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A qualitative investigation into how physiotherapists currently review people with Multiple Sclerosis and their opinions of telephone reviews in this population

Item Type	Other
Authors	Condon, Marie
Download date	2026-05-13 00:35:20
Item License	https://creativecommons.org/licenses/by-nc-sa/1.0/
Link to Item	https://hdl.handle.net/10344/1515



UNIVERSITY *of* LIMERICK

O L L S C O I L L U I M N I G H

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BSc (Physiotherapy)

2011

A qualitative investigation into how physiotherapists
currently review people with Multiple Sclerosis and their
opinions of telephone reviews in this population

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PY4007 and PY4008 Final Year Project

Word Count: 5250



2.3 AUTHORS DECLARATION

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I, the undersigned declare that this project which I am submitting is all my own work and that the data presented is authentic.

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Acknowledgments

This project would not have been possible without the guidance and the help of so many people who in one way or another contributed and extended their valuable assistance in the preparation and completion of this study.

First and foremost, my utmost gratitude to Dr Susan Coote without whose knowledge and assistance this study would not have been successful.

Michelle and Carol, thank you for their unselfish and unfailing support and proof-reading skills.

To my friendly and cheerful group of classmates who helped me through the last four years provided never-ending “brainy” craic through the laughter, tears and stress of it all – I thank each and every one of you. I hope our friendships will continue to flourish outside the boundaries of UL.

Beyond physiotherapy (which sometimes seemed to be nothing more than a distant dream) my experience of UL would not have been so memorable without so many things: the college court experience with the Cooney’s, Lynchies, the gang and the Kilty shore crew, the green polo, the formation of bird watching society, spotting rugby players making it worthwhile to walk through campus, decent tunes, camoige, bounce or break, great housemates, the lodge and molls, house parties, 21st parties and more importantly pasta or milk-mixing after parties, the eventful trips to Cork, the more eventful return visits, Myrtle Beach and the introduction of the “top buzzers” into my life - “always on the beer”, our new recruits in 4th year – Maarrieee and Lia – dinner has never been so good, the hockey club the many lodgers I put up and people I have met over my stay in UL. The last four years have been totally shwayte!

I don’t think I would have made it through my final two years in college without Conor. He stuck with me despite being the less than ideal girlfriend, always making me laugh through to my grumbles and groans and constantly fitting his schedule around mine – Thank you (x)

I gratefully thank my grandparents for all their tuition at the “Farran School of Life” - hard work never killed anyone! Last but not least, I thank my parents for consistently supporting me throughout my academic studies.

Abstract

A qualitative investigation into how physiotherapists' currently review people with Multiple Sclerosis and their opinions of telephone reviews in this population

Authors: Marie Condon, Dr Susan Coote

Background: Guidelines recommend people with Multiple Sclerosis (PwMS) receive regular physiotherapy reviews (NICE, 2003). However little is known about how PwMS are currently reviewed. Reviews can be face-to-face, telephone or postal. The telephone is increasingly used to improve access to healthcare systems (Car, 2003). Yet no research is available on using telephone reviews with PwMS.

Objectives: To explore: (i) how physiotherapists currently review PwMS and (ii) physiotherapists' opinions of telephone reviews in this population.

Methods: Three focus groups were conducted with physiotherapists working with PwMS in urban (n=4) and rural (n=2) primary care settings and an acute hospital (n=3). Sessions were audio-recorded, transcribed verbatim and thematic analysis was performed.

Results: Physiotherapists conversed that reviewing PwMS is not regularly done due to service constraints and inconsistencies in patient review pathways. Despite this, service provision was enhanced mainly by MS Ireland. Telephone reviews were perceived as beneficial. However concerns regarding compromised quality of care arose due to loss of visual cues, patients' ability to self-report and confidentiality issues. Concerns were allayed somewhat if a reliable self-reporting patient was chosen, reviews were structured and based on function.

Conclusion: Physiotherapists are not regularly reviewing PwMS due to cutbacks in health services and problems with patient pathways. Due to the current economic climate further research is best aimed at refining patient pathways. Used appropriately, telephone reviews with PwMS have the potential to be beneficial. Further research is required to ascertain benefits in reality and to ensure the safety of telephone reviews in this population.

Keywords: Multiple Sclerosis, physiotherapy, review, telephone, current practice, focus group

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1. Introduction

Multiple Sclerosis (MS) is an inflammatory disorder of the brain and spinal cord in which focal lymphocytic infiltration leads to damage of myelin and axons (Compston and Coles, 2008). This can cause patients to experience physical, visual and cognitive deficits limiting activities of daily living (Freeman, 2001). MS can adversely affect an individual's quality of life and is associated with high costs for MS patients, their families, and society as a whole (Trisolini et al, 2010). Therefore services for this population need to be as effective and efficient as can be.

The average onset of MS occurs in the late twenties while life expectancy remains unaltered (WHO, 2008). The years of rehabilitation consequently required places a significant demand on health services across the lifespan, particularly in primary care and rehabilitation sectors (Coote et al, 2009). A Lansdowne Market Research report in 2006 found people with MS (PwMS) reported physiotherapy as their greatest need. Physiotherapy services however are limited and treatment duration is short as illustrated by concerning findings by Coote et al (2010). Similarly in the UK ensuring timely access to physiotherapy has long been an issue (Foster et al, 2011).

Clinical guidelines recommend PwMS should be reviewed regularly (NICE, 2003). Particularly those with severe impairments and dependency should have their needs reviewed at least yearly (NICE, 2003). Regular reviews promote pro-active disease management and are essential to produce better health outcomes, slow disease progression, reduce disability and improve quality of life (Department of Health, 2004).

Getting to physiotherapy clinics can be troublesome for PwMS due to their problems with fatigue, walking and mobility difficulties (Garrett et al, 2006). To improve access to physiotherapy, therapists must therefore strive to be as efficient as possible within their resources. Traditionally reviewing PwMS is conducted face-to-face with

a physiotherapist. Although guidelines propose reviews can include telephone or postal reviews (NICE, 2003) which may be more convenient to patients.

The telephone is a point of entry in many modern health care delivery systems (Car and Sheikh, 2003). Several common conditions can be managed via the telephone using established protocols to control cost, avoid unnecessary appointments and maximise efficiency (Allen-Davis et al (2002) cited in Haghight et al (2007)).

While TRs are more common among other healthcare professions, a small number of research studies on the use of telephone consultations in physiotherapy have been undertaken. Physiotherapists attained similar decisions regarding patient diagnosis when using telephone assessments compared to face-to-face assessments (Turner, 2009). Likewise when applying the Expanded Disability Status Scale to PwMS in different settings high correlations exist between telephone and face-to-face examination (Lechner-Scott et al, 2003). Patient satisfaction levels appeared comparable between both methods of assessment by physiotherapists (Taylor et al, 2002; Claytson and Woolvine, 2004).

Interestingly telephone consultations by other healthcare professionals were shorter in duration than face-to-face approaches (Pinnock et al, 2003; Roberts and Partridge, 2006; Wasson et al, 1992). Not surprisingly, the telephone appears to be more time efficient in managing continuing illnesses (James et al, 1994; Wasson et al, 1992) without clinical disadvantage or patient dissatisfaction (Pinnock et al, 2003).

As mentioned earlier, PwMS receive little physiotherapy, however what is not clear from the literature is what portion of this consult consists of review assessments and how clinicians view TRs in this patient group as a replacement for face-to-face reviews. This dichotomy has formed the basis for this research project.

2. Aims

This study aims to:

- (i) explore current practice in relation to reviewing PwMS and
- (ii) explore physiotherapist's opinions of TRs in this population.

3. Methodology

3.1 Study Design

Qualitative methodology orientated around a qualitative descriptive approach was undertaken. This allowed collection of a comprehensive summary of review happenings in everyday terms with a goal of improving practice through TRs (Sandelowski, 2000). This study design was chosen as most appropriate to meet the aims of the study. Phenomenology may not provide enough depth to explored ideas (Earle, 2010) and time constraints restricted the use of the constant comparison required for grounded theory (Hallberg, 2006).

Focus groups were deemed suitable to provide a deep holistic understanding of participant's reality of reviewing PwMS (Hollis et al, 2002) and to explore physiotherapists' perspectives of TRs. This method allows instant clarification of how and why participants think a certain way (Kitzinger, 1995). Focus groups were believed more suitable than individual interviews as information is more easily accessed (Kitzinger, 1995) and information-rich descriptions and ideas are generated in a non-threatening environment (Hollis et al, 2002).

3.2 Ethics

Ethical approval was obtained from the Clinical Research Committee of the Cork Teaching Hospitals.

Written informed consent (Appendix 8.5) was obtained from participants.

Participants' names were replaced with codes to uphold confidentiality.

3.3 Question Development

Questions were devised in conjunction with the principal investigator and recommendations by Krueger (1998) to investigate the aims of the study (Appendix 8.1).

A pilot study was conducted with four MS researchers to verify questions and give feedback on the actions of the novice moderator and co-moderator. Following this the moderator became more mindful to ensure all participants contributed equally.

3.4 Inclusion/Exclusion Criteria

Physiotherapists' who work with PwMS.

3.5 Participant Recruitment

Purposive sampling of physiotherapists working in an acute hospital and in urban and rural primary care settings was executed. It was anticipated different setting may have different opinions regarding reviews and TRs. A recruitment email (Appendix 8.2) and information letter (Appendix 8.4) were sent to the physiotherapy managers of the three settings by the principle researcher. These were subsequently circulated to physiotherapists working in the respective settings. Details of interested applicants were sent to the researcher to organise focus groups with physiotherapists who met the inclusion criteria.

3.6 Data Collection

Three focus groups were conducted, two were held in St Finbarrs' Hospital, Cork and one in Dunmannway Community Hospital, Cork during November and December 2010. Sessions lasted 45-80 minutes. Participants sat around a table with the researcher to facilitate a relaxed environment (Kitzinger 1995). Background information (Appendix 8.3) and informed consent were obtained from participants. Sessions were audio-recorded.

The researcher moderated discussions adhering to the questioning route to ensure all queries were covered (Krueger, 1994). Probes were used to promote discussion or clarity and ensure all members participated (Krueger, 1998). A co-moderator sat outside the group scripting the main ideas, group dynamics and body language. Focus

groups concluded with the co-moderator summarising the main points discussed, confirmed by participants (Krueger, 1994).

3.7 Data Analysis

De-briefing sessions between the moderator and co-moderator followed each focus group. These investigated and equated preliminary findings (Krueger, 1998). The moderator logged a reflective diary to certify conformability of results (Rolfe, 2006). Focus groups were transcribed verbatim by the moderator using Jefferson transcript techniques (Atkinson and Heritage, 1999) and reviewed for accuracy.

Theoretical thematic analysis was executed to identify themes in the social context there were reported (Braun and Clarke, 2006). The researcher became immersed in data by repeated reading transcripts (Braun and Clarke, 2006) and referring to co-moderator notes, reflections and debriefs. Initial codes summarised sentences. Codes were further analysed to derive inductive themes and subthemes. These were subsequently investigated for frequency, specificity, extensiveness and intensity (Krueger 1997).

On completion, transcripts were reread and themes were agreed with the co-moderator to ensure an accurate reflection of the data was presented. Member checking e-mails (Appendix 8.6, 8.7, 8.8) with the main findings from each group were sent to enhance validity (Morse et al, 2002). An audit trail (Appendix 8.9) of the research process enhanced transparency of data analysis (Huston and Hobson, 2008).

4. Results

4.1 Participant information

Subject	Years qualified	Work setting	Years in setting	% of caseload MS	Additional experience with MS	Confidence treating MS (0-10)
Focus Group U						(Pt = Patient)
U1	20	Urban Community	11	5-10 %	Yes	7
U2	10 MSc +	Urban primary care	3	25 %	Inpt, outpt, classes, palliative care	9
U3	6 + MSc	Urban Community	2	<5%	Acute inpts	7.5
U4	18	Urban primary care	11	15 %		7
Focus Group R						
R1	13	Rural community	6	2 %	Yes	5
R2	7	Rural Community	5 months	Minimum	Acute setting	7
Focus Group H						
H1	10	Acute hospital	5	20 %	Outpts for 5 years	7
H2	11	Acute hospital	3	10 %	Neuro job previous to current job	6
H3	7 ½	Acute Hospital	4 ½	1-2%	Acute inpts and outpts	5

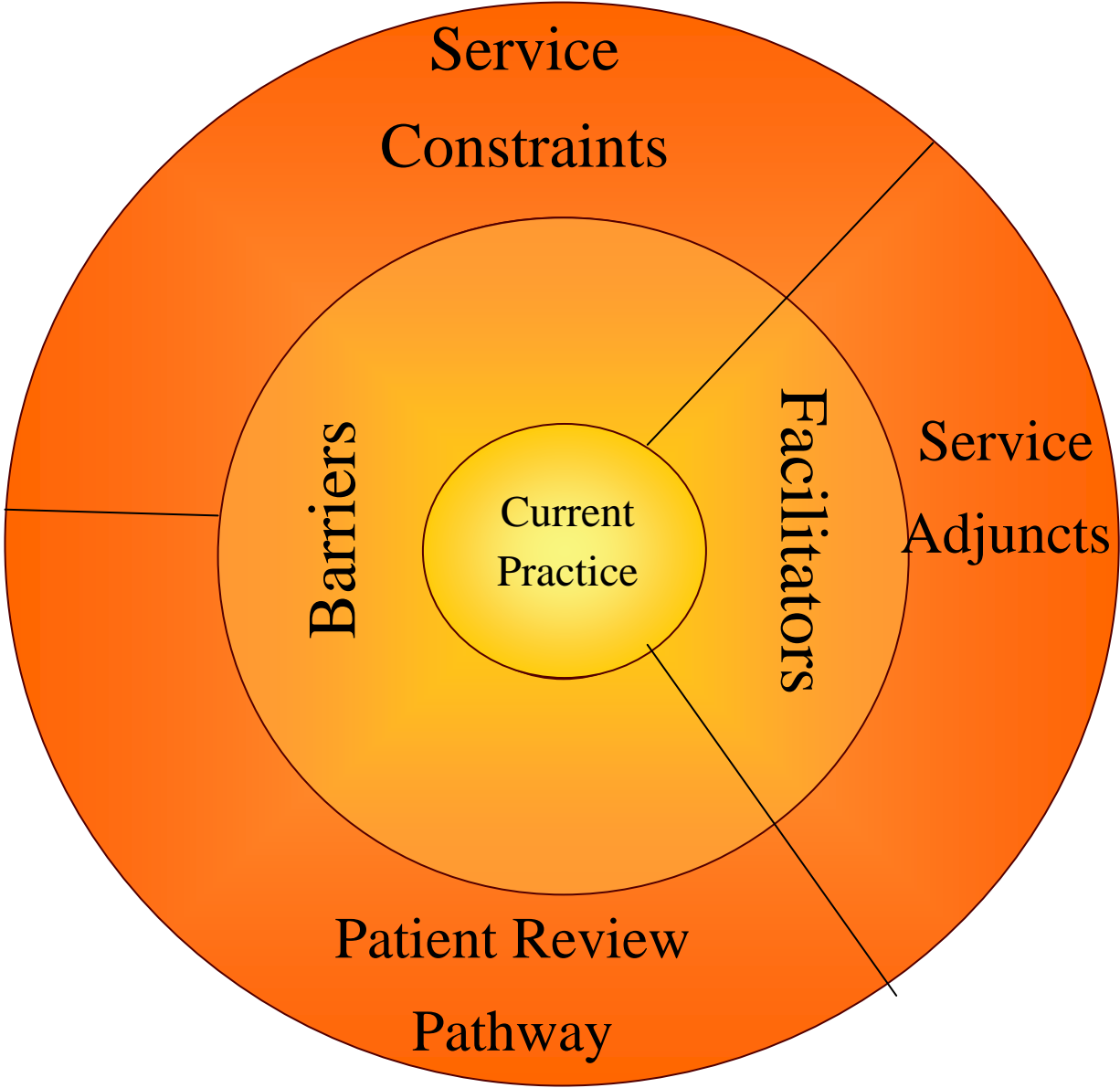
4.2 Group Dynamics

In groups R and U all participants seemed at ease with one another. There was a sense of camaraderie and participants appeared comfortable verbalising opinions and personal experiences. A more formal atmosphere was evident in focus group H. This appeared to be due to the lack of familiarity between participants. In groups U and H, two participants appeared more dominant than others and one was more dominant in group R. These participants had predominantly higher levels of experience and MS caseload which may be contributing factors. Prompting and increased eye contact was used by the moderator to ensure all members expressed their views. Different viewpoints were expressed and respected by all participants.

4.3 Findings of Current practice of reviewing PwMS

Physiotherapists' reported reviewing PwMS is not regularly performed at present due to two central themes; barriers and facilitators (Illustration 1). Service constraints and patient review pathways were frequently and extensively discussed as barriers to reviewing PwMS. Service adjuncts were found to facilitate a more effective review service and decreased the need for more regular reviews by increasing service provision to PwMS. Themes are presented in detail below with accompanying quotations reflecting the context in which they arose.

Illustration 1: Opinions of Current Practice of Reviewing PwMS



4.3.1 Barriers to Reviewing PwMS

- Service Constraints

Cuts in the healthcare resources have a strong influence on physiotherapist capacity to review PwMS. This was discussed extensively by all participants. Therapists reported negative effects on service provision due to limited time and staffing cuts, as intensively discussed by one participant in group U.

“...not appropriately staffed...it is very hard to call them up when...you can’t offer them an appointment so a strategy for coping...is sometimes not to phone them and that’s NOT something I’m proud of.” (U1 P6)

“...time to review those patients has just been cut to next to nothing.” (H3 P12)

- Patient review pathway

Problems with pathways for referred PwMS for reviews extensively and frequently came into discussion among all participants in groups U and H and one participant in R. Self-referral and inaccurate referrals were intensively and specifically conferred.

“...in theory we are trying to be responsive but you are kinda depending on that person to contact you and that’s probably where a lot of people are falling into cracks.”(U2 P7)

4.3.2 Facilitators to Reviewing PwMS

All participants were aware of the importance of regular reviews. Despite service constraints, service provision to PwMS and reviews are enhanced through adjunctive services. This topic was not discussed in as great depth as the barriers indicating more barriers than facilitators are present.

- Service Adjuncts

Service adjuncts specifically exercise interventions provided by MS Ireland facilitate increases in service provision to PwMS. This subsequently decreases strain on physiotherapists by reducing the need for more frequent reviews and targeting reviews at those who need them most. This was uttered frequently by all participants in group U, two participants in H and one participant in R.

“I saw him with the exercise buddy initially...because of that I haven’t got back sooner...that’s fantastic...that’s somebody we don’t have to worry about...” (U4 P15)

“...exercise classes are a great way...of reviewing your patients...you can eyeball people...pick them out...then feed them into a review system” (H2 P30)

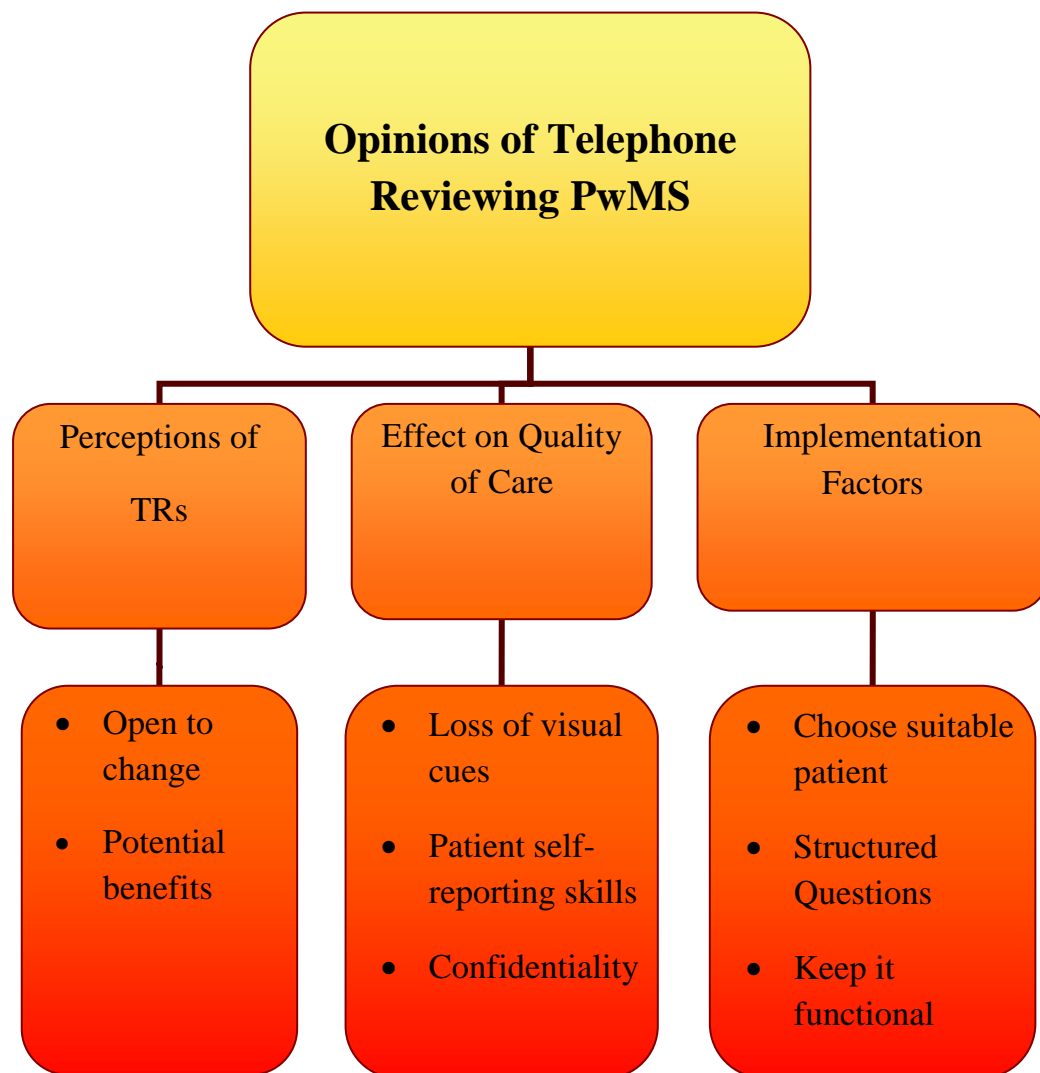
Two participants in group U discussed developing a “*passport of care*” or “*care package*” to facilitate improvements and co-ordination in service provision as previously experienced in different settings.

“...when you’re pregnant you get this care pack...co-ordinated between your consultants and your community side of things...as a patient she was easy to deal with just because she forgot the name of someone, everything was there.” (U1 P76)

4.4 Findings of Opinions of TRs with PwMS

Three main themes emerged from focus groups regarding opinions of TRs (Illustration 2). Most frequently and extensively discussed were their perspectives of TRs and potential negative effects to quality of care (QoC). Implementation factors could possibly limit these off-putting outcomes. Themes are presented in detail below with accompanying quotations reflecting the context in which they arose.

Illustration 2: Physiotherapists opinions of TRs in PwMS



4.4.1 Perceptions of TRs

- Open to change

All participants indicated an attitudinal willingness to embrace the idea of change towards TRs. One participant strongly disagreed originally but altered her consistency after further discussion; therefore participants' perceptions may have been skewed from participating in the focus groups. Therapists in urban areas appeared most open to providing TRs to PwMS illustrated through the intensity of their comments.

"Ya! Definitely I think there is a place for it in MS." (U4 P27)

- Potential benefits

Despite this openness, a comprehensive discussion was carry out by the bulk of participant's regarding the pros and cons of TRs. The overall benefits to the therapist outweighed the disadvantages.

"...It seems like good use of time alright...that did help in paediatric setting for you." (R1 P19-20)

Two participants in focus group H briefly discussed benefits of TRs to the patient.

"...it would cut down the amount of times they would have to come in." (H1 P16)

4.4.2 Effect on Quality of Care

- Loss of visual cues

Loss of visual cues and the ability to "eyeball" a patient is a major drawback of TRs compared to face-to-face reviews. This was frequently discussed by the majority of participants with one member in particular speaking intensively on the topic.

“...you miss the use of a gait aid...are they safe with their gait aid...are they using the rollator and abandoning it and going to last five steps into the chair?” (U4 P35)

- Patient self-reporting skills

The absence of visual cues heightens the importance of a patient’s ability to accurately describe their condition. With cognitive problems associated with MS the verbal information may not always be reliable. All participants in all groups spoke frequently and intensively about the problems associated with of in-accurate reporting skills.

“...cognition and insight...that is probably the biggest kinda of grey area I would have around very subjective, am, interviews, because they may or may not be worth nothing to you.” (H2 P18)

“...it’s the people that are living along with MS with cognitive impairment of which...I would be quiet concerned about and that’s when the telephone review system...all falls apart.” (U2 P22)

- Confidentiality

All participants in group U and R repeatedly aired concerns regarding compromises to confidentiality through the use of TRs. In the urban setting this was discussed in relation to patients in the clinic overhearing the physiotherapist on the telephone.

“... patients would ring me so generally I am with a patient so that’s, I suppose there would be issues with confidentiality and stuff...” (U3 P31)

One physiotherapist in group U specifically revealed confidentiality worries with mistaking identity on the telephone as she previously experienced.

“...it has happened where sometimes you think you are talking to one person while in fact you’re not talking to the person you think you are” (U1 P31)

In the rural setting, confidentiality was discussed more frequently in relation to people around the patient overhearing the TR. This may effect the information patients discloses.

“Having you know a relative there that they don’t want to talk honestly...or home help. Would they want to say they are worse than they are?” (R1 P29)

4.4.3 Implementation Factors

Awareness of the potential effects to QoC enabled a more directed discussion of practical solutions to overcoming these when implementing TRs.

- Choose suitable patient

Knowing the patient and their suitability to the telephone as a mode of review was described as paramount if using TRs. All physiotherapists unanimously agreed upon this, frequently and extensively returning to the topic.

“...[They have to] have a good, a good perception of where they are...they aren’t overly optimistic but yet they are not negative either...” (R1 P22)

“...you would use you own judicious choice and say defiantly wont, you know, won’t be getting Mary on the telephone but defiantly talk to you know Sally. You know? And cherry pick who is appropriate for that type of review” (H2 P17)

All groups extensively agreed upon that physiotherapists would not feel confident reviewing other therapists' patients they didn't know over the phone. Therefore "*continuity of care*" is essential.

"...you wouldn't be comfortable really taking over someone else's caseload and review by telephone..." (U2 P79)

One participant frequently referred to the idea of profiling patients for reviews to determine their suitability for TRs.

"I am happy with the answers they have given me and their profile repeats that...good indicators that what they are telling me is accurate....Whereas another patient might give us the identical answers but the profile...isn't reliable." (U1 P58)

- Structured questions

Each group frequently highlighted if implementing TRs, a structured design would be required to avoid missing relevant information. An open format would be necessary to draw out new or changed symptoms or situations.

"You could maybe do a tick list for you know the big pain, function kind of things... and some open questions...to draw out any other problems...make it more standardised." (H1 P28)

In two different focus groups one participant believed giving questions to patients before TRs may help their ability to self-report.

“...say these are the questions I will be asking you the next time I ring you so... I want to know about transfers...how many times you’re getting out of the house a day...”
(U1 P50)

- Keep it functional

The content of the phone review was widely agreed upon, in all groups, to be based around function as all patients can relate to it. Again this may increase their ability to reliably self-report.

“I would just relate it to function. Because even the bright people aren’t even gonna know whether they’re, is their hand 90 degrees contracted” (R2 P24)

The functional content would have to be flexible to deal with differences among patients.

“We could have a list, maybe a working list of 50 questions and...that we can edit that down for any individual.” (U1 P49)

5. Discussion

5.1 Current practice of reviewing PwMS

This study delivers a valuable understanding of how and why physiotherapists' are not currently reviewing PwMS. It is evident that physiotherapists are not using available resources such as TRs to review progress. While they hold a vision of regular reviews, this is facilitated by adjunctive exercise interventions. This however is sharply contrasted by the current reality of service constraints and loosely organised review pathways acting as barriers to reviewing PwMS. The first aim of this study was only briefly met as reviews are not regularly done. Further in-depth discussion was consequently directed at why physiotherapists were not currently reviewing PwMS.

Participants in all groups recognised the importance of regular reviews for PwMS as recommended by NICE guidelines (2003). This study conversely recognised that according to physiotherapists in included urban, rural and acute hospital settings reviewing PwMS is a “*luxury*” and not regularly performed. This is supported by an investigation into perceptions of PwMS regarding physiotherapy services in Donegal. The majority of participants (68.7%) reported having no appointment arranged for the future (Buckley et al, 2008). These conclusions are however contradictory to quantitative results by O'Donovan and Coote (2011) which investigated current practice of physiotherapists treating PwMS. In their findings the highest proportion of physiotherapists reported reviewed PwMS every six months. These studies were conducted with different cohorts of physiotherapists, which may account for variations in reviewing practice. Clarity of this topic could be established through national study combining quantitative and qualitative methodology.

Service constraints mainly non-replacement of staff and a subsequent reduction in therapist time were identified as limiting factors for reviewing PwMS. There was strong agreement on this topic, highlighted by the frequent and extensiveness of discussions generated. These constraints are no surprise considering the budgetary

cuts publicised for the healthcare system in recent years (Carney, 2010). The impact of this was highlighted by Houston (2011) who stated rehabilitation services have been significantly reduced to the point where those with neurological illness are provided with less community support.

Physiotherapists linked inconsistencies in patient review pathways as a limiting factor for reviewing people with MS. The prominence of the topic in group U may be due to participants' accumulating the largest percentage of MS caseload and therefore have more patients to review. Buckely et al (2008) found no link between initial referral for physiotherapy and subsequent referrals pointing towards a lack of a model for re-referring PwMS for physiotherapy reviews. Regrettably there is a paucity of evidence published on clear and concise models for referring PwMS for physiotherapy reviews. NICE (2003) recommend health care professionals and patients agree on a suitable interval and method of review at the end of an episode of care. This was not presented as well-established current practice.

Access to rehabilitation services can be increased through open-referral and self-referral systems (Maheswaran and Davis, 1998; Andreassen and Wyller, 2005; NICE, 2003). Findings by Andreassen and Wyller (2005) discovered with self-referral for in-patient rehabilitation, many stroke and MS patients did not fill out applications for rehabilitation themselves nor were aware of the grounds for the application. This indicates that an entirely autonomous referral procedure may not be realistic for patients with these disabilities. Similarly, this study emphasised cognitive ability and poor safety awareness in PwMS can reduce attentiveness to self-refer. Open-referrals have the potential to be inappropriate for rehabilitation services, reducing services' effectiveness (Maheswaran and Davis, 1998). Inappropriate referrals were also highlighted in this current investigation. Both this study and Andreassen and Wyller (2005) recognised that several patients would not receive access to rehabilitation without these open-referral systems. There is considerable scope to improving referral pathways in physiotherapy for reviewing PwMS. One participant frequently discussed the idea of profiling patients to suitable type of reviews. There is a paucity of

evidence regarding review methods and if one is more effective over others for different groups of PwMS. Further research is therefore needed on the topic.

Service adjuncts mainly, exercise interventions introduced by MS Ireland significantly increase services provided to PwMS. These can reduce the need for more regular reviews. It also relieved the “*guilt*” therapists experienced due to the limited service they provide to PwMS. Insufficient research is conducted primarily on this topic however we can draw from studies which explore it indirectly. PwMS in studies by Toomey and Coote (2010) and Condon, O’Keeffe and Coote (2010) reported restricted access or non-existence of physiotherapy services for PwMS prior to the introduction of the Getting the Balance Right (GTBR) programme. A follow-up study to the GTBR programme also found participants received the majority of physiotherapy from the MS society or received no physiotherapy Condon, O’Keeffe and Coote (2010). The greater part of the largely biased respondents agreed the Health Service Executive should run GTBR classes. In this current investigation, participants reported exercise classes were beneficial in decreasing the need for regular reviews and helping direct reviews at those who need them the most. This could potentially be a means of increasing service provision to PwMS and making the review service more effective.

5.2 Physiotherapists’ opinions of TRs in PwMS

This investigation reveals this collection of physiotherapists consigned generally positive perceptions of adapting to TRs for certain PwMS. Participants were wary of providing TRs due to potential compromises in QoC. Physiotherapists agreed ways of implementing phone reviews to minimise negative impact to QoC.

Knowledge gleaned from different healthcare professions found review telephone assessments more time efficient (James et al, 1994). Pinnock et al (2003) reported TRs augmented the quantity of asthmatics reviewed. Similar to MS, asthmatics have a chronic condition requiring long term management. Participants of this study

compatibly believed TRs could save time for physiotherapists. Wasson et al (1990) conducted a trial where telephone calls substituted GP clinic visits for patients with chronic conditions. The intervention found TRs a beneficial uses of resources. The project was repeated in a different GP setting by Welch and colleagues (2000). Results found no impact on the number of clinic visits without authors being able to justify why. This indicates much further information is required regarding telephone care for each disorder in each setting. Results therefore may not be able to be extrapolated to the MS population.

TRs were discussed as a valuable tool for reducing patient's visits to the physiotherapy department. A qualitative study by McKinstry et al (2009a) on telephone consulting in primary care found this was the main reason telephone consultations were used by rural GPs in the UK. TRs were also a successful way of identifying patients who require face-to-face reviews to avoid unnecessary trips to outpatient departments (Brough et al, 1996). This enabled resources to be better targeted at those who required intervention three months post-transurethral prostatectomy and could similarly be applied to physiotherapy.

Loss of visual cues by adapting to TRs was not surprisingly discussed extensively when reflecting over former research. This safety concern is in harmony with themes outlined by McKinstry et al (2009a). A retrospective case review investigating legal cases of medical malpractice due to telephone consultations claimed injuries have potential to be catastrophic (Katz et al, 2008). These findings, despite methodological limitations, heighten awareness of risks when patients present medical complaints on the phone.

Confidentiality relating to overheard conversations was explicitly explored in all groups as an issue that may affect QoC in TRs. This was correspondingly discussed by McKinstry et al (2009b) when his team investigated confidentiality and the use of the telephone. Identification error was also considered a potential problem in both

these current focus groups and by McKinstry et al (2009b). Research by Patel et al (2005) identified this as sloppy practice. While Sokok and Car (2005) found identification error could be limited through the simple yet stringent use of a password to improve security.

Participants in all groups expressed concerns regarding the reliability of patient self-reported symptoms. This was expected considering cognitive loss occurs in about half the PwMS (Chiaravalloti and DeLuca, 2008). Mohr et al (2000) excluded PwMS with major cognitive deficits from telephone implemented cognitive behavioural therapy because this deficit was assumed to interfere with accuracy of self-reported information required for outcome measures. Lechner-Scott et al (2003) however looked at cognitive deficit when comparing the EDSS administered over the phone and through neurological examination. No difference in agreement was found in those with cognitive deficits compared to those without indicating accurate self-reporting skills. Yet it must be noted only one patient had severe dementia.

All three focus groups strongly agreed the potential threat to QoC would be enhanced by the therapist knowing and choosing only appropriate patients. This was illustrated by the frequency and extensiveness of discussions. Continuity of care was believed to enhance safety with GP telephone consultations (McKinstry et al, 2009a). However there is no sound empirical evidence to date that knowing the patient improves telephone safety. Katz et al (2008) reported having no prior knowledge of the patient led to 28% of medico-legal cases. Likewise McKinstry et al (2009a) alluded to the idea that there may be a potential paradox in familiarity which may reduce safety. Health care professionals may make assumptions and take chances with patients they know, while they may not with patients whom they don't have a familiarity with. Again there is no evidence on how to know if someone is suitable for a TR. Although the idea of profiling suitable patients based on their previous reliability self-reporting symptoms was indicated by participants in this study, further research is needed to clarify how to profile patients.

Structure was believed to be an important factor if implementing the TR system. This was also deemed important by Katz et al (2008) who reported lack of protocols for managing telephone calls has led to many medic-legal cases. A variety of open questions with a check list of the content to be covered was recommended. Such a structure described is similar to that outlined by NICE (2003). Consisting of a mixture of open questions and a list of activities and impairments which should be questioned when appropriate, this structure may be a useful tool if developing an algorithm for TRs.

Function was advocated to be the core content of TR by all groups. Unfortunately there is a dearth of research on what reviews should comprise of. NICE guidelines (2003) again put an emphasis on asking around activity and impairment domains. Linking back to O'Donovan and Coote (2011), they found asking around current problems was the most commonly reported part of subjective reviews. No account was given whether current problem were asked at an impairment, activity or participation level, making it difficult to equate results.

5.3 Methodological Limitations

A limitation inherent to qualitative research is its vulnerability to change. These present results are only valid under the circumstances and time which they were obtained (Denzin and Lincoln, 1998). Similarly opinions voiced are specific to participants therefore results are not absolute for the whole physiotherapy population (Kitzinger, 1995)

The inexperience of the moderator and co-moderator may have influenced their ability to collect and analyse data particularly regarding the first study aim. Pilot focus groups helped familiarisation with conducting sessions and presenting findings to

participants helped validate findings as outlined by Krueger (1994) and Morse et al (2002) respectively.

5.4 Implications for Future Practice

This study outlines recommendation for future research throughout the discussion. On the whole PwMS are not regularly reviewed by physiotherapists. Given the economic climate placing service strains on physiotherapists, the patient review pathway may be a more realistic barrier to tackle to increase reviews. Further research is required to ascertain the most suitable and time effective method for reviewing PwMS. Results of this study advocated exercise interventions as a review facilitator. Therapists should be cognisant of this benefit and utilise it when organising reviews or exercise interventions to improve services to PwMS.

Overall TRs were perceived to be beneficial for physiotherapists' reviewing PwMS. To uphold QoC during TRs, physiotherapists must be mindful of patients' ability to self-report and potential compromises to confidentiality. Structured functional questions and the use of a password may limit these dilemmas. Further research is required to assess the cognition ability required by a patient to actively participate in a TRs. Additionally the views of PwMS regarding telephone reviews should be compared to physiotherapists' views.

6. Conclusion

This study aimed to investigate how physiotherapists currently review PwMS and their opinions regarding telephone reviewing this population.

Results revealed PwMS are not being currently reviewed by physiotherapists. This is due to barriers posed by service constraints and patient review pathways. Despite these limitations, participants illustrated an awareness of the importance of regular reviews. Exercise interventions mainly provided by MS Ireland were seen to facilitate service provision and decrease the need for more regular reviews to PwMS. As physiotherapists, we have the duty to review these patients under our care. We therefore have to strive to improve our capacity to review them. This could be achieved through enlarging exercise interventions and investigation ways to improve review pathways.

Participants were receptive towards TRs due to their potential to enhance access to physiotherapy by saving time for the therapist and travelling for the patient. Results emphasise the potential effect on QoC worrying clinicians. Participants' concerns were lessened by if a structured and functional approach using only suitable PwMS was undertaken. Despite these recommendations further exploration is required to certify the benefits and safety of TRs, the suitability of TRs to specific patients and patients' views of being telephone reviewed.

No funding was received for this project.

The author would like to declare that no conflict of interest arose in this study.

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8. Appendices

8.1 Questioning Route

Opening Questions	<p>1) What experience do you have treating people with MS and</p> <p>1a) what portion of your case load is MS.</p>
Introductory Questions	<p>2) How often do you review your MS patients?</p> <p>3) How do you decide when to review your MS patients?</p> <p>4) What do you assess when reviewing MS patients? / Why do you assess that?</p> <p>5) How do you decide if the patient needs treatment? / What do you base it on?</p>
Transition Questions	<p>6) What do you think are the barriers to reviewing MS patients?</p> <p>7) What do you think of telephone assessments? Have you heard of them or have you ever used them? / Are they effective?</p> <p>7a) What do you think you could assess over the telephone? / Where did you hear of them being used? Why would you not consider it?</p> <p>Why is face to face so important? / What could a telephone assessment miss that face to face wouldn't?</p>
Key Questions	<p>8) Would you consider reviewing MS patients over the telephone?</p> <p>9) If you were to consider telephone assessments what would you consider to be the essential aspects to assess?</p> <p>10) What outcome measures would you use to consider if the patient needs treatment or not?</p> <p>11) What information gained by phone would you use in deciding to treat or not to treat?</p> <p>12) Could only a physio do the review or could a lay person? / Do you need lots of clinical experience to a telephone review?</p> <p>13) What is the best balance between reviewing and treating? Which is more appropriate? How do you find a balance between treating and reviewing?</p>
Closing Question	<p>14) Are there any other comments?</p>

8.2 Recruitment email

Dear Liz, Eileen and Gay,

As you are probably aware we have a number of projects looking at various physiotherapy interventions for people with MS ongoing at UL.

One of the current 4th years, Marie Condon, is doing a project around follow up or review assessments for people with MS. Her aim is to investigate what is going on currently, what the basis for that is, and what physios opinions are of the possibility of using telephone assessments for review. We have obtained ethical approval for the study from the HSE South committee.

We had some early discussions with Jamie and Eileen regarding investigating this in the PCCC team, but would ideally like to extend this to CUH and West Cork too.

I attach the information leaflet for the study, which essentially involves an hour of your physio departments time sometime between now and December, at a time that suits you, perhaps tagged onto the end of a staff meeting or in-service time??

I would be really grateful if we could conduct a focus group with 4-6 physios in your department who are involved in the management of people with MS.

If you have any further questions let me know,

With thanks

Susan

Dr Susan Coote, MISCP

Lecturer

Department of Physiotherapy

University of Limerick

Limerick

+353 61 234 278

8.3 Background Information Sheet

Please fill out the following questions:

Name: _____

Email Address: _____

Place of Work: _____

How long are you in this job: _____

How long are you qualified as a physiotherapist: _____

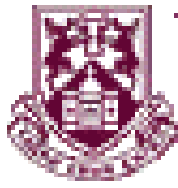
Any additional qualifications/masters/postgrads: _____

What percentage of your caseload is MS: _____

Have you any previous experience working with people with MS: _____

How experienced do you feel you are working with people with MS on a scale of 0 to 10 with 0 being not experienced at all and 10 being an expert:

0	1	2	3	4	5	6	7	8	9	10
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Participation Information Sheet

Title of Study:

A qualitative investigation into physiotherapy review assessments of patients with Multiple Sclerosis and opinions of telephone reviews in this population

Introduction:

Clinical guidelines recommend patients with MS are reviewed regularly. Traditionally reviewing patients is conducted face to face with a physiotherapist. Recent evidence has shown telephone assessments to be effective reviewing patients in the areas of musculoskeletal problems, respiratory problems and radiotherapy. The aim of this study is to explore how and why MS patients are currently being reviewed, how decisions to treat or not to treat are made, and to explore physiotherapist's knowledge, attitudes and ideas regarding telephone assessments.

Procedure:

If you agree to participate you will attend a focus group at a time and venue suitable to your department members. Focus groups, which are essentially recorded conversations, are aimed at generating discussions among physiotherapists with similar experiences. A researcher will be present to direct questions on the topic. There will be two tape recorders in the room so that the researcher can listen actively and engage in the discussion without having to write everything down. There are no right or wrong answers to the questions that are raised in the group; therefore you should feel to express your opinions and experiences. At the end of the focus group

session you will be asked to confirm the main findings of the focus group. Once the data has been analysed, results will be e-mailed to you to confirm that the identified themes are accurate. Your participation will last approximately an hour.

Benefits and Risks:

There are no anticipated risks to the participants. No direct benefits will be gained either, although you will be furthering the research in this area and contributing to the development of physiotherapy services for people with MS.

If you do not wish to disclose any information, you can keep it to yourself or discuss it with the researchers afterwards. You can leave the focus group at any time you wish.

Confidentiality

Each participant will be assigned a code when analysing data, so your anonymity will be maintained also, summarized results will only be reported. We will not disclose any information that can be identified with you, nor connect your name to any information we present. All information will be confidential within the research team and we will emphasize that all information shared within the group would ideally remain within the group. Your participation within the study is **completely voluntary** and you may withdraw at any time without giving any explanation.

If you have any questions regarding the study please feel free to contact any of the research team:

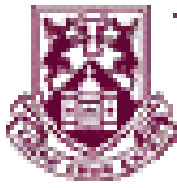
Dr. Susan Coote: susan.coote@ul.ie Tel: 061-234278

Marie Condon: 0732109@studentmail.ul.ie

If you have any concerns about this study and wish to contact someone independent, you may contact:

The Chairman of the Clinical Research Ethics Committee of the Cork Teaching Hospitals at Lancaster Hall, 6 Little Hanover Street, Cork. Tel: 021 4901901

8.5 Participant Consent Form



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Participant Consent Form

My signature indicates that I have read and understood the participant information sheet. All my questions regarding the project have been answered satisfactorily. I am fully aware of my role in participating in this study. I know my participation is voluntary and that I can withdraw from the project at any stage without giving reason. By signing this consent form I am giving permission to be audio-taped and the results to be used as part of this study.

Signature of Research Participant

Date

Printed Name of Research Participant

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

8.6 Member Checking Email Group U

Hi All,

I would greatly appreciate it if you could read the summary below of the focus group and confirm I have written a true interpretation of your views as a group. If I have left something out please do not hesitate to let me know. I can be contact on the following email address: 0732109@studentmail.ul.ie

Kind Regards,

Marie Condon

4 people attended the session held at St Finbarr's Hospital, Cork on 16/11/2010. The session lasted approximately 1 hour and 20 minutes.

The main points that arose are:

Section 1: MS Patient Reviews

Current review practice:

Reviewing not currently done or a "luxury" – due to lack of staff and time

Review referral sources: PHN, MSI, CUH, GP, patients/physio(swinging door)

Review options discussed at the end of an episode of care by one participant

Regular reviews are important and ideally would be reviewing more

Service Constraints

Cuts in staffing, non-replacement of staff

Decreased time by therapist

Long waiting lists

Everything has to be very worthwhile

Review Pathway Problems

No structured review pathway leading to problems

Inaccurate referrals

How efficient can a patient with MS be to self-refer, especially with cognitive problems?

Service facilitators

MSI advocating for people with MS

Getting the balance right and exercise buddies lessening “guilt” of physios and increase service to people with MS.

Carmel Coughlan talked at MDT to PHNs to improve accuracy MS referrals

Passport of care – package with all MDT involvement for patients to bring to all service input info, patient to be responsible for it

Section 2: Telephone reviews

Perceptions of telephone reviews

Open to idea of developing formal telephone reviews. Majority of participants have prior knowledge of using informal/unstructured telephone reviews.

Could save time

How useful is the information gained over the phone? Will it change treatment?

Safety consideration with phone reviews

Patient cognition – is the info you are receiving accurate and reliable?

Who do you talk to? Patient/carer - consent issues if talking to carer

Confidentiality - If patient in department, they would over hear conversation

Missing seeing function, safety and “subtle” things in MS

Implementing phone reviews

Know your patient – will be individual to them

Pick them appropriately – depending on cognition and social support.

Requires clinical experience by physio

Could give patient questions prior to review e.g. with HEP at end of episode of care

Structured questions/algorism and open questions that can be tailored to individual patients

Profile patients suitable for phone reviews based on reliability/accuracy of info they give you initially, DNAs, physio needs

8.7 Member Checking Email Group H

Hi All,

I would greatly appreciate it if you could read the summary below of the focus group and confirm I have written a true interpretation of your views as a group. If I have left something out please do not hesitate to let me know. I can be contact on the following email address: 0732109@studentmail.ul.ie

Kind Regards,

Marie Condon

Three people attended the focus group help at St Finbarr's Hospital, Cork on 22/11/2010. The session lasted approximately 45 minutes.

The following is a summary of the main points:

Section 1: MS Patient Reviews

Service Provision:

Reviewing is currently a "luxury"

Used to perform 6 month follow ups in CUH, now mostly refer to primary care

Ideally patients should be reviewed regularly, have longer review periods, and exercise class participants should be followed up on

Service Constraints:

Used to provide exercise class, no longer run due to cuts and non-replacement of staff

No time to review patients

Currently giving patient idea of how long intervention will last as physios have limited time due to decreased staff

Review Pathway:

Consultant referrals initially – patients almost always referred for physio but referrals are very generic

Depends of patient and clinical decision thereafter

Service Facilitators:

Exercise classes could be used to pick out people who need reviews/extra intervention
“Getting the balance right” and other community based exercise interventions for MS are excellent

Section 2: Telephone reviews

Opinions of phone reviews:

Would be useful with certain patients if doing long term reviews to cut down times patient has to come in

Should consider it more

Could have been more useful when reviewing more MS patients

How useful will the information be?

Safety considerations with telephone reviews:

Afraid of missing something serious when can't see patient

How disease aware and safety aware is patient?

Patient might not have cognitive ability/insight to give accurate information

If not would need to speak with carer, would need consent from patient first

Implementing phone reviews:

Physio must know patient – continuity of care by physios

Physios must use clinical judgment to pick appropriate patients

Everyone will be different – can cause difficulties making set protocol

Use of structured check list and open questions

Questions should be tailored to individuals

Content could be based around function and current issues

8.8 Member Checking Email Group R

Hi All,

I would greatly appreciate it if you could read the summary below of the focus group and confirm I have written a true interpretation of your views as a group. If I have left something out please do not hesitate to let me know. I can be contact on the following email address: 0732109@studentmail.ul.ie

Kind Regards,

Marie Condon

Two people attended the focus group held in Dunmanway Community Hospital on 3/12/2010. The session lasted approximately 45 minutes.

The following is a summary of the main points:

Section 1: MS Patient Reviews

Current Service Provision

No regular reviews conducted/not priority at present

Service provision influenced by patients' wants

Ideal service would have regular reviews, trying to begin this but limited by service constraints

Review Pathway Problems

Review referral inaccurate and not urgent

Problems leaving it up to patients

Speculation in small communities – patients may not want to be seen going to physio

Service Constraints

Time

Caseload

Review not a priority due to urgent patients on waiting list

Service Facilitators

Exercise interventions

Section 2: Telephone reviews

Opinions of phone reviews:

Seems to be a good idea if saved time

Would help regular reviews

Difficulty if patient is under impression they are going to get an appointment

Quality of care considerations with telephone reviews:

Confidentiality - Somebody at home is listening to patients conversation may affect what they say

Would be afraid of missing something important by not seeing patient

Can you trust what the patient reports? Purely subjective information

Implementing phone reviews

Know your patient

Choose compliant patient

Cognitively tuned in patient

Continuity of care with physiotherapist

Would need structure to phone review

Would need to be tailored for individual for each patient

May need to set questions with prior to phone review

8.9 Audit Trail

- After completing each focus group and debrief session the researcher documented the main ideas, group dynamics and general thoughts on the focus group in a reflective diary.
- When transcribing the conversations the Jefferson Transcription technique (Atkinson and Heritage, 1999) was used to note different expressions in speech including emphasis, intensity and hesitancy.
- Transcriptions were then read while listening to the audio-recordings to ensure the transcripts accurately reflected the discussion.
- Theoretical thematic analysis (Braun and Clarke, 2006) was undertaken through the following steps:
 - The researcher immersed self in data by re-reading transcripts multiple times.
 - Transcripts were examined line by line and the idea of the sentences were summarised using a code.
 - Codes were grouped together in Microsoft Word documents to form initial themes.
 - Themes were re-examined and re-grouped into more accurate themes and sub-themes using colour coding.
 - The frequency, extensiveness, specificity and intensity of themes were reported.
 - Following this, transcripts were re-read and themes were discussed and confirmed with the co-moderator.
 - Finally emails were sent to participants to confirm the main themes identified reflecting the main ideas discussed.