SPMN First One Day seminar.
Integrated services for clients with complex disabilities.

A hundred and seven delegates and delegates and over twenty commercial exhibitor staff gathered at the Dean Park Hotel in Kirkcaldy for the first SPMN seminar. Delegates represented a wide range of professional backgrounds, in keeping with the stated hopes of the new organisation.
Ten talks were delivered by thirteen speakers including the chair.

Alistair Murdoch, chair of SPMN, opened the day by welcoming all and setting the scene for the day.

Anne Brown, Anne Haddow, Caroline Hill.
What are complex needs: The carer view - problems & perceptions.

The opening presentations for the day came from the mothers of three young women with complex needs - Fiona, Jennifer and Gillian. We heard their individual and yet in many ways, similar stories of the difficulties encountered throughout their daughters' lives. All three have experienced the huge change that comes about after the transition from children's to adult services - the sudden loss of the therapy input and team approach that was so much a part of their daughters' lives during their school years. All three have come to understand the vital nature of postural management for their daughters and other young people like them. They presented us with their suggestion of how adult services should include:-

"a postural management team which would take a holistic approach to the assessment, delivery and monitoring of postural care for our young people. What we would like the team to do is –
1.Develop postural care pathways.
2.Monitor and review appliances and equipment and
3.To work with and train family carers and care staff in day, short break and residential establishments in the importance of postural management."

William Munro
Role of the Orthotist.

Mr Munro pointed out that Orthotists are actually quite a rare bred of healthcare worker (740 registered with HPC, compared to 15000 podiatrists). He described the role of Orthotics as protection, control, modification, correction and support for body parts and their function. He described a multi disciplinary practice depending also on Physiotherapists Nursing, OT, Podiatry, Rehab Eng, AND Rehab doctors.

He described a span of activity covering the spine, hips, knees, ankle and foot, and suggested that the most important role for Orthotists for patients with complex needs is often to slow down the development of a kypho-scoliosis.

With modern materials the success of Orthotics treatment can be improved, by striking a balance between maximum support or correction, and care for tissue viability.

With increasing use of Botulinum toxin for control of lower limb spasticity, there is an increasing role for Orthotics, and more advanced Orthoses, allowing measurement and recording of flexion and extension are now available. Multi-disciplinary working is required in these circumstances.
There is often inadequate importance placed on good foot and ankle stability, and earlier use of better Ankle foot Orthoses is important.

Challenges for the future include appropriateness of referrals to orthotic services, particularly for adults; adequate time and facilities for complex cases; adequate facilities for modern services; delivery of services as close to patients as possible; and coordination of increasingly complex services.

Anne Findlay
Role of Community Physiotherapy

This was a well-received and informative talk, which gave delegates food for thought. Anne opened her presentation with a brief description of the progress made by community physiotherapy for adults with a learning disability since these clients were relocated into the community following the closure of the long-stay hospitals. Ann also alluded to how the role has changed as improvements in survivability have lead to increased demand for the service from a growing number of adults. The roles of the community physiotherapist was characterised as ones to promote independence, enablement, comfort, prevention of deterioration and address the needs of carers. Community physiotherapists must be generalists in so far as knowing to whom to turn to in the turn to for onward referral or advice, and also treatment specialists. In respect of physical management, the role involves: maintenance of range of movement; setting of 24 hour treatment programmes; education of carers in the technique; equipment training; review; advocacy for resources. An example of the cross-disciplinary nature of the role was given using a case of severe flexion contracture in the lower limb, and how surgical and special seating interventions were used to enhance quality of life. Ann referred to various communications links including

Liaison Nurses and 'Passport' type manuals to inform of treatment aims and objectives. Overcoming difficulties in service provision at transition to adulthood was a key issue, as were: access to specialist facilities such as gym and hydrotherapy; research and funding; restrictions to postural management raised by health and safety concerns of care-providers.

Linda Blackie
Role of the Speech And Language Therapist

Linda began her presentation highlighting the number of speech and language therapists throughout Britain (10,000) and the different areas that they practice within (Education, NHS, Voluntary sector and Private practice).

She then discussed in some detail her role as a therapist in relation to communication. This entailed discussion regarding the different components of assessment, her aims of intervention and the types of direct and indirect treatment involved. Linda then spoke about her role within Education in relation to communication and how this involved training and use of sign and symbol work.

Finally Linda reported on her role in treating dysphagia. This involved highlighting the aims of the speech and language, the presenting problems of dysphagia, her aims and intervention as well as management and education.

Tracy Oram
The role of the Community Occupational Therapist.

The main aim of the community OT in relation to postural management is to meet an individual's needs within their home environment. This is achieved via:

1. the provision of equipment - where the aim is to provide continuity of postural support in all pieces of equipment
2. assessing for adaptations to current housing – where the aim is to allow appropriate access to all facilities within the home.
3. assessing for the need for re-housing – this includes assessing levels of medical priority for waiting lists, assisting clients with grants and provision of assessments for owner occupiers

Liaison with other agencies (housing associations, equipment providers, other professionals etc) is an important part of the process, as is an awareness of the Improvement grant system and the implications of spending public money.

Craig Kirkwood
Role of Clinical Engineering.

Dr Craig Kirkwood from TORT in Dundee gave a very humorous interesting insight of the role of the Clinical Engineer in the postural management of the person with complex needs. He firstly dispelled the myth that his role was one of a repair man and

went on to clearly identify his role as being one of design of specialist equipment to solve a seating problem. He went into detail of the 9 step design process, of recognising the need, defining the problem, planning the project, gather relevant information, conceptualise alternatives, evaluate the alternatives, select the preferred alternative, communicate the design and then implement the preferred option. He stated clearly that the problem with this was often this process was expected to be completed within the time slot of a clinical appointment not giving the engineer enough time to properly consider the all the alternatives for the problem presented to him.

Dr Brian Pentland
Rehabilitation Medicine-Interventions.

In contrast to when he trained, doctors training in rehabilitation do now receive a little training in postural management.
Doctors can practice inter disciplinary working, where they learn about other specialities.
Doctors have a knowledge of epidemiology, pathophysiology, the clinical course of a disease, radiological investigations including soon PET scans which assess function, surgical and drug treatments.
They can assess mental and emotional state.
They can control spasticity using drugs orally or using botulinum toxin or phenol injections.
Complex disability may be purely a physical problem or a physical and psychological problem.
These cases do not fit easily into categories, or into the managed clinical network concept, and this has implications when trying to get resources for them.
Rehabilitation services are patchy still, but when looking back to the Piercy Report of 1956 there has been enormous progress.

Lunch and Exhibition

AGM **Scottish Society of Rehabilitation**

Afternoon session.

Moira Dewar, Physiotherapist & Joyce Macdonald, Occupational Therapist
The Fife postural management Clinic.

Moira Dewar and Joyce MacDonald of the Fife Postural management team gave a very interesting perceptive on 24 hour postural management following the assessment process of a young woman referred to their service. This process involved an initial meeting to establish service involvement, then an assessment of sitting and lying, using a number of varied assessment tools so outcome could be measured. The postural management equipment on issue to the person was established. Specific identified areas of concern to her postural management were then prioritised by the team. A detailed risk assessment is carried out including moving and handling issues. It was identified that this is an integrated care package with a number of agencies involved with the provision of equipment support and advice for the family and carers. They feel their service is a good example of teams working together in collaborative practise for a common goal.

William Munro & Derek Jones
Case Study

Plenary session. Questions and answers

SPMN first AGM For minutes click here.