

key steps
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key steps

to delivery of a person
centred relapse service



2. Clinical roles

Outline of Clinical Roles

Specialist Nurse

Neurologist

Generalist Nurse

Specialist Physiotherapist

Specialist Occupational Therapist

Contenance Advisor

SPECIALIST NURSE

MS specialist nurses work in a holistic way and are often the fulcrum of the multidisciplinary team. Their roles are diverse and they must exercise high levels of judgement, discretion and decision-making in clinical care. The MS specialist nurse has been described as a "potential linkworker" in coordinating service provision for those living with MS. Such nurses use their knowledge, skills, experience and understanding of MS and its impact on the individual to determine what level of care is needed and to direct resources accordingly. By adopting an holistic, collaborative and coordinated approach, they can enable people with MS to achieve their maximal potential towards self management.

Specialist tele-triage skills

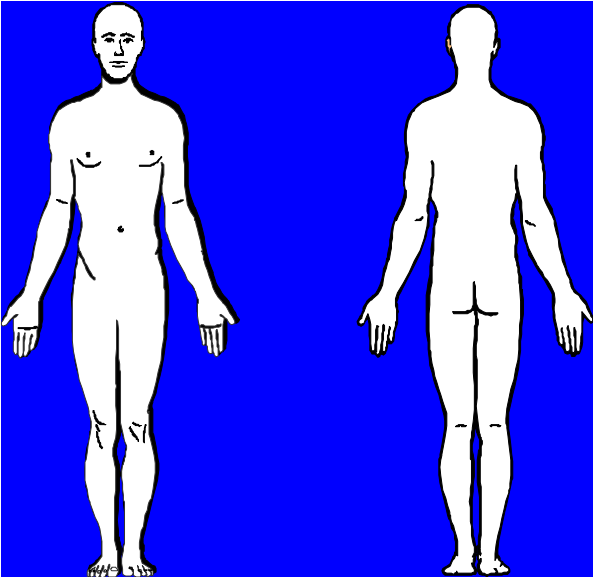
In addition to competence in clinical assessments specialist nurses must develop specific telephone communication skills which differ significantly from face-to-face interactions.

Tele-triage skills

- Active listening & detailed history taking
- Frequent clarifying & paraphrasing (to ensure that messages have been got across in both directions)
- Picking up cues (such as pace, pauses, changes in voice intonation)
- Offering opportunities to ask questions
- Offering advice and information
- Documentation

Specialist MS nurses can use **expert** clinical assessment skills to screen appropriate patients to clinics or direct them to other areas of support and treatment locally. Clinical assessment questions can be developed into a clinical care pathway document to help standardise the approach to evidence based practice. Box 9 contains a summary of potential key questions.

Box 9 Head to toe assessment

	<p>Useful visual aid to ensure all questions are asked and that 'hidden symptoms' are picked up</p>
<ul style="list-style-type: none"> ▪ History of current symptoms ▪ Effect of symptoms on daily function: home, work, family, caring role ▪ Assessment of hidden symptoms: mood, pain, fatigue, bladder/bowel, memory, cognition ▪ Psychosocial assessment: screening for low mood ▪ Impact of symptoms on others and assessment of social situation ▪ Infection screening ▪ History of steroid use, previous efficacy and side-effects ▪ Current medications ▪ General medical history ▪ Services currently accessed by patient in the community ▪ Need for referral to specialists at own site ▪ Support plan if patient's symptoms do not warrant treatment or patient wishes to self-monitor 	

Specialist Nurse Assessment in Outpatient Clinic

Following on from a tele-triage assessment the MS specialist nurse plays a pivotal role in face to face assessment of relapse within the outpatient setting. Key specialist areas are summarised as follows:

Introduce and explain the use of the MS impact scale - MSIS 29 to PwMS as a useful tool to assess impact of relapse on physical and psychological function

Interpret MSIS-29 score and summarise impact factors

Review history to detect any changes since tele-triage assessment (improvement of symptoms, deterioration, presence of new symptoms)

Assess physical and emotional presentation at clinic (does patient appear tearful/ depressed, unkempt, unsafe, socially isolated?)

Record baseline temperature, pulse, blood pressure

Perform urinalysis and follow algorithm to direct care pathway

Record blood glucose level as appropriate

Identify and prioritise need for multidisciplinary referrals and make referrals as appropriate.

Record assessment summary in medical records

Deliver verbal handover including baseline test results to neurologist

Deliver verbal and written handover to generalist nurse on patients deemed suitable for intravenous treatment.

Six week follow-up appointment

Interpret MSIS-29 score, compare and summarise

Assess and record patient's perceived efficacy of treatment (Do you think IV steroids worked for you? How would you rate your recovery? Do you have any residual symptoms?)

Assess and record any side effects experienced

NEUROLOGIST

The role of the neurologist in assessment of relapse is an important one. General aspects of the role include assessing the patient's presentation and history including previous steroid use and performance of a physical examination.

The guide below summarises the medical process in the acute relapse clinic and hopefully will provide a useful guide to the decision making process:

- The role of this clinic is not to reiterate an exhaustive history of the patient's illness from day one, it is designed to focus on the current acute episode. Nonetheless it is important to know how long the patient has had MS, its course and over the last two years, and the relapse frequency.
- Attention can then be turned to this relapse, its onset, tempo (worsening, plateauing or resolving) and of vital importance the effect on the person's function in all aspects of life: work, family and leisure. This cannot be overemphasised: a relatively minor weakness of a dominant hand can have a significant effect on a mother with a new born baby, but less effect on someone who has retired; being unable to walk 20m might make a big difference to a policeman, but be less important to an office worker.
- Also important is the response to previous steroid courses (has the disease become 'steroid-resistant'), the frequency of previous steroid courses and bone density status. In particular if a further steroid course is unlikely to be effective, this should be honestly discussed rather than 'trying again', with little chance of success.
- The side-effects of IV steroids are of course generally minor (see appendix 10), though the rarity of avascular necrosis should be mentioned. We have also seen one episode of severe abdominal pain and one acute severe depressive presentation – both ~1/500 patients.
- A full drug history is taken, with particular attention paid to disease modifying treatment (now eligible or need to change?), concomitant NSAIDS and excessive alcohol intake.
- A full neurological examination should be carried out particularly focussed on the affected functional system.
- Concordance model of prescribing outcome of assessment and decision reached – Offer IV steroids.
- Handover to MS Specialist Nurse
- Write prescription
- Dictate GP letter

GENERALIST NURSE

The role of the generalist nurse in MS relapse management is to cannulate and administer the intravenous infusion. The nurse should be deemed competent in cannulation and intravenous drug infusions working within local clinical governance infrastructures. The nurse must be aware of the side effect profile of intravenous steroids and perform observations and assessments. The generalist nurse should have access to specialist advice and an MS education programme from the clinical nurse specialist.

Receive verbal and written handover from specialist nurse Orientate to environment Provide information re procedure and answer questions Check patient identification and prescription as per clinical governance protocols Explain care of cannula and obtain written informed consent Insert cannula and administer treatment Explain out of hour contact procedures verbally backed up with written information.		
Day 1	Day 2	Day 3
Check that baseline observations have been completed Cannulate Administer treatment Observe for side effects Explain cannula care	Record observations Assess side effect profile Check cannula patency Administer treatment Observe for side effects	Record observations Assess side effect profile Check cannula patency Administer treatment Observe for side effects Remove cannula Book follow-up appointment Distribute MS relapse impact scale

SPECIALIST PHYSIOTHERAPIST

A person with MS identified as having a significant change in their physical function should be referred to a neuro-physiotherapist. The presence of the following changes in level of function should act as an alert to refer for urgent physiotherapy assessment and treatment:

- **Person reports an acute alteration in their level of mobility which impacts on their independence and / or safety.**
eg. person reporting a recent increase in the number of falls or reliance upon external assistance to enable them to walk
- **Person reports an acute alteration in their level of functional ability which is impacting on their ability to remain at home or work or manage with their current support network.**
eg. difficulty transferring on and off the toilet, difficulty feeding, inability to stand

The role of the physiotherapist in the relapse service is to:

1. Assess level of function/impairment and disability
2. Support and enable the person to maintain / regain safe and independent functional ability
3. Provide education and advice on self-management techniques to improve and/or maintain muscle activity, balance, joint range and mobility
4. Identify and discuss if any aids / equipment may be beneficial
5. To explore options for ongoing physiotherapy as required and make referrals to other disciplines as indicated

Assessment

The physiotherapy assessment aims to establish how symptoms may be impacting on the person's functional ability. Initial discussion identifies the person's previous functional ability and mobility. Any current/previous therapy input is also established. A physical assessment is undertaken as appropriate and modified according to symptoms and level of fatigue.

• Gait
• Functional activities:- lying/sitting, sit/stand, standing, stairs (if appropriate)
• Transfers
• Muscle strength
• Co-ordination
• Balance
• Sensation
• Spasticity / spasms
• Pain
• Fatigue / exercise tolerance

Outcomes measures are used as appropriate e.g. 10 metre timed walk, balance measures, Visual Analogue Scale.

SPECIALIST OCCUPATIONAL THERAPIST

Occupational Therapists support individuals to achieve participation in the daily activities that are relevant and meaningful to them. Referral to Occupational Therapy for further advice may be required when the performance of tasks has an impact on a person's ongoing ability to fulfil roles.

If individuals are seen at a tertiary centre, they may already have access to local rehabilitation teams and may be able to directly access this service themselves or be re-referred.

At the tertiary centre urgent slots are available where there has been a recent significant deterioration in a person's ability to perform day to day activities impacting on role performance.

Role of the Occupational Therapist

- Advising other team members on how to access equipment locally or local occupational therapy teams
- Analysis of activity performance
- Assist the individual to adapt the way an activity is undertaken
- Identifying environment modifications and equipment
- Educating and advising on appropriate alternative activities or occupations
- Assisting an individual to resume role and activity participation following a relapse
- Referral on to external agencies such as Social Services, Access to Work scheme, wheelchair service or local rehabilitation teams

Assessment may consider the following:

Self care

- Toileting and personal hygiene
- Bathing and showering
- Dressing
- Meal preparation
- Eating and drinking

Productivity

- Housework
- Shopping
- Child care
- Work role (voluntary or paid)

Leisure

- Home or community based activities

Environment

- Controlling local environment (use of phone, alarm, answering door)
- Community mobility
- External access to home
- Internal access to home facilities

CONTINENCE ADVISOR

Bladder dysfunction is a commonly reported symptom of MS; experienced in an estimated 75%¹⁷ and bowel dysfunction in approximately 50% of those with an MS diagnosis¹⁸.

Most bladder symptoms occur from a combination of neurogenic detrusor overactivity; which causes urinary frequency, urgency and urge incontinence, and detrusor sphincter dyssynergia, which can cause frequency and incomplete bladder emptying resulting in residual volumes that may lead to urine infection.¹⁹

Bowel dysfunction is less common than urinary dysfunction and can be more difficult to manage. Common symptoms reported are constipation and urgency; incontinence is a less common symptom but can understandably be extremely distressing.

When undertaking a MS relapse assessment it is valuable to assess the often hidden symptoms of bladder and bowel function. Some factors to consider when reviewing the person are summarised in Box 10 below.

Box 10 Factors to consider when taking the patient's history

- Characteristics of the incontinence/bladder problem, including the nature and duration of symptoms
- How the problem is currently managed
- Past medical, surgical and obstetric history, including drug history
- Bowel habit
- Nutritional and fluid intake
- Functional and cognitive abilities
- The person and/or carer's perceptions and expectations
- Effect on quality of life
- Social and environmental factors

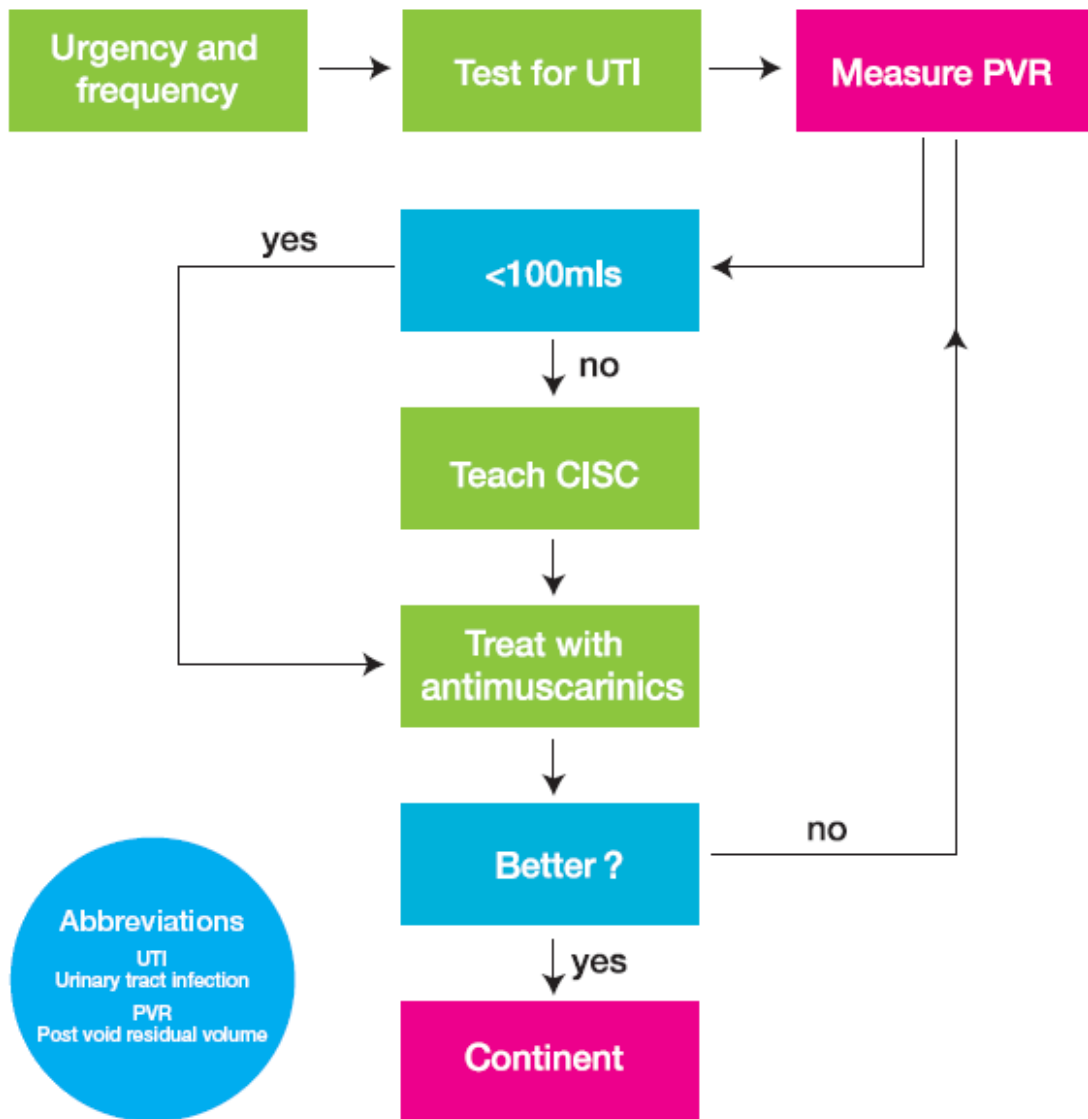
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If bladder symptoms are reported a referral to specialist colleagues for continence assessment is recommended. A range of treatments and management options for bladder symptoms is available including behavioural, pharmacological and surgical interventions.

Before initiating therapy it is vital that bladder emptying is assessed by measuring post-micturition residual volume; this result enables the specialist to recommend the optimum management strategy.

The UK consensus statement on the management of the bladder in multiple sclerosis sets out the recommended management of continence symptoms including urinary tract infection (UTI), post voiding residual volume (PVR), urodynamics and clean intermittent self catheterization (CISC).²¹

Further information regarding continence care can be accessed in the UK MS Clinical Care Manual 2006 (UKMSSNA).²²



From Fowler et al. ²¹

Bernadette Porter, Fiona Matheson, Jeremy Chataway and others.
Key steps to delivery of a person centred relapse service.
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