1. Purpose of this document

1.1. These guidelines have been developed with reference to the NICE Guidance on Multiple Sclerosis (MS) and a consensus of best practice by the Southern and Eastern Devon Physiotherapy Rehabilitation Clinical Interest Groups.

1.2. The draft guidelines were also commented upon by Multiple Sclerosis Clinical Nurse Specialists.

1.3. This guideline applies to best practice in both the acute as well as the community setting.

1.4. Any member of staff who becomes aware of new evidence which may cause review of the existing guidelines should contact either the author or the Care and Clinical Policies Group.

2. Training

2.1. Clinicians should have access to other qualified physiotherapy staff that can support them if necessary through (peer) supervision and joint session(s) when appropriate.

2.2. The Multiple Sclerosis Society and The Multiple Sclerosis Trust are resources that are available for further advice and information.

2.3. Skills and competencies will be reviewed at yearly appraisals.

2.4. Physiotherapy staff working regularly with people with MS will attend internal and/or external training courses as available. Attendance at these is agreed as part of individual personal development plans.
3. Roles and Responsibilities

3.1. Multidisciplinary packages of care have a positive impact on the daily life of a person with MS. This will require good communication between professionals and agencies involved.

3.2. Specialist neurological physiotherapy has been shown to help improve mobility in people with MS.

3.3. Due to the complex nature of the condition, physiotherapy intervention should ideally be provided by clinicians with specialist skills and experience in the management of MS. Within generic teams, clinicians with neurological skills should be providing the intervention and have access to specialist resources.

3.4. The qualified physiotherapist is responsible to the assessment and treatment of the person with MS. The team’s support worker(s) work under their supervision. The support worker is able to perform interventions and they also assess for and prescribe standard equipment, such as mobility aids within their competency level.

4. Referral

4.1. Referrals for people with MS with urgent deterioration in function should be offered to be assessed within 24 hours on a workday. In other cases, the Trust standards regarding waiting lists should apply.

4.2. People with MS are able to self refer to physiotherapy once they have accessed the physiotherapy team previously. Referrals can also be made by other health and social care professionals.

5. Assessment

5.1. If a person with MS starts to experience a new limitation in his or her activities the cause should be identified.
   - Is it due to an unrelated disease?
   - Is it due to an incidental infection?
   - Is it due to a relapse of the MS?
   - Is it part of a gradual progression?

5.2. Assessment needs to show evidence of a subjective and an objective assessment.

5.3. Subjective assessment
   - Course of the condition (inc relapses)
   - Social situation (inc leisure)
   - Employment / Education.
5.4. **Objective Assessment**

- Basic ability to communicate
- Basic observation of cognition & memory
- Motor ability – muscle tone, muscle strength, soft tissue length, range of movement
- Posture and any positioning needs
- Sensation
- Perception
Physiotherapy guidelines for the Management of People with Multiple Sclerosis

- Coordination / Ataxia
- Respiratory system
- Function, gait plus mobility (including wheelchair mobility)
- Transfers
- Vestibular system / balance
- Tremor
- Upper Limb function

6. **Goal Setting**

6.1. Goal setting needs to be attained with the person with MS via a multi-disciplinary approach and should be person centred and mutually agreed.

6.2. Goals should be focused at the level of activity and/or participation.

6.3. Goals should be timed and should make reference to long and short term aims.

7. **Treatment and Management**

7.1. Consider:

- Supervised exercise programmes involving moderate progressive resistance training and aerobic exercise to treat people with MS who have mobility problems and / or fatigue.
- Stretches
- Walking Aids / Aids / Positional devices / Wheelchair(s)
- Gait re-education
- Advice and education
- Fatigue management strategies – see treatment flow-chart (Appendix 2)
- Core stability work
- Postural / seating advice (Including 24 hour postural care if required)
- Advice re manual handling
- Liaison with the other services
- Task related practice
- Management of spasticity – see treatment flow-chart (Appendix 3)
- Orthotics / Functional Electrical Stimulation for drop foot
- One-to-one and/or group exercise (local MS exercise groups)
o Encourage people with MS to exercise as part of their self management and consider referral to The Exercise on Prescription Scheme in the community.

7.2. Any advice given to patients and carers regarding manual handling should be documented and a written copy given to the carer / patient following a risk assessment if required.

7.3. Home exercises should be supplied with the physiotherapists name and contact details.

8. Outcome Measures

8.1. There is an expectation that Physiotherapists will use at least one of the following outcome measures at assessment and at the end of treatment.

8.2. The outcome should be selected considering the person’s goals and abilities:

   o Timed Walk
   o Modified Fatigue impact scale
   o Self-reported walking scale
   o MS impact scale
   o Berg balance scale
   o Ashworth scale
   o Falls diary

9. Information and Education

9.1. People with MS should have access to information regarding MS, including services and support in their area. Where exercises or activities are given, this should be supported with written information. This may include a selection of generic handouts or written by the clinician who is providing the advice.

9.2. People should be offered information / resources from the MS Society and/or MS Trust.

9.3. People should be offered contact details of the local MS Society.

9.4. People should be offered the name and contact details of their Physiotherapist.

10. Discharge Planning

10.1. Following provision of assessment and treatment, the person with MS will either be discharged from the service with the potential to refer themselves back when necessary, or will have a booked review arranged.
10.2. The decision whether a person with MS should not be given a booked review and should be put onto a self-referral system will be based on a number of factors. The following points are offered to guide the decision.

10.2.1. People with MS who are suitable for a self-referral system include:

- Those who are able to articulate their needs, and can access and use a telephone
- Those who have a carer who make a referral to the service on their behalf
- These patients should be supplied with a ‘Self-Referral leaflet’ (Appendix 4)

10.2.2. People with MS for whom you may consider the need for a booked review include:

- People with a history of depression or mental health disorder.
- People who have very little contact with either an MS nurse specialist or neurologist.

10.2.3. People with MS for whom a booked review should be made:

- People with severe cognitive impairment
- Vulnerable people living alone
- People with severe spasticity or who are at risk of evolving contractures which will have a significant impact on their function.

10.3. Other agencies and professions should be made aware of any discharge arrangements.

10.4. When care is transferred from one Physiotherapist to another, written information should accompany the transfer to outline the assessment findings, treatment record and future goals.

11. References

11.1. Management of Multiple Sclerosis in Primary and Secondary Care, NICE guideline 186, Oct 2014.

12. Appendices

Appendix 1: Ashworth Scale
Appendix 2: (Flowchart) Options for the Physiotherapy management of Fatigue in Neurology

Appendix 3: (Flowchart) Options for the Physiotherapy management of Spasticity

Appendix 4: Self-Referral to Physiotherapy for People with Multiple Sclerosis (MS) Leaflet

Appendix 1

Definitions of the Ashworth Scale (1964) and modified Ashworth scale (Bohannon & Smith, 1987)

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<th>Modified Ashworth Scale</th>
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<tr>
<td>No increase in tone</td>
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<tr>
<td>Slight increase in tone giving a catch when the limb was moved in flexion or</td>
<td>1</td>
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<tr>
<td>extension.</td>
<td>Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the affected part(s) is moved in flexion or extension.</td>
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<td>1+</td>
<td>Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM (range of movement).</td>
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<td>More marked increase in tone but limb easily flexed.</td>
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<td>Considerable increase in tone – passive movement difficult.</td>
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<tr>
<td>Limb rigid in flexion or extension.</td>
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More marked increase in muscle tone through most of the ROM, but affected part(s) easily moved.
Considerable increase in muscle tone, passive movement difficult.
Affected part(s) rigid in flexion or extension.
Appendix 2

OPTIONS FOR THE PHYSIOTHERAPY MANAGEMENT OF FATIGUE IN NEUROLOGY

Person complains of fatigue

Yes

Any aggravating factors?
- Temperature
- Depression
- Infection
- Skeletal muscle relaxants
- Spasticity

Yes

Appropriate treatment referral or education

No

Assess: Physical function
Establish baseline of current activity

No

Consider management options:
- Paced exercise
- Energy conservation techniques
- Coping strategies
- Relaxation

Is fatigue still a problem?

Yes

Discuss with Clinical Specialist and Reassess

Paced exercise regime
Identify an activity e.g. Walking or swimming.
Record how much can be done comfortably at each time.
At the end of the week, work out the average reduce by a 1/3. This is the baseline.
Perform the activity to the baseline level for the next week.
Review the activity each week and gradually increase the baseline.

No

Review
Appendix 3

OPTIONS FOR THE PHYSIOTHERAPY MANAGEMENT OF SPASTICITY

Spasticity and UMN syndrome present?

Yes

Does it interfere with function, care or cause pain?

Yes

Any aggravating factors?
Infection
Skin irritation
Inappropriate posture
Ill-fitting orthosis
Pain
Constipation

Yes

Assess: Neural component of tone vs muscular component of decreased length. Identify goals of treatment and outcome measures

Choose appropriate management option. Consider:
Stretching regimes Splinting & casting, orthotics
Passive regimes Gait movement retraining
Strengthening Positioning and posture
Antagonist Management
Advice leaflet Liaise with MDT

No

Is spasticity still a problem?

Yes

Discuss with Clinical Specialist:
Reassessment
Oral medication
Botulinum toxin

Review

No

Monitor and give advice leaflet

Yes

Appropriate treatment referral or education
Appendix 4 Self-Referral to Physiotherapy for People with Multiple Sclerosis (MS) Leaflet (See Separate Leaflet)

Amendment History

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<td>1</td>
<td>Draft</td>
<td>17th June 2013</td>
<td>Review and update current guidelines</td>
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<td>11th October 2013</td>
<td>Minor changes made after initial consultation</td>
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