PHYSIOTHERAPY NEW ZEALAND | MOVEMENT FOR LIFE
Kōmiri Aotearoa

THE LATEST NEWS & VIEWS FROM PHYSIOTHERAPY NEW ZEALAND
NOVEMBER 2017

PHYSIO MATTERS

Your guide to published clinical trials

Also in this issue:

- Renew your membership for 2018
- How to deal with workplace burnout
- New resource to promote reflective practice

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Editorial and Advertising

- Send editorial items to the Editor, erica.george@physiotherapy.org.nz
- Letters to the Editor are limited to 250 words and may be edited.
- Send advertisements and course information to pnz@physiotherapy.org.nz
- Advertising rates and specifications are on our website.
- Deadline for editorial and advertising booking is **no later than 20th of the month, two months before the issue is published.** If this date falls on a weekend or a holiday, please supply by the closest working day before.
- Members may read Physio Matters on our website and follow workable links.

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Booking deadlines

Issue	Booking deadline
February 2017	12 December 2016
March 2017	20 January
April 2017	19 February
May 2017	18 March
June 2017	20 April
July 2017	22 May
August 2017	20 June
September 2017	20 July
October 2017	21 August
November 2017	20 September
December 2017	20 October

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Updates from the President

LIZ BINNS

PRESIDENT
PHYSIOTHERAPY NEW ZEALAND

Please join me in welcoming Warren to his time here at PNZ, where we will be utilising his skills in 'Building a Stronger Future'

I would like to introduce you to Warren Smith. Warren has been involved with the Physiotherapy New Zealand **'Building a Stronger Future'** process from its inception, preparing background papers and communications, supporting workshops with the co-designer representatives, and subsequent distillation of outcomes for endorsement.

Members who have attended the co-design workshops will have had the opportunity to meet Warren already, but I thought everyone should know who will be guiding us though the **'Building a Stronger Future'** process until the end of this month.

Warren is a consultant for Maven Consulting Limited, with a background in business analysis, strategic planning, corporate services management, and online channel management. He has an ability to plan and conduct detailed analysis and presents findings and outcomes in visually appealing and simple, digestible forms. He has a Master of Philosophy in purchasing psychology, Master of Business Studies in management, Post-Graduate Diploma in Business and Administration, Bachelor of Commerce and Administration and a Bachelor of Science in mathematics.

In the health sector, Warren has contracted as a business analyst for ACC. He has had a supporting role in planning alignment of mental health pathways and process improvements cross the Capital & Coast, Hutt Valley and Wairarapa District Health Boards. He has also had experience in initiating health information standards.

Warren undertook current state analysis (documentation, sector agency interviews, and secondary research) and stakeholder governance establishment for the development of an Education Sector Digital Channel Strategy, supporting the delivery of the wider Education System Digital Strategy to 2020.

Over the last few years Warren has led sector collaboration, strategic plans, operating models and partnerships in shared corporate services (IT, HR, property, finance, and communications) across ten agencies in the transport sector.

At Early Childhood New Zealand, Warren led a strategic information and communications systems review and digital strategy, focusing on online delivery channels, and prioritising investment in business-enabling technologies. He has carried out similar information system analysis and strategies at a number of irrigation organisations and the New Zealand Transport Agency, involving current state analysis through interviews, surveying and document review, identifying key thematic issues and opportunities to act upon in the future state, with alignment to wider strategies and trends.

Please join me in welcoming Warren to his time here at PNZ, where we will be utilising his skills in 'Building a Stronger Future'.

Liz Binns
President

Updates from the National Office

SUE DOESBURG
PROFESSIONAL ADVISOR

By the time you read this our new CEO, Sandra Kirby, will have been in post for approximately 4 weeks. It's been a busy orientation period for her with attendance at the APA conference in Sydney and the Physiotherapy New Zealand (PNZ) Leadership Day in Auckland during October and then back to Auckland again in late October for the Business Symposium and AGM.

No doubt Sandra will have many thoughts for her first National Office column, which will be in the December issue of *Physio Matters*.

ACC Physiotherapy Contract Redesign

In the meantime, we're pleased to be able to provide an update on how PNZ is contributing to the redesign of the ACC Physiotherapy Contract. Initial discussions with ACC involved the CEO, myself and three members of the PNZ Private Practice Advisory Group (PPAG). But as you'll see from the ACC article on pages 14 and 15 of this issue, the group has grown and formalized to become the Physiotherapy Expert Reference Group (ERG).

Don't hesitate to share your thoughts, ideas and questions relating to the redesign – they are welcomed by ACC and can be sent to physiocontract@acc.co.nz

The purpose of the ERG is to provide clinical guidance on the development of proposed changes to the Physiotherapy Contract, taking in to account how the patient journey will be affected. Along with this they will consider issues of clinical safety and provide advice on managing clinical risk.

The first formal meeting of the group was on September 28 and another meeting is scheduled for this December. The quarterly meetings will be a mix of face-to-face and videoconference, with the group continuing for the duration of the Physiotherapy Contract redesign through to May 2020.

Biographies of group members are provided in the ACC article and you'll see that each member brings relevant experience and skills to the table – but as opportunities present, they will also communicate with colleagues to gain the wider views of the profession.

Don't hesitate to share your thoughts, ideas and questions relating to the redesign – they are welcomed by ACC and can be sent to physiocontract@acc.co.nz

National Office Staff

After almost two and a half years as our Marketing and Communications Manager, the time has come for Nick Taylor to move on to a new challenge. Nick's last day at National Office is November 1, and following a few days off he will begin a new role with Deer Industry New Zealand. During Nick's time at PNZ he has completed in-depth work on both our member and public website. We appreciate all he has done and wish him well for the future.

Sue Doesburg
Professional Advisor

DISTANCELEARNING

POSTGRADUATE

UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

University of Otago

Musculoskeletal and Pain Management

Pain is one of the most common reasons for people to see a health professional. It is a main feature of many health conditions, and the impact of pain on peoples lives is broad and invasive.

If you have ever wondered why pain is so complex, or how to help people manage their pain more effectively, the postgraduate papers in Pain and Pain Management available via distance learning will provide you with a good foundation for practice.

Postgraduate qualifications of interest to Physiotherapists:

The PG Certificate/Diploma/Masters in Health Sciences
endorsed in Musculoskeletal Management

The PG Certificate/Diploma/Masters in Health Sciences
endorsed in Pain and Pain Management

Some of the topics covered include:

- MSME 704 Introduction to Pain
- MSME 708 Introduction to Pain Management
- MSME 705 Regional Disorders (Spine)
- MSME 706 Regional Disorders (Limbs)
- MSME 707 Musculoskeletal Management
- MSME 711 Pain Assessment
- MSME 710 Recreational and Sports Injuries
- MSME 702 Musculoskeletal Tissues
- MSME 703 Musculoskeletal Disorders
- PAIN 701 Neurobiology of Pain (MSME 704 is a pre-requisite)
- PAIN 702 Biomedical Management of Pain
- PAIN 703 Psychosocial and Cultural aspects of Pain

Applications now being accepted for study in 2018.
Closing date 10 December 2017.

Contact the Programme Manager for further information:
Department of Orthopaedic Surgery and Musculoskeletal Medicine
University of Otago, Christchurch
Tel: +64 3 3641 086
Email: rebekah.higgs@otago.ac.nz
Web: otago.ac.nz/msm-pain-management

IASP

Our programmes are endorsed by the International Association for the Study of Pain

The clinical trials and evidence-based practice nexus

Mark Elkins and Julia Hush, members of the Australian Physiotherapy Association, provide some tips to keep in mind when searching for and reading a published clinical trial, and consider issues around translating clinical trial results into practice and ways in which you can help your patients to better understand research.

On 20 May 1747 aboard the HMS Salisbury, Royal Navy physician James Lind began what is widely considered the first randomised clinical trial. He recruited 12 men already afflicted with scurvy – at that time, a leading cause of death among long-distance sailors – and divided them into six groups of two.

'Their cases were as similar as I could have them. They all in general had putrid gums, the spots and lassitude, with weakness of their knees,' wrote Lind. He then allocated different treatments to each group: cider, sulphuric acid, vinegar, seawater, oranges and lemons, and a spicy paste mixed with barley water.

Lind reported: 'The consequence was, that the most sudden and visible good effects were perceived from the use of oranges and lemons; one of those who had taken them, being at the end of 6 days fit for duty.' Of course, it is now known that scurvy is caused by vitamin C deficiency. Clinical Trials Day is celebrated around the world each year on 20 May to recognise the importance of randomised clinical trials. To that end, there's no doubt that clinical trials have hastened the development of physiotherapy into an evidence-based profession. But how confident are you about reading and interpreting a published clinical trial and then helping your patients understand the research?

The following pages provide some guidance, and, in doing so, highlight the role of clinical trials in shaping evidence-based practice.

Your guide to published clinical trials

One important characteristic of clinical trials is that they provide estimates of the effects of interventions that are less biased than the estimates from other research designs, such as cohort studies or case studies. Trials that have a control group can estimate the effect of an intervention. Trials that compare two interventions (eg, exercise versus orthoses) can estimate the difference in effect of those interventions.

However, physiotherapists can sometimes experience difficulty understanding clinical trials and knowing how to apply a trial's results to a patient.

Finding a published clinical trial

Physiotherapists are luckier than many professionals when it comes to searching for randomised trials. This is because a database with very comprehensive coverage of randomised trials of physiotherapy interventions is available for free online. The Physiotherapy Evidence Database (PEDro; pedro.org.au) indexes over 28 000 randomised trials of physiotherapy interventions. Anyone can search the database using search terms related to features of the trial, such as the type of intervention, the symptom experienced, the affected body part, and the subdiscipline of physiotherapy. There is a useful search help section on the PEDro website that guides physiotherapists through finding relevant research on the database effectively.

Many of the trials that are indexed on PEDro now have links to free full text, with new trials added each month. Physiotherapists can easily keep up to date with new trials in their area of practice by signing up to the free 'Evidence in your inbox' service via the PEDro website.

Reading and understanding a published clinical trial

It can be helpful to read the Abstract first to get an idea of what the paper is about, but readers shouldn't stop there. There are many other details about the study that should still be considered before accepting the results and the authors' interpretation of them.

The Introduction should explain what clinical question the paper is addressing and build an argument as to why that is an important question. Specifically, the Introduction should build up the argument by considering:

- how prevalent the clinical condition is
- what problems are caused by the clinical condition
- current management of the condition
- limitations of current management
- rationale/evidence about why a new treatment might be helpful in this setting
- existing evidence that has already addressed this question

The last point might be surprising but it is important. When an individual trial provides an estimate of the effect of an intervention, that estimate is rarely a definitive answer. If a trial has estimated the effect of an intervention, it is worth replicating the trial to further refine that estimate. The efficacy of a treatment is usually only established when a meta-analysis of several trials shows a statistically significant and clinically worthwhile effect. Therefore, it is considered particularly helpful when the Introduction cites a recent systematic review because this sets the scene for what the new results may contribute.

The Methods section should provide detail to evaluate whether some sources of bias were eliminated by using design features such as concealed allocation, intention-to-treat analysis and blinding. When a clinical trial has used these features, the results are more believable. Also expect a description of the criteria used to define who was eligible to participate in the study and how they were recruited. This helps clinicians to work out whether the people studied in the trial were

similar enough to their patients for them to apply the results in their clinic.

Hopefully, the interventions delivered in the study will be described in a lot of detail. This detail is worth reading – even if the reader is familiar with the intervention – because the authors may have used it differently. Often interventions in trials are added to or compared to 'usual care', which should also be described in detail. Reporting guidelines such as TIDieR have been introduced to foster thorough descriptions of the interventions in published trials. The Methods section should also list all outcome measures, when measurements were scheduled and which outcome was the primary outcome. Hopefully, the trial will have been prospectively registered so that readers can verify for themselves that the authors did not diverge from the planned methods.

The Results section should explain whether there were any departures from the planned methods. There are sometimes unavoidable reasons to amend a trial protocol. For example, the cost of a laboratory test may increase during the trial and exceed the budgetary allowance for its use. If such amendments are unexplained, however, the reader should be concerned that the authors may be deliberately leaving unwanted results unreported. Adherence to the scheduled course of intervention sessions by the participants should also be summarised. In addition, the characteristics of the groups at baseline should be presented without any statistical comparisons and a flow diagram should display any dropouts from the trial.

Having read all that, the reader is finally in a position to judge whether the trial's results are robust and believable. With practice, this can take only a few minutes, and is an important first step to get in the habit of doing because physiotherapists need to recognise when a study design is too flawed to apply the results to their patients.

Interpreting results and translating clinical trials into practice

A crucial point that some researchers and readers still do not grasp is that the estimate of the effect of the intervention in a controlled trial is determined by the 'between-group' difference, not the 'within-group' difference. Therefore, statistically significant change within one group, together with non-significant change in the other group, does not constitute evidence of an effect. Indeed, statistical significance itself can be a distraction from some really important issues, such as whether the effect is large enough to be clinically worthwhile to patients.

Statistical significance does not ensure that the effect of the intervention is clinically worthwhile, because even trivial effects (eg, a difference in pain intensity of 0.5 on a scale from 0 to 10) can be statistically significant. Another important issue is how precise an estimate is generated by the study. Large sample sizes help to generate precise estimates. A good way to assess the precision of the estimate is with the 95 per cent confidence interval. A study's data are consistent not just with the main estimate (eg, the mean difference between groups on a pain score), but also with other values within the confidence interval, so a study with a narrow confidence interval provides a precise estimate of the effect of the intervention.

Another important issue is whether there are systematic reasons for a reader to anticipate different effects in the local clinical setting from those observed in the trial. Clinicians can ask themselves whether their patients are like the patients in the study: same disease severity? same health literacy? same baseline health status? Similarly, clinicians can ask themselves whether they are able to deliver the intervention like it was delivered in the study: same session duration? same program duration? same equipment?

It is also interesting to consider whether the estimate of the effect of the intervention (and the confidence interval around it) exceed the smallest worthwhile effect. This is the smallest effect of the intervention that would make it worth the time, effort and risk involved in undertaking the treatment. There are some complex issues involved in establishing the smallest worthwhile effect of an intervention, but clinicians can circumvent these issues to some extent.

One approach is to explain to each patient that we don't know exactly how he or she will respond to the treatment, but that research gives us an estimate of the average benefit gained from the treatment when applied to others with the same condition. In the absence of other information, we can anticipate that the patient will receive a similar benefit. This allows each patient to decide for themselves whether the anticipated effect seems worth the time, trouble and risk of the intervention – without the need to invoke a number for the smallest worthwhile effect.

Clinicians may be able to assist patients here by explaining the estimate of the effect of the intervention in terms that the patient can understand. For example, an improvement of 49 metres in six-minute walk distance might be explained to the patient as 'instead of being able to walk from here to the bus stop in six minutes, you would be able to walk from here to the post office'. The clinician can then ask, 'Would that improvement in your walking make the training worthwhile for you?'

Communicating with patients about evidence from clinical trials

The previous scenario where a physiotherapist interprets the results of research in terms that are understood by the patient is an example of a critical element of shared decision-making within the evidence-based healthcare

Figure 1. Control group risk

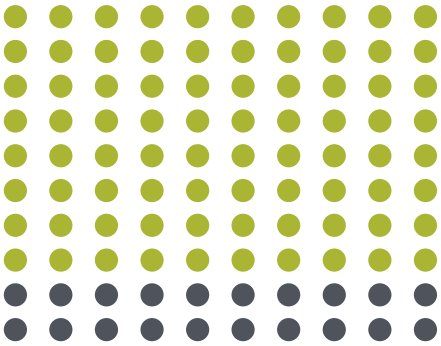
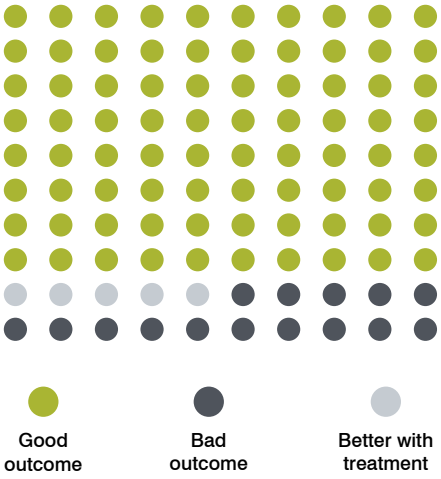


Figure 2. Treatment group risk



framework. Two key principles of successful communication with patients about research from clinical trials are that the information must be: (1) easy to understand; and (2) be patient-centred (ie, individualised to the patient).

Whether a clinician uses verbal, written or other communication formats with a given patient will depend on factors such as the patient's preference or learning style, cultural background and (health) literacy level, as well as available resources.

Often more than one method is useful. Physiotherapists most commonly use verbal communication to provide information and help patients understand treatment options based on evidence from clinical trials. However, a limitation of this method is that patients might not clearly comprehend the information or they forget what they have been told. Written materials (eg, printed information sheet) are a valuable addition to verbal information when communicating with patients and provide a resource that patients can refer to. Interestingly, research suggests that written health information should be pitched at a 5th or 6th Grade reading level, so this needs to be considered when preparing written resources for patients.

To communicate with patients about likely treatment effects, it is often helpful to present the information in terms of benefits and risks. To do this, it can be helpful to use visual tools such as graphs, charts or tables to convey information. One example that is useful when discussing an intervention's effect on the risk of an event is a pictograph (see Figures 1 and 2). Figure 1 shows the number and proportion of people who experience the outcome of interest among those untreated; and Figure 2 shows how the number and proportion are changed among those treated. The patient can visually gauge the effect of the intervention on their risk of the outcome, without having to tackle statistical terms such as relative risk and absolute risk.

Graphs and charts can also be useful to show possible treatment benefits or harms. For example, the hypothetical graph in Figure 3 shows how the typical pattern of changes in the magnitude of benefits from an intervention can be conveyed to patients visually (e.g. long-term benefits of an intervention compared with usual care over a one-year period, with most benefit obtained within the first three months).

One format for sharing decision-making with a patient about selecting a treatment is a decision aid. These tools are designed to engage patients in making decisions by providing them with information about the possible benefits and harms of an intervention, based on clinical research. They can be paper-based, on video, or computer-based. Many decision aids that are currently available have been designed for use by medical practitioners (eg, helping patients decide whether to use hormone replacement therapy). However, some of these same tools can be adapted for physiotherapy practice.

As with any other resource, the physiotherapist needs to be confident that a decision aid is high quality. Tools to assess the quality of decision aids are the CREDIBLE criteria and the International Patient Decision Aid Standards (IPDAS) tool. You can find an inventory of existing decision aids on the Ottawa Health Research Institute website: decisionaid.ohri.ca.

Figure 3. Change in function over time in each group in a hypothetical controlled trial

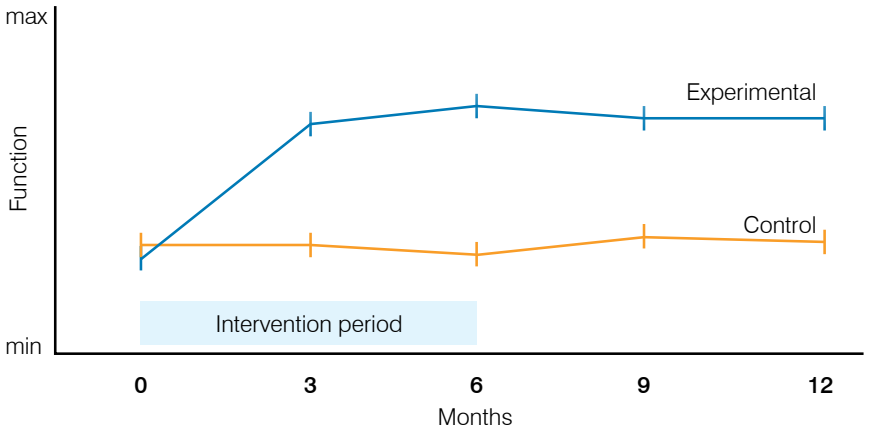


Figure 3 shows how a graph can visually present the average pattern of improvement due to the intervention. In this hypothetical trial, most of the benefit of the intervention on function is typically obtained in the first half of the six-month intervention period and the benefit is largely but not completely maintained beyond the end of the intervention period.

Finally, it is important that health professionals aim to be unbiased when presenting such information, by equally presenting both positive and negative perspectives. To assess this, it is useful for clinicians to ask themselves whether they are presenting the clinical evidence in a particularly positive or negative light. An example of framing information positively is: out of 100 people who have this treatment, 80 (80 per cent) will benefit. Information framed negatively usually focuses on potential harm, for example: out of 100 people who have this treatment, 20 (20 per cent) will not benefit or may possibly be harmed. Positive or negative framing could also occur if the physiotherapist focuses on just the relative risk without making the absolute risk apparent to the patient.

How information is framed by the therapist does have an influence on patients' decision-making, so it is a good idea to use strategies to consciously reduce potential bias. One way to do this would be to use a pictograph or bar chart illustrating benefit and harm, side by side, using the same denominator and scale.

Guiding patients towards clinical trials

Some patients don't need encouragement to engage with research; they actively search the internet for evidence about possible interventions for their clinical condition. These and other patients could be directed towards Physiotherapy Choices (physiotherapychoices.org.au), which is a database designed for use by consumers of physiotherapy services, including patients, health service managers and insurers.

The database provides a catalogue of the best research evidence of the effectiveness of physiotherapy interventions. As many published trials of physiotherapy interventions now have lay-language summaries, this is a user-friendly resource.

Mark Elkins is Clinical Associate Professor in the Faculty of Medicine at the University of Sydney, and a co-director of the Centre for Evidence-Based Physiotherapy which maintains the Physiotherapy Evidence Database. He is also the Editor of the Australian Journal of Physiotherapy.

Julia Hush is an Associate Professor in physiotherapy in the Faculty of Medicine and Health Sciences, Macquarie University, where she teaches in the postgraduate Doctor of Physiotherapy program. She is a member of the Australian Journal of Physiotherapy Editorial Board.

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Summary of key points

- Physiotherapists can search PEDro to easily identify randomised trials of interventions in their clinical area.
- The Abstract, Introduction and Methods should all be read before deciding whether the results are believable and relevant to your clinical practice.
- In a randomised controlled trial, the effect of the intervention is determined by the between-group difference.
- In addition to statistical significance, consider the precision of the estimate of the effect of the intervention by noting the confidence interval around the estimate.
- By explaining the anticipated effect of a proposed intervention to a patient in terms they can understand, physiotherapists can determine whether the intervention is likely to be considered worthwhile by that patient.
- Written and pictorial tools can help the physiotherapist to engage the patient in shared decision-making.

Inter-professional education in Wellington

The Wellington Branch of Physiotherapy New Zealand (PNZ) have recently signed a memorandum of understanding (MOU) with a local public health organisation Te-Awakairangi Health. Learning and Research Advisor Nick Clode tells *Physio Matters* about the benefits of the union.

The MOU sets out both organizations' intention to bring together GPs, physiotherapists and other Allied Health professionals to embark upon joint professional education experiences.

Historically, the Wellington Branch have offered training courses that mainly have been bespoke to physiotherapists. More recently, the Branch have attempted to sculpt a greater number of inter-disciplinary learning opportunities in recognition of the value of inter-professional learning. This has included offering professional education topics which are generic across healthcare disciplines. Courses offered have included Motivational Interviewing and Acceptance and Commitment Therapy and have been attended by occupational therapists, counsellors, nurses, and physiotherapists.

The MOU takes this work a step further by engaging GPs in professional education events. GPs are typically hard to capture as an audience and it is hoped this forum will be an opportunity for physiotherapists to showcase their expertise, knowledge and experience in front of medical professionals. It will also provide a useful networking opportunity for physiotherapists and aims to support greater collaborative care working in the region.

The idea behind inter-professional learning is the premise; learn together to work well together. Participating in inter-professional education courses allows individuals from different professional groups to get to learn more about each other and discuss how to manage common problems. With the aging population and increasing complexity of medical conditions presenting to primary care, there is an urgent need for healthcare professionals to work better together. By utilising the skills of different professional groups, patients can benefit from the 'wrap around' approach often required to manage chronic problems. This model has been shown to improve patient care but also to increase practitioner support and job satisfaction.

Andrew Imrie

Bronnie Lennox Thompson

The Wellington Branch and Te-Awakairangi ran their first collaborative learning event with GPs, physiotherapists, occupational therapists and pharmacists (amongst others) on August 9 this year. The educational component to the workshop was led by a physiotherapist (Andrew Imrie) and occupational therapist (Bronnie Lennox Thompson). The presentation covered the conservative management of persistent pain, a generic topic pertinent to most health professional groups. The workshop was well attended with 84 people turning out for the event.

Feedback about the initiative from attendees was positive. Kerry Muller, a pharmacist prescriber, had this to say about what attracted her to attend the event:

"I learn a lot from other members of the MDT, we all learn from each other … I came to learn more about the perspective of the physio and OT."

Physiotherapist Julia Johnson provided her perspective on how inter-professional networking helps improve patient care:

"It's about working with people you trust and are confident with … you trust their opinion … it helps you pick-up things you may not have."

Julia refers to increased familiarity arising with making a personal connection as being an important element in developing relationships of mutual trust.

Paul Abernathy, managing director of Te-Awakairangi Health, feels the MDT may help get GPs to see Allied Health professionals in a different light and see Allied Health as "experts" who are "performing research that has direct application to their world."

The Branch and Te-Awakairangi Health plan to run further joint workshops in 2018. It is hoped these sessions will provide opportunities for physiotherapists to network with the other professional groups in order to provide a platform for greater MDT collaboration and integrated care in the region.

The Wellington Branch would like to acknowledge the work of PNZ's outgoing former CEO Joe Asghar, for providing the catalyst for discussions between the Wellington Branch and the PHO.

The chronic pain presentations from the evening were filmed and have been made available by the Wellington Branch on the PNZ website under the resources section.

Nick Clode
Learning and Research Advisor

References available on request.

Have you checked out our new website yet?

In July, ACC launched its new look website. Although the web address remains the same (acc.co.nz), there's a lot less content, so it should be easier to navigate.

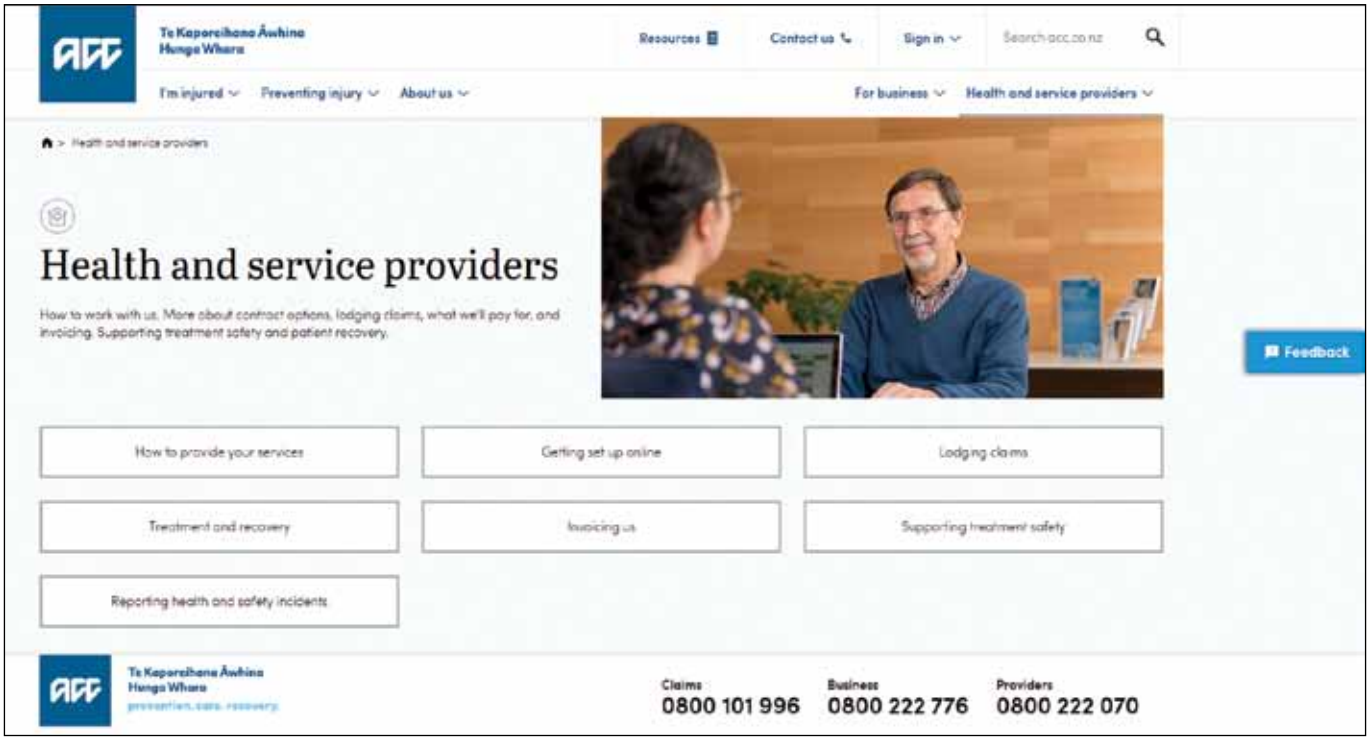
But we've ensured the content it does hold is up to date and is based on what we know our customers need and use.

If you're new to ACC and want to know how to set yourself up for business, click on one of the seven tabs to access guides to everything you'll need to know. The resources section, accessed from the top of the home page, is where you go to order ACC materials, find forms and search for documents and publications – including the Treatment Provider Handbook.

And rather than remembering where things are located or bookmarking everything, try searching for things instead. But be aware – if you haven't visited the site since July, any specific links you might have had set up will have been lost.

We also have two new tools available through the health and service provider tab, at the top right hand corner of the home page – the Read codes look up tool and the work type detail sheets tool, accessed through the 'Lodging claims' and 'Treatment and recovery' tabs.

The site will continue to evolve and we encourage you to visit it whenever you have a moment, to see how it's shaping up. We also encourage you to use the feedback button, to the right of the page, as you explore the new look and feel of this site, as this will help guide any changes needed to improve the experience for our customers.



ACC Physiotherapy Services Contract Redesign update

Earlier this year ACC announced that they will be working with Physiotherapy New Zealand (PNZ) on a redesign of the Physiotherapy Services Contract.

The redesign will take place over the next three years, in three phases (see figure below). It is likely that some changes will be relatively quick to implement through annual contract variations. Others will need to be tested before they can be considered for any implementation. Ultimately we will end up with a new contract to be retendered in 2020.

Expert Reference Group

ACC has formed an Expert Reference Group to support the redesign process. Members have been nominated by PNZ to reflect private practice, DHBs and academic leaders across the profession.

The first meeting of the Physiotherapy Expert Reference Group was held on 28th September 2017, in Wellington.

Members of the Group are; Dr Peter Larmer (Associate Professor, AUT), Kurt Thomas (PNZ Executive Member), Denis Kelly (Private Practice Advisory Group), Sue Doesburg (PNZ Professional Practice Advisor), Jo-Anne Gibbs (DHB representative), Grant Chittock (Chair, Private Practice Advisory Group) and Gill Stotter (Business Owner and Chair, Professional Development Committee).

The first meeting was a chance to start identifying opportunities for the Redesign. Our next meeting is in December 2017 – we'll keep you posted on progress of the work with this group.

Peter Larmer

Peter has more than 20 years in musculoskeletal Private Practice. He has since taken an academic role at AUT where he is Head of the School of Clinical Sciences, and previous Head of the Department of Physiotherapy. He has held the position of Senior Clinical Advisor to ACC and been the Chair of the NZSP ACC Advisory Committee. Peter was the project lead for the Physiotherapy Treatment profiles.

Kurt Thomas

Kurt is a PNZ National Executive member. He has been working in Multidisciplinary Private Practice for 14 years in both New Zealand and Australia.

Kurt has worked under both Regulation Physiotherapy Services and the Physiotherapy Contract over this time as well as various other ACC contracts and understands the Accreditation Process which is currently required to hold the Physiotherapy Services Contract. His role as the PNZ National Executive representative is to work in the best interests of the PNZ membership.

Denis Kelly

Denis comes from a background of musculoskeletal physiotherapy and he owns a private practice clinic in Winton, Southland. Denis has a background of private practitioner governance through a long association with the New Zealand Private Physiotherapy Association. He is a past chairman of NZPPA and now sits on the PPAG. Denis has recently completed his term on the PNZ National Executive and is currently sitting as Vice Chairman on the International Private Physical Therapy Association.

Sue Doesburg

Sue's clinical background is musculoskeletal physiotherapist based in DHB outpatient clinics. This was followed by 10 years as a Manager/ Leader of DHB

Back row: Dr Peter Larmer (Associate Professor, AUT), Kurt Thomas (PNZ Executive Member), Denis Kelly (Private Practice Advisory Group), Sue Doesburg (PNZ Professional Practice Advisor)

Front row: Jo-Anne Gibbs (DHB representative), Grant Chittock (Chair, Private Practice Advisory Group), Gill Stotter (Business Owner)

Physiotherapy services. The DHBs that Sue worked in provided ACC services under the physiotherapy contract, so she's very familiar with the certification process. Sue has been in the PNZ Professional Advisor role for 2 ½ years and liaises closely with ACC regarding member queries and concerns.

Jo-Anne Gibbs

Jo-Anne has worked in both private and public physiotherapy services. She is currently Team Leader of Musculoskeletal Outpatient & Hand Therapy at Capital Coast DHB and oversees the provision of physiotherapy outpatient services across three sites. As a member of the DHB Leaders SIG, Jo is able to voice the perspectives of DHB outpatient physiotherapy provided under the contract and under treatment regulations.

Grant Chittock

Grant a registered physio and managing director of Motus Health Ltd, which is a large multi-centred practice operating in urban and rural locations across a range of various funding streams and contracts.

Gill Stotter

Gill has owned a small private practice for almost 25 years and the practice has been accredited since 2004. She has been an active member of the physiotherapy profession with roles on the ACC committee and National Executive with four years as President. She is now currently chair of the Professional Development Committee and a member of the Physiotherapy Board Scopes of Practice steering group. Her role on the ACC reference group is to understand and voice the diverse views of the profession, promote clinical governance and a sustainable business physiotherapy model to achieve quality patient centred outcomes.

Contract redesign – Where next?

- There will be additional opportunities to engage face-to-face with ACC at PNZ meetings and conferences next year.
- ACC will inform the sector of contract variations in April 2018 (to take effect 1 June 2018).
- Updates will be provided every 8-12 weeks.
- PNZ members will receive updates through *Physio Matters*.
- ACC Contract holders will receive updates and survey requests via email.
- Our next Physiotherapy Expert Reference Group meeting will be in December 2017 – we intend to meet quarterly.

How can I get involved?

Any thoughts, ideas or questions you have around the redesign can be sent to physiocontract@acc.co.nz

Membership and insurance renewals 2018

With renewals opening on November 1, we take a look at what membership benefits are on offer for 2018.

Renewing your membership with Physiotherapy New Zealand is easy. Visit the member website www.pnz.org.nz and log in using your current email address and password. Once logged in, you'll be directed to your personal dashboard.

To renew your membership, click on the 'RENEW MEMBERSHIP' button and follow the prompts.

You will need to pay for your membership at the time of signing up. We accept payment by credit/debit card or by account-to-account bank transfer.

If your employer is going to pay for your membership, you will need to arrange with them to either pay for the membership at time of purchase, or pay for this yourself and claim it back from your employer.

Renew online early and save!

If you renew your membership between 1 November and midnight 18 December 2017, you will save 10% on your purchase.

Membership fees for 2018

Membership fees have not increased this year. They are still based on hours of work rather than income.

Renew today to take advantage of these member benefits and be part of the largest network of physiotherapists in New Zealand.

Advocacy for you and your profession

PNZ represents your interests to key people and stakeholders within the industry, including ACC, Allied Health, Ministers and many more.

If you renew your membership between 1 November and midnight 18 December 2017, you will save 10% on your purchase.

Professional Development

Branches, SIGs and National Office all provide a variety of learning opportunities, discounted (and sometimes free) for members. You'll also receive our monthly electronic calendar with a list of all the continuing professional development (CPD) happening in New Zealand.

Specialised learning

Join one (or more!) of our 12 Special Interest Groups (SIGs) for targeted information and training relevant to your chosen area of interest. Our SIGs include:

- Cardiothoracic
- Pelvic, Women's and Men's Health
- District Health Board Leaders
- Hand Therapists
- Neurology
- NZ Manipulative Physiotherapists Association (NZMPA)
- Occupational Health
- Paediatrics
- Physiotherapy Acupuncture Association NZ (PAANZ)

Category	Discounted Rate (between 1 Nov – 18 Dec)	Full Rate (from 19 Dec)
Full Time (more than 30 hours per week worked in any role)	$621.00	$690.00
Part Time (30 hours or less per week worked in any role)	$306.00	$340.00
First and Second Year Graduate (from AUT or University of Otago undergraduate physiotherapy programmes)	$261.00	$290.00
Non Earner	$153.00	$170.00
Retired (aged 60 years or over)	$63.00	$70.00
Overseas Members (living overseas and registered with the Board)	$135.00	$150.00
Student – New Zealand undergraduate physiotherapy students	Free	Free
Physiotherapy Assistant	$90.00	$100.00

- Physiotherapy in Mental Health
- Physiotherapy for the Older Adult
- Sports Physiotherapy New Zealand

Insurance

Add professional liability insurance to your membership and get cover for up to one million dollars. Through AON New Zealand, we can offer members a liability insurance package to cover member's individual liability through a single group policy.

Support for Māori

Tae Ora Tinana provides support with cultural guidance, professional support and mentoring at any stage of your career.

Branch connections

Included within your PNZ subscription is membership to your regional Branch, who offer networking and CPD at a local level.

Marketing

We produce a range of public awareness campaigns designed to draw attention to physiotherapy. These campaigns showcase the value of physiotherapy through a variety of channels including social media, advertising and the mainstream news media. They are all designed to drive traffic to the Find a Physio database on our public website.

Advertising

All members receive a free listing in our online Find a Physio database which receives more than 100,000 visits per year. Members also get discounted advertising in *Physio Matters*.

Industry publications

PNZ members will receive monthly issues of *Physio Matters*, containing the latest in:

- advocacy;
- professional development;
- national and international news;
- research;
- and member stories.

PNZ also publish the New Zealand Journal of Physiotherapy three times a year. The journal consists of papers contributed for peer review under various categories including:

- research reports;
- scholarly papers (clinical and professional perspectives);
- case studies;
- and clinically applicable papers.

Resources and research at your fingertips

PNZ continually develops new resources for members which are shared on the member website, including access to news feeds, webinars, Human Resources support, professional education videos, practice guidelines and articles on a wide range of physiotherapy and health subjects. You can read more about the reflective practice resource recently developed by PNZs Professional Development Committee on page 18 of this issue.

Need help?

We are always happy to help you with any questions you may have. Please contact us at the National Office on (04) 801 6500 or pnz@physiotherapy.org.nz

New resource promotes reflective practice

A new resource to support and advance reflective practice is now available to Physiotherapy New Zealand (PNZ) members. Published on the PNZ members' website, the resource includes information and guidance on reflective practice and a template to record the reflection process.

Reflective practice is a regulatory requirement of the Physiotherapy Board, but reflection is an essential part of ongoing professional development for all physiotherapists. "Engaging in reflection should not to be regarded as another layer of compliance," says PNZ Professional Development Committee Chair Gill Stotter. "It should be viewed as a valuable exercise that will benefit both you and your practice."

Professional Development Committee members Jackie Chiplin, who has 30 years' experience as a clinician, and AUT University Lecturer Verna Stavric joined forces to develop the resource. "Our goal was to provide up-to-date, evidence-based information and resources about reflection and how to develop this skill to promote deeper learning and professional growth," explains Jackie.

What is reflective practice?

Reflective practice is based on reflection. Reflection requires physiotherapists to consciously examine an experience with the aim to of identifying what they did well and what they could do better, and in doing so facilitate learning. It can focus on an everyday experience, a new task or procedure, applying theory to practice, an aspect of patient management or care, or an interaction with a patient or colleague. When physiotherapists engage in reflection on a regular and ongoing basis, and apply their learning to improve their practice, they are engaging in reflective practice.

Physiotherapists can also use reflection to identify the next step in their continuing professional development (CPD). In fact, it is regarded as integral to the CPD cycle, particularly for the planning stage. As Gill explains: "Reflection and continuing professional development feed into each other. When you reflect on your strengths and weaknesses, you can identify what you need to be doing for professional development to address your weaknesses. That way reflection, can help you meet your short- and long-term career goals."

Reflection can be carried out on for positive as well as negative experiences. "Reflection is not just about examining the challenging and difficult cases. It should also be used when things have gone well, so you can identify the aspects that were successful and what you can learn from these for other similar situations," says Gill.

Reflection does not always have to be a formal process. "I don't want physiotherapists to think that they have to sit down every day and write a reflective practice statement, because that's not feasible," says Gill. "When issues arise, it's good to make a note of them, and then when it's convenient, to think back on them. It should become an ingrained part of your day-to-day practice because that's how a reflective practitioner operates. No matter how experienced you become as a practitioner, you still gain a lot from regular reflection."

Meeting the Physiotherapy Board's obligations

The Board expects all practicing physiotherapists to engage in reflective practice as outlined in the Physiotherapy practice thresholds in Australia and Aotearoa New Zealand, and physiotherapists are required to show this for recertification of their Annual Practicing Certificate. If selected for a random recertification audit, physiotherapists must produce evidence of reflective practice by way of three written reflective statements demonstrating reflection on an ethical issue, a cultural issue and on an event related to their field of practice.

The resource and how to use it

The new PNZ resource includes a template that aligns with the Boards' expectations for reflective statements. The template is presented in the form of a table that can be downloaded and saved or printed for personal use. It prompts physiotherapists to describe an experience, what they did, what they learned and how the experience influenced their practice. Physiotherapists selected for a recertification audit can submit a selection of their completed templates to the Board as evidence of their reflective practice.

As part of the new resource, the information on the PNZ members' website has been updated and expanded. "We started with an introduction to reflection and a template based on the Board's requirements, but we also wanted to encourage members to consider developing their reflection skills and reflecting more deeply to progress their professional development and practice," explains Verna.

To this end, the resource describes four different models of reflection: Gibbs' reflective cycle; Johns' model of structured reflection; Kolb's learning

cycle; and Rolfe, Freshwater and Jasper's framework of reflective practice. While each model has a slightly different approach, they all address three fundamental components of the reflection process: identifying what happened, including the physiotherapist's role, behaviour or decisions; identifying learning from what happened, such as what did or didn't work well; and thirdly, identifying how this learning will influence and be applied to their future practice.

Through their research, Jackie and Verna found that reflection has grown from being typically a personal or private process to one that can also be undertaken with others, be that a colleague or professional supervisor, or in a group setting. An extensive literature search and a review of what is being done in other areas of health and education also showed that reflection can be recorded and expressed using many different modes, such as a journal, a blog, photographs and artwork. They advise physiotherapists to experiment with different models and approaches to find out what works best for them.

"We acknowledge the wide variety of situations physiotherapists work in and the different learning styles people have, so we have put together resources showing a range of reflection models that are available and ideas about how to record reflection that might suit members' different situations and learning styles," says Jackie.

Linking resources

The reflective practice resource has been designed to complement the existing CPD tools developed by the Professional Development Committee. These include the professional development planning resource to assist physiotherapists with their CPD planning; the guidelines for formal professional development to help physiotherapists assess the quality of a CPD course; and the professional supportive and evaluative relationships resource to help physiotherapists establish and engage in professional relationships, such as supervision for reflective practice.

Putting the resource to good use

With the reflective practice resource now at their fingertips, what's the next step for PNZ members? "Read the resource, understand the different ways of doing reflection, find out what suits your practice, and then begin performing reflection as part of your daily routine, so that you're using it and learning from it," says Gill.

Written by Esther Bullen

What does being a health professional mean?

If you are asked this question, can you answer it? What are the hallmarks of professionalism?

A profession has been defined as:

"An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served, to the profession and to society."

Professionalism includes the obligation to maintain and improve standards.

Specifically:

- Act in accordance with relevant thresholds, codes and standards.
- Keep your professional knowledge and skills up to date.
- Recognise, and work within, the limits of your competence.
- Be committed to autonomous maintenance and improvement in your clinical standards in line with evidence-based practice.
- Demonstrate reflectiveness, personal awareness, the ability to seek and respond constructively to feedback and the willingness to share your knowledge and to learn from others.
- Be personally accountable for your professional practice – you must always be prepared to explain your decisions and actions.

The Physiotherapy Board is principally concerned with protecting public health and safety in line with the Health Practitioners Competence Assurance Act. Like it says in the title, the risk is controlled by ensuring competence. Physiotherapists have the Aotearoa New Zealand Code of Ethics, the Physiotherapy practice thresholds in Australia & Aotearoa New Zealand (the Thresholds) and the Physiotherapy Board Standards (when ratified) as base competencies.

The Thresholds describe the threshold competence for registration of a physiotherapist. There are seven integrated roles:

1. Physiotherapy practitioner
2. Professional and ethical practitioner
3. Communicator
4. Reflective practitioner and self-directed learner
5. Collaborative practitioner
6. Educator
7. Manager/leader

Lifelong learning is part of professionalism. UNESCO defines it as having four pillars:

- Learning to know
- Learning to do
- Learning to be; the development of human potential to its fullest.
- Learning to live together; the understanding of others, their traditions, history, and spirituality. This pillar is important as it relates to cultural competence.

Lifelong learning is important to us – that's why annual recertification requirements are part of how we assess the ongoing competence of the profession.

The attributes of a health professional are complex. Tapper and Millett (2015) suggest the formal element of a profession could be described as employing potentially dangerous knowledge for public good, by ethically bound people of good character. In short, ethical and professional standards are our profession's core.

Jon Warren
Professional Advisor
Physiotherapy Board of New Zealand

References available on request.

Member Tom Bond receives leadership award for ICU initiative

Wellington Regional Hospital physiotherapist and PNZ member Tom Bond developed a rehabilitation monitoring tool for long-stay intensive care unit and his innovation won him a Health Quality & Safety Commission (HQSC) 'Open for Leadership' award in August this year.

The monitoring tool allows hospital staff to assess and evaluate the progress of a patient's physical ability, which in turn helps to measure the progress of their recovery from a critical illness. The tool can also be used to predict what level of rehabilitation support the patient may need going forward.

The driver behind the establishment of the tool was the lack of any consistent measurement tool or method of passing on information specific to the rehabilitation progress of long-stay ICU patients.

Tom researched existing measurement tools and consulted with other staff before choosing to trial the Chelsea Critical Care Physical Assessment Tool (CPAX), which has now been implemented in ICU.

Tom Bond

Former Associate Health Minister Peter Dunne presented the award to Tom at Wellington Hospital on August 30.

"Tom's leadership in identifying a need and driving change – which has now been integrated into ICU systems at the CCDHB – make him a deserving recipient of this award," said the former Minister during the awards ceremony.

The HQSC Open for Leadership awards recognise and celebrate health professionals, in their first five years of practice, who demonstrate excellent practice, quality improvement and leadership skills. They are part of the Commission's work to build capability and leadership in the health sector.

HQSC chief executive Dr Janice Wilson says before the tool was introduced at the hospital, there was no consistent measurement tool or method of passing on information specific to the rehabilitation progress of patients.

"After identifying a gap in the monitoring of long-stay ICU patients, Tom researched existing measurement tools and consulted with other staff. The Chelsea Critical Care Physical Assessment Tool (CPAx) was chosen for trialling. As a result of this project, it has been implemented by Capital & Coast DHB.

"The tool enables staff to assess and evaluate the progress of a patient's physical function and ability to engage in activity, which helps measure their recovery from a critical illness. This makes it easier to predict how much and what sort of future rehabilitation support they may need.

The driver behind the establishment of the tool was the lack of any consistent measurement tool or method of passing on information specific to the rehabilitation progress of long-stay ICU patients.

"Tom's initiative has directly resulted in improved care for long-stay ICU patients, which is something to celebrate," says Dr Wilson.

"This award is about our team and I'm grateful to the CCDHB, my ICU colleagues and my mentor, Daniel Seller, who encouraged and supported me through the process. We now have a quality process that benefits consumers and health professionals," said Tom upon receiving the award.

Tom is the second PNZ member to win the 'Open for Leadership' award, after MidCentral DHB physio and fellow member Emma Lett won the award back in February for her work in helping streamline access to equipment for physiotherapy patients.

Written by Erica George

Mobilising mechanically ventilated critically ill adults in an Intensive Care Unit

Physiotherapists have long been associated with getting people moving and participating in physical activity. This is as important in the hospital setting as it is in the community, explains Barbara Saipe from the DHB Physiotherapy Leaders SIG.

I'd like to share with the wider physiotherapy community one exciting area of development involving District Health Board (DHB) physiotherapists that you might not know about if you do not work in an Intensive Care Unit (ICU).

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It is not a new concept that prolonged bed rest results in deconditioning. Following on from that understanding, an increased awareness has developed of how quickly deconditioning and functional decline commences and how rapidly it progresses. More and more emphasis has been placed on the early mobilisation of hospital patients and physiotherapists have been leaders in promoting, facilitating and driving those changes for many years.

A common and well known example of this aspect of our clinical practice is in the field of elective orthopaedic surgery for hips and knees. Patients are now typically mobilised by a physiotherapist on the same day as their surgery, four-to-six hours post operatively, when undergoing total hip and knee replacements for osteoarthritis. But what about the many extremely unwell and complex patients who are admitted to ICU's around the country? Would they spring to your mind in this context?

In the past ICU ventilated patients were managed with deep sedation and bed rest. Over the last 10-15 years studies have investigated the feasibility, safety and effectiveness of early progressive mobilisation of adult ICU patients. The findings have contributed to a shift in clinical practice in the ICU setting towards reduced sedation and earlier progressive mobilisation of patients, including those who are mechanically ventilated. This practice is well established in larger DHB ICU's in New Zealand.

Physiotherapists have played a key role in many of these studies and in developing safety criteria to determine patient readiness for mobilisation while mechanically ventilated.

For your further interest, the following is a 2014 paper produced by a collaboration of 23 multidisciplinary ICU experts from Australia and New Zealand including a significant number of physiotherapists. It is available to view on this link: www.ncbi.nlm.nih.gov/pubmed/25475522

Barbara Saipe
Professional Leader Physiotherapy
Capital & Coast District Health Board

Dropping like flies: the rise of workplace burnout and how to tackle it

Burnout is on the rise. It is a growing problem for the modern workplace, having an impact on organisational costs, as well as employee health and well-being. These include possible long-term health risks and, due to its contagious nature, a toxic working environment of low morale, scapegoating, and increased workplace politics.

The annual cost of burnout to the global economy has been estimated to be $245 billion (NZD). Such costs have led to the World Health Organisation predicting a global pandemic within a decade.

Organisations have focused on burnout to protect their profits, placing blame for lowered performance on individual employees, rather than making adequate adjustments to safeguard against stress. This emphasis on the employee has led to psychometrically profiling those that may be at risk of burnout due to their psychological make-up, rather than organisations taking responsibility and making systematic changes to reduce stress caused by structural level problems.

This blame game is often unhelpful – not just for the employees in question, but also because it risks a skills shortage in certain professions such as health and social care. Plus, it further contributes to the burnout cycle: with limited staff and resources, demands are placed on fewer employees.

Causes

Research into burnout has been linked to office politics, menial working tasks that interfere with work duties and high job demands that lead to exhaustion. Rising workloads and long hours are the main culprits; however, some employees are better able to cope or are more adaptable than others.

Perception of stress is also a contributing factor. If you perceive you do not have the right resources to cope with your workload, or perceive it to be more than you can cope with, you are much more likely to succumb to stress-related disorders.

Individual differences and personality types also play a role in the risk of burnout. Type A personalities, for example – who have a mix of behavioural traits that include hardiness, impatience, competitiveness and drive – and people who like to have large amounts of control, are also linked to higher rates of stress at work. Research shows that employees with these personalities tend to be more restless, hostile and time-conscious, which puts them at greater risk of workplace stress.

It is important, however, not to make banal assumptions when it comes to understanding how different people experience stress. This runs the risk of organisations screening out applicants for jobs on the basis of personality or attributing blame to employees, rather than taking responsibility as an organisation to make adequate changes to safeguard their employees from stress.

Many global organisations have intervention plans that place the onus on the employee to manage their health and well-being through training programmes such as building resilience and coping skills. But this often has the semblance of blaming employees, while abdicating responsibility and not making any real changes to policies.

The reality is that organisations are stressful, often purporting an employee wellness agenda that isn't really implemented in practice.

Different dimensions

There are three main dimensions of burnout according to the Maslach Burnout Inventory, the most commonly used burnout scale: exhaustion, cynicism and a sense of personal accomplishment, with exhaustion being the most obviously displayed. Signs of burnout can vary between employees and manifest in multiple industries, from healthcare and education settings to legal and corporate finance firms.

Burnout causes a range of psychological and physical problems and can affect people long after they no longer face the stressful situation. These include fatigue, irritability, depression, withdrawal, mental and physical health problems, and self-medication with alcohol and drug use. Consequently, it is something that employees and organisations must manage carefully.

Employees come in all shapes and sizes. As a result, it is imperative that managers and organisations do not prescribe a one-size fits all model to managing employee well-being. Instead, they should work on an individual basis with each employee, finding flexible interventions and providing an adaptable and agile working environment along the way.

Many workplaces are built around teamwork, collaboration and endless meetings to harness creativity. This model does not bode well, however, for people whose creative juices and energy levels are depleted through constant collaboration. In fact, many individuals, especially those that are more introverted, feel exhausted and find it difficult to get their work done in this kind of environment.

As such, organisations can provide a space for these personalities to work alone, where their productivity increases and creative juices can flow. Similarly, organisations can work with employees, providing agile working conditions to help create a sustainable working culture and work-life balance, thus reducing the likelihood of burnout.

Of course, individuals have a role to play too. It is important that people manage their own personal expectations, harnessing their skills and reflecting on their own personal values. This is particularly the case if you're working in a role that does not readily align with your own values or predisposition. It's important to reflect on what matters to you, as living an inauthentic life can lead to burnout when your personal values are conflicted.

Sarah Tottle
Business Psychologist
Lancaster University

Sarah Tottle's article was originally published on The Conversation website. Republished with permission.

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What creates a healthy place of work?

When work or workplaces contain unhealthy characteristics, employee burnout and other safety issues are more likely to occur. Here are some suggested basic actions to implement healthy workspaces from Worksafe New Zealand – both for employees and employers.

Work content

Healthy work	Unhealthy work	Suggested focus for employers	Suggested focus for employees
A balance on effort and rest	Extended, intense, physical and mental effort without breaks. No ability to switch off from work out of hours.	Make sure there are sufficient breaks in periods of intense physical and mental effort and adequate recovery time outside work.	Know limitations; do not accept pressure or create it by 'competing'; use recovery time wisely; have a life outside work.
A variety of tasks	Boring, repetitive, unfulfilling tasks.	To the extent possible, provide a variety of tasks for each employee; match the right people to the right tasks.	Do not be afraid to try something new; where practical, share less interesting tasks with other people.
A sense of personal control	Little control or independence in the workplace – there is no ability to decide how or when to carry out tasks.	Provide employees with the means to take some control over the way they do their work – perhaps the order in which they do tasks or the means used to accomplish them.	Take responsibility for personal tasks; use discretion provided wisely; respect the employer's position when there is no latitude available.

Workplace relationships

Healthy work	Unhealthy work	Suggested focus for employers	Suggested focus for employees
Poor relationships are resolved swiftly	Poor relationships in the workplace remain unsatisfactory.	Provide fair mechanisms to identify and reconcile workplace relationship difficulties and conflicts – opportunities to meet and exchange views; promote dialogue.	Work on maintaining healthy personal relationships; understand the difference between giving way and giving in; apologise if necessary.
Good communication	Poor communication among people at work, particularly between extremes in the workplace hierarchy.	Have strategies for communicating about work; promote honest feedback in both directions; praise success at work; have systems for employee participation.	Contribute to a positive atmosphere in the workplace; avoid criticising destructively or undermining colleagues; ask necessary questions.
Workplace hierarchies	No-one appears to be in charge; pecking orders rife. Artificial and/or marked separation between people.	Experienced people valued for their ability to inspire confidence and give direction. Hierarchies do not dominate; status (the ability to contribute) is valued at all levels.	Refuse to play status games; take responsibility for personal tasks; use discretion provided wisely. Acknowledge the usefulness of well-designed hierarchies.

Employee support

Healthy work	Unhealthy work	Suggested focus for employers	Suggested focus for employees
Appropriate rewards	Personal contributions ignored or demeaned. A mismatch between effort and reward.	Let employees know how they contribute to the organisation; acknowledge work well done and suggestions made.	Maintain skills and knowledge; have a realistic sense of self worth; acknowledge others' accomplishments.
A supportive workplace	No support or leeway when a person has a bad patch.	Have realistic expectations about outputs; offer support in difficulties; acknowledge skills/expertise; Stand between staff and external criticism.	Ask for help when you need it; accept support when you need it; give support when possible.
Personal growth	No opportunities for personal growth.	Provide opportunities to work well and improve performance; match individuals to tasks; provide opportunities to progress.	Maintain skills and knowledge; learn from mistakes; contribute to the organisation's goals; be willing to accept the change and knocks that are necessary for personal growth.

Teaming up for better care

Dr Lynne Taylor from AUT tells *Physio Matters* about the recent relocation of the AUT Health clinic on Auckland's North Shore and the advantages for students working alongside other health disciplines.

Many AUT graduates will remember the AUT physiotherapy clinics run on the Akoranga Drive campus.

The AUT Health clinic has now moved 800 meters down the road to Northmed, a new healthcare centre, where AUT Health is far more visible to the public. The other advantage for our clients is that we share the centre with other healthcare providers including dentists, pharmacy, radiology, and another physiotherapy practice.

What makes us different is that AUT Health clinic provides clinical practice experience for our students, as well as providing a service to the community. This gives us the unique opportunity to develop and evaluate models of health care to meet the demands required for the health workforce of tomorrow.

Alongside our established physiotherapy services in neurological rehabilitation and musculoskeletal physiotherapy (as well as podiatry, oral health, occupational therapy and psychology clinics), AUT has developed an inter-professional care and training model for undergraduate health students. Under this model, students and staff from different health-related disciplines collaborate to meet patients' physical, psychological and social needs – and patients are very much part of the team.

In 2015, AUT Health launched an inter-professional diabetes programme supporting people with Type 2 diabetes and their families. Patients are cared for by a team of students and staff from podiatry, oral health, physiotherapy, occupational therapy, nursing, psychology counselling, psychotherapy, nutrition, and health promotion.

In a follow-up study, patients reported feeling more empowered to self-manage their condition, while students and staff gained new perspectives, understanding and improved collaborative skills.

The diabetes programme has been the catalyst for a number of new inter-professional health programmes. Last year saw the launch of AUT Health's Living Well programme, supporting whaiora (people seeking wellness) to

Exterior of AUT Health clinic.


AUT Health clinic reception.

meaningfully explore living with life-changing conditions together.

Three other programmes have also been recently launched. The first is a pulmonary rehabilitation programme supporting people with chronic respiratory disease. While primarily a physiotherapy-led exercise-based program, anxiety and depression, nutrition and issues related to their activities of daily living are also addressed by an inter-professional team of students.

The second, Kid's Jam is a music-based programme designed for primary school children who experience ongoing challenges with participation and engaging with their peers.

Finally, Creative Futures is an inter-professional programme designed for people living with Parkinson's disease. The programme includes students from speech-language therapy, occupational therapy, dietetics, older adult management, and physiotherapy.

All these programs encourage students and practitioners from the different disciplines to partner with clients in a client-centred way.

Sam Newman, Physiotherapy Clinical Educator talking with postgraduate physiotherapy and undergraduate podiatry students.

Brenda Flood, Senior Lecturer in Inter-professional Education and Practice Development at AUT, explains why these programmes are so important. "By the end of the programmes, students have made new friends, gained new understandings of how they can work together in an inter-professional team environment, have an understanding of what the role of other disciplines entails, are able to reflect on themselves and their contribution, and recognise the value in multiple points of view," she says.

"They feel safe and supported and have developed new ways of integrating 'knowing, acting and being' in preparation for the dynamic, evolving and complex nature of the practice context. Patients enjoyed the partnership with students, and both groups agreed that care was significantly better."

With these new programmes, AUT Health will continue playing a substantial role in improving patient outcomes and developing an inter-professional health workforce for the future.

Dr Lynne Taylor
Head of Physiotherapy,
Auckland University of Technology

Brenda Flood
Senior Lecturer
Auckland University of Technology

The AUT Health clinic can be found at Northmed Medical Precinct, 3 Akoranga Drive in Northcote, Auckland.

Navigating the third year of study as a physiotherapy student in New Zealand

What is it like being a third year student of physiotherapy at the moment? Third year student and Education Representative on the University of Otago School of Physiotherapy's student executive Hayden Kilgour gives us some insight.

For third year students, there are stressful times ahead as we pick and choose our preferences of placement location for next year. The fourth year of the course involves students working in a full time clinical setting. This, from what we hear and as we can imagine, is a huge step up in terms of hours in the clinical setting. It is something that all students seem to be excited about and is a step everyone is really keen on.

For some students, it is especially exciting as they have the possibility of moving a little bit closer to home. Being near home is a way for people to save some money but also be around friends and family they haven't been close to for the past three or more years.

However, when we found ourselves at the point of completing the forms, we realised there were so many more aspects to the decision that many of us hadn't anticipated. Students are now considering networking for possible job opportunities, sports medicine opportunities, sporting opportunities at local clubs or higher-level sports, and even down to the cost of flights for travelling home as these may be cheaper in some places. I think everyone assumed the decision was going to be so much easier than it was and most people didn't realise the range of placement locations that were on offer, so a lot of students had to think about considering places they didn't know were on offer – right up until about two weeks before making their decision.

Which direction will the next step of our physiotherapy journey be in? © iStock

Students were able to rank eight placement options from one to eight in order of their preference – leaving university staff with the tedious task of sorting everyone into a position at one of the physio centres. The centres are scattered throughout the South Island and the south of the North Island. Students are not able to go wherever they like due to our colleagues in Auckland having their own jurisdiction. This ensures that all students from both Universities have an available placement.

However, students are able to have more of a say into where they would prefer to do their community rotation placement in their fourth year. They are given the option to travel home to a specific practice or even overseas if they wish – provided it is within reason and doesn't create too many logistical issues.

As you can see, we third years are given lots of options, lots of decisions and lots of unknowns to navigate! No one knows for sure where they will end up next year – but that adds to the excitement of the situation and everyone is very much on edge to find out whether they have ended up in the same centre as some of their classmates.

As you can see, there certainly are exciting times ahead as we find out which direction the next step of our physiotherapy journey will be in.

Written by Hayden Kilgour

Calendar

TITLE	DATE	LOCATION	CONTACT DETAILS
PHYSIOTHERAPY NEW ZEALAND			
PNZ Conference 2018	14-16 Oct 2018	Auckland	pnz@physiotherapy.org.nz
SPECIAL INTEREST GROUPS:			
New Zealand Manipulative Physiotherapy Association			
COMT – Ankle Foot and Review	11-12 Nov 2017	Wellington	www.nzmpa.org.nz
COMT – HVT and Review	25-26 Nov 2017	Auckland	www.nzmpa.org.nz
COMT – W10	2-3 Dec 2017	Auckland	www.nzmpa.org.nz
Mulligan – Part C and Exam	2, 3 & 4 Dec 2017	Auckland	www.nzmpa.org.nz
Physiotherapy Acupuncture Association of New Zealand			
Case Study Day 2017	Various	Nationwide	paanz@physiotherapy.org.nz
Acupunture in Sports	4 Nov 2017	Wellington	paanz@physiotherapy.org.nz
Dry Needling – Foundation course	11-12 Nov 2017	Christchurch	paanz@physiotherapy.org.nz
Dry Needling – Foundation course	3-4 Feb 2018	Auckland	paanz@physiotherapy.org.nz
Point Finding	10-11 Feb 2018	Auckland	paanz@physiotherapy.org.nz
Advance Upper Body – Dry Needling	17-18 Feb 2018	Christchurch	paanz@physiotherapy.org.nz
Acupuncture for Hands and Mobilisations with Movement – the basis of the Mulligan concept	3 Mar 2018	Wellington	paanz@physiotherapy.org.nz
Headache Day	4 Mar 2018	Wellington	paanz@physiotherapy.org.nz
Myofascial Cupping	10 Mar 2018	Auckland	paanz@physiotherapy.org.nz
Qi Gong	24 Mar 2018	Paeroa	paanz@physiotherapy.org.nz
Introductory Facial course	13-15 Apr 2018	Wellington	paanz@physiotherapy.org.nz
Dry Needling – Foundation course	5-6 May 2018	Auckland	paanz@physiotherapy.org.nz
Women's Health	23 Jun 2018	Wellington	paanz@physiotherapy.org.nz
Korean Hand Acupuncture	24th Jun 2018	Wellington	paanz@physiotherapy.org.nz
Women's Health	30 Jun 2018	Auckland	paanz@physiotherapy.org.nz
Korean Hand Acupuncture	1 Jul 2018	Auckland	paanz@physiotherapy.org.nz
CRPS	28 Jul 2018	Wellington	paanz@physiotherapy.org.nz
Sports Physiotherapy New Zealand			
Promotion and prescription of physical activity and exercise	11 Nov 2017	Auckland	https://goo.gl/ePyYVX
The Upper Limb in Sport	18 Nov 2017	Auckland	https://goo.gl/s2oP1R
Sideline Management	2 Dec 2017	Christchurch	eikeda@aut.ac.nz
Cardiothoracic			
Bariatric Patient Workshop – Innovative approaches for clinicians	4-5 Nov 2017	Auckland	https://goo.gl/BTv1a6
Paediatrics			
When Walking is Not Enough – Analysing and (Re)Habilitating running skill in children and adults with neurological injury	4-5 Nov 2017	Christchurch	craigaela@gmail.com

Calendar

TITLE	DATE	LOCATION	CONTACT DETAILS
BRANCHES			
North Shore			
November Branch Meeting and AGM	13 Nov 2017	Auckland	northshore@physiotherapy.org.nz
Otago			
Southern Physiotherapy Symposium 8	3-5 Nov 2017	Queenstown	https://goo.gl/f1dnNE
Southern Physiotherapy Symposium 8 Workshop I: Professor Bill Vicenzino	3 Nov 2017	Queenstown	https://goo.gl/Tx4Ibp
Southern Physiotherapy Symposium 8 Workshop II: Professor Lorna Paul	3 Nov 2017	Queenstown	https://goo.gl/GxKweG
Southern Physiotherapy Symposium 8 Workshop III: Professor Dr Bronwyn Thompson	3 Nov 2017	Queenstown	https://goo.gl/M9yKD9
Nelson/Marlborough			
Assessment and treatment of the lumbar spine and pelvis	9-10 Nov 2017	Nelson	https://goo/gl/CzbP18
EXTERNAL PROVIDERS/ORGANISATIONS			
APPI Ante/Post Natal Pilates	4 Nov 2017	Auckland	info@unitehealth.co.nz
Mulligan Concept functional treatment of the pelvis	4-5 Nov 2017	Invercargill	jillianmmcdowell@gmail.com
The Sports Thorax – ConnectTherapy™ & the Thoracic Ring Approach™ with Dr. Linda-Joy Lee	15-18 Nov 2017	Auckland	https://goo.gl/laea3b
McKenzie Institute New Zealand - Part C – Advanced Lumbar Spine & Extremities - Lower Limb	16-19 Nov 2017	Wellington	www.mckenzieinstitute.org/nz
Certificate in Orthopaedic Manual Therapy Programme	27 Nov - 21 Dec 2017	Australia	www.manualconcepts.com
McKenzie Institute New Zealand – Part A: The Lumbar Spine	16-18 Mar 2018	Wellington	minz@mckenzieinstitute.org

For all event listings, please visit pnz.org.nz

www.pnz.org.nz

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