association of Paediatric Chartered Physiotherapists (2024) to facilitate this process.

Goal Setting

- Establishing goals is crucial for directing therapy and ensuring a family centered, evidence-based approach.
- Goal setting tools such as SMART Goals (Specific, Measurable, Achievable, Relevant, and Time-bound), GAS (Goal Attainment Scaling), and ICF (International Classification of Function) model can be utilized to set goals in collaboration with the caregivers, and multidisciplinary team.
- Regularly review the goals and use them as key outcome measures.
- Refer to Working with Children-Guidance on Good Practice by Burslem et al. (2016) for additional details.

7. PLAN OF CARE/ TREATMENT PLAN

Dosing

- To ensure that physiotherapy provides the greatest value and avoids patient and family burnout, physiotherapists must adhere to evidence-based recommendations for dosing.
- Dosing in physiotherapy includes frequency, intensity, duration, and type of intervention.
- Physiotherapist's decision for dosing will depend on the clinical assessment and the available research. Refer to Guidelines for determining frequency by Bailes et al. (2008) for further information.
- **Frequency**
    - The following table provides a guideline for determining dose and is adopted from the Guidelines for determining frequency by Bailes et al. (2008)

FREQUENCIES	FACTORS
Intensive therapy (3-11 visits per week)	For children • Who are quickly moving towards their goal • Who have immediate and complex needs • At risk for losing function due to current medical condition Frequent therapy, for a limited length of time
Weekly/Bimonthly (1-2 visits per week or every other week)	For children • Who are making continuous progress toward their goals • Who need a skilled physiotherapist for regular visits for a limited time

	● Whose exercises/activities can be safely performed by the patient or caregiver
Periodic therapy (Monthly or at regular scheduled intervals)	For children ● Who show slower progress towards their established goals ● Whose routine home program are safely carried out by the parent or caregiver ● Who need a periodic checkup with a therapist to check on their function, provide treatment and update the home exercise program
Consultative therapy (As necessary)	For children ● Who are ready for new tasks as a result of change in life stage or medical condition, and the tasks are safely carried out by the parent/caregiver. ● Who have a need for a specific adaptive equipment

- **Duration**
  - Each session can vary from 30-60 minutes.
- **Changing frequency and ending therapy**
  - **Transition from one frequency of therapy to another occurs when:**
    - Child moves from one life stage to another
    - Child moves from one functional level to another
    - Child moves from one program to another
    - Child moves from one environment to another (eg: going from hospital setup to home)

- **Discharge**
  - When expected goals have been achieved
  - When family chooses not to continue
  - When the therapy provided no longer produces functional and measurable results

Physiotherapy intervention

- Physiotherapist's intervention can be planned based on Package of intervention for Rehabilitation.
- Intervention should address all the domains of ICF (Annex, 1) (Darrah, 2008) including impairment to body structure and function, activity limitation and participation with a focus on real-life situations and personal factors
- Collaborate with family and multidisciplinary team to set clear goals and to ensure active involvement from both the child and family and guides the intervention
- Use a goal-driven approach to direct the interventions. Regularly monitor progress and adjust intervention plan as needed
- Incorporate the 'F Words' (Function, family, fitness, fun, friends, future) Framework (Annex, 2) to ensure that the intervention planning goes beyond the biomedical model and is tailored to the child's unique needs and circumstance (Rosenbaum & Gorter, 2012)

The following table may serve as a guideline for intervention planning for a child with cerebral palsy Package of intervention for Rehabilitation module 3 (Neurological conditions).

TARGET	ASSESSMENTS	INTERVENTIONS
Pain Management		
	Assessment of pain	Pain-relieving positioning
		Massage
Respiration functions		

	Assessment of respiratory functions	Airway clearance techniques
		Functional positioning
Motor functions and mobility		
	Assessment of joint mobility	Positioning for the prevention of contractures
		Provision and training in the use of orthoses
	Assessment of muscle functions	Muscle-strengthening exercises
	Assessment of muscle tone functions	
	Assessment of movement functions	Environmental enrichment
	Assessment of gait pattern and walking	Gait training
		Provision and training in the use of assistive products for mobility
	Assessment of mobility	Mobility training
		Functional positioning
		Provision and training in the use of adapted seating equipment
		Provision and training in the use of assistive products for mobility
	Assessment of hand and arm use	Constraint induced movement therapy
		Bimanual therapy
		Functional training for hand and arm use
		Provision and training in the use of

		orthoses
Exercise and fitness		
	Assessment of exercise capacity	Fitness training
Activities of daily living		
	Assessment of activities of daily living (ADL)	ADL training
		Provision and training in the use of assistive products for self-care
		Modification of the home environment
Education and vocation		
	Educational assessment	Modification of the school environment
	Vocational assessment	Modification of the workplace environment
Lifestyle modification		
		Education, advice and support for healthy lifestyle
		Education, advice and support for self-management of the health condition
Family and carer support		
	Assessment of carer and family needs	Caregiver and family training and support
Intervention for the prevention and treatment of secondary conditions related to cerebral palsy		
Osteoporosis and fractures		
	Screening for osteoporosis	Weight-bearing exercises

*Please refer to Package of intervention for Rehabilitation module 3 (Neurological conditions) for additional details.

8. DOCUMENTATION

- Physiotherapists must start the documentation at the time of the initial contact and records should be written immediately after the session or within or before the end of the day
- Physiotherapists must ensure they maintain documentation at three different encounters
    - Initial notes (All the information we gather from the initial visit (Should include date, time, attendance, SOAP notes, and collaborative goals)
    - Progress notes (Subsequent visits are recorded as progress notes (record changes that occur between sessions, review goals, and include any new information and problems)
    - Discharge notes (Includes the factors that contribute to the patient's health status at the end of treatment with the physiotherapist (Include a summary of presenting condition and treatment, Comparison of initial and final status, reason for discharge or ending treatment, and follow-up and referrals)

      (Shakshouk, El-Talawy, & Abd El-Aziem, 2019); Guidelines for writing clinical notes**)**

9. RE-ASSESSMENT/ RE-EVALUATION FOR FUNDING

Reassessment on the development of children with functional limitations under rehabilitation and documentation of the revised treatment intervention should be carried out every six months while children with gross developmental delay may need a longer interval for reassessment (Tan & Yadav 2008).

Parents/ care-giver education should be given on the disease progression and status of the patient condition as there are numerous psychosocial benefits for parents, including an increase in parental empowerment, a decrease in parental stress and the improvement of parental self-efficacy levels (Hohlfeld, Harty, & Engel, 2018). This makes the impact of the therapeutic

intervention more sustainable compared to clinician-implemented interventions (Sanders & Kirby 2012; Strauss et al. 2013).

For conditions with degeneration or deterioration (progressive conditions), correct identification of neuroregression is important. In cases where physical progress is not seen any further, intervention can then be focused on symptom management and quality of life (Holland & Brown, 2017), possibly in the context of long-term management.

For conditions with non-progressive conditions that plateau in their development despite continued treatment, home care plans can be given and discharged from physiotherapy outpatient. However, the process of therapeutic surveillance is especially important, because children with functional limitations are at risk for skill regression or lack of progress because of changes in their health or changes in their environments (Pediatrics American Physical Therapy Association, 2014).

If applying for the social funding, progress report and condition explanation need to be submitted to the relevant institutes.

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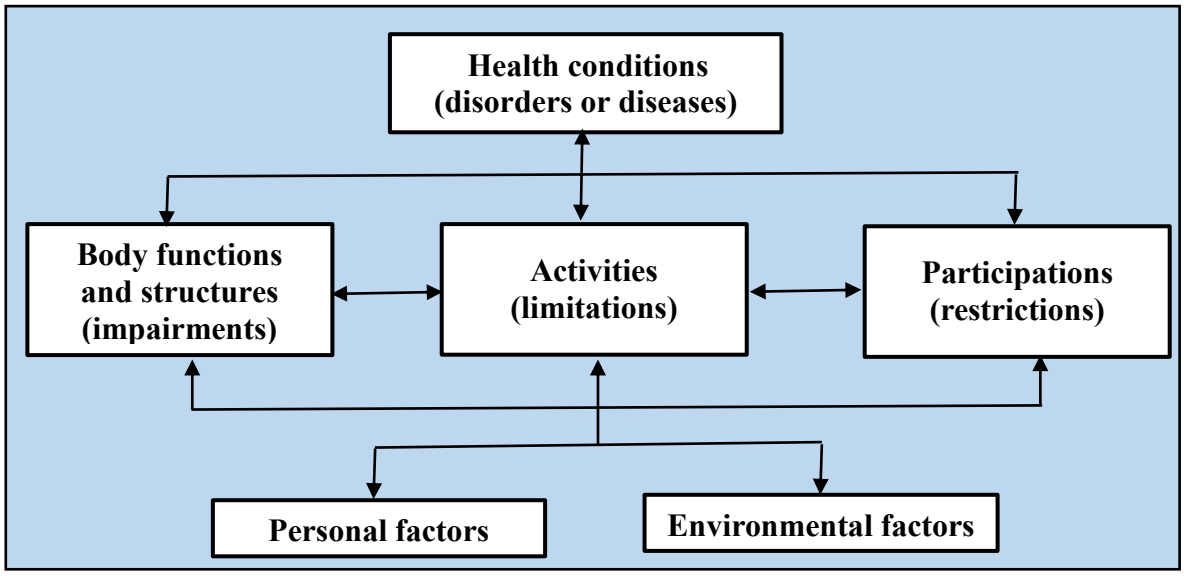
ANNEX 1

1. **International Classification of Functioning, Health and Disability (ICF) 2001**



(World Health Organization, 2001)

2. **International Classification of Functioning, Health and Disability (ICF) 2001 example**