BRITISH ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN AMPUTEE REHABILITATION

It's Conference Time!

5 - 6th November

The Journal
Issue 44, Autumn 2015

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Welcome

Hello all,

Preparations for the 2015 Conference and AGM are well underway so at the time of publication I would hope that you have already taken advantage of the Members' Early Bird offer (closing date 29th August), if not there's still time to get your place. The Conference is open to members and non-members alike, and if you are not sure about committing 2 days to amputee rehabilitation CPD, then come along for 1 day. As you can see in this journal the programme promises to fulfil a number of learning needs identified on your membership applications and requests submitted on the feedback forms from last year's conference.

As ever we will have the AGM at the conference so I would hope to update you on our network's activities and involve you, the Membership, in the planning for 2016. I will provide evidence that BACPAR; the members and committee, continue to work selflessly on BACPAR's projects.
The Amputee rehabilitation iCSP network, moderated by BACPAR members, is a good way of being kept up to date with BACPAR news but also useful for gaining advice for clinical queries, relating to both in and outpatient practice as well as support for service development. The Committee also finds your responses, to it's pleas for help posted here, invaluable.

If you haven't done so already, and you would like to get involved in BACPAR's projects then don't hesitate to contact me (Louise.Tisdale@nhs.net) or an appropriate committee member (see the contact list in the Journal) and let us know what you would be interested in doing. Another opportunity to get involved includes becoming part of the Committee itself, with a number of posts up for grabs at the AGM this year.

UK Physios have been sharing good practice around the world in 2015; first at WCPT in Singapore and later in Lyon at World ISPO Congress, I was fortunate to attend the latter with the support of a BACPAR bursary (as well as support from my Trust and ISPO UK NMS) and in lieu of this I will share the presentation I made at Lyon re Independent Prescribing (and hopefully a little more) at the BACPAR Conference. Links to amputee rehabilitation content from both ISPO and WCPT Congresses are available on the BACPAR website.

In advance of the AGM I ask that you review the previous year's minutes and the 2015 Work Plan. If you are unable to attend the AGM please send your apologies to the Honorary Secretary along with any questions you want a response to within the AGM.

See you in Wolverhampton in November.

Louise BACPAR Chair 2015

Editorial

So all good things must come to an end - two terms of editing the BACPAR Journal (that will be twelve issues to us in real terms). Thank you so much to everyone who has come up with articles at the last minute over the years and saved it from looking like a very small piece of paper!

Huge shout out to Louise Tisdale, our chair, for always being supportive and giving her time and to my long suffering husband who has sorted out all sorts of strange issues with the Journal and also my inability to work the software with unfailing patience every single time.

So here we go - my last Journal ever, enjoy!

Sue Flute, Editor

Secretary's Report

This is my first report as Secretary for BACPAR, so here goes!
Autumn means it's nearly time for the Annual BACPAR Conference, we have an excellent programme this year, I have had many applications already- but still room for plenty more! The programme is available on the website, as are application forms.

There are lots or roles due up for election this year at the AGM, as a new member to this Professional Network, I would urge new members to become involved. It may be daunting to start, but certainly is an excellent opportunity to become involved in one of the most active and successful Professional Networks. I have learnt lots in the few months I have been involved!

As Secretary I receive the Educational and Research Bursary applications, in the spring of this year we had many applications. However into Autumn the number of applications has dropped. Remember that if you have been a full BACPAR member for 2 years you can apply and this can be done retrospectively. Applications are considered at the Spring and Autumn BACPAR Executive committee meetings held in March and September.

Enjoy reading this journal edition and hopefully see you at Conference

Amy Lee Secretary

BACPAR Executive Committee Posts for Election at BACPAR AGM November 2015

Elected at the AGM in 2012

PRO Julia Earle
Education Officer Mary Jane Cole
Membership Secretary Gillian Atkinson
Research Officer Penny Broomhead
Guidelines Coordinator Sara Smith
Journal Officer Sue Flute (second term)

All the people in the posts other than The Journal Editor can be re-elected for a second term.

Per the constitution all exec roles are for 3 years a term and you can only be in post for 2 consecutive terms If the post holder does want to be re-elected after first term they have to be nominated and be seconded. All posts due for election/re-election except Chair and Vice Chair are offered to the membership at the AGM.
Any one who is interested in a post please see the BACPAR website for contact details.

OUR JOURNEY

At first it's really daunting when we first go to the gym,
We came in in our wheelchairs as we haven't got a limb.
Starting off we have to learn to transfer from the chair,
To help us to the toilet with a pivot here and there.
Then it's to the bars we go with the PPAM aid blown up tight.
A bag inside a metal frame to keep our balance right.
As weeks go by we're getting there,
Experiences we've learnt to share.
Now we go home, but won't forget
The friends we met at the gym and yet,
The last word really has to go.......
To the brilliant team at PHYSIO!

Karen Christie, recent amputee at Ninewells Hospital, Dundee

BACPAR Conference

5th–6th November 2015

Day 1

- How to get Funding for your Research Ideas
- How Different Models of Care Impact on Ppam aid use in Scotland
- Debate: Elbow Crutch use for Lower limb Amputees?
- "Prescribing another Tool in the Amputee Rehabilitation Physiotherapy Toolbox"
- Diabetic Foot Master Class
- Hyperhidrosis
- NCEPOD implementation in Birmingham
- Stump Oedema Audit
- Ortho Europe Ppam aid
- Otto Bock Genium

Day 2

- Hope and Power
- The Glasgow Cohort: Pre Peri and Post Amputation
- Limb Use after the 1st Year
- Socket Management
- "Fifteen years of experience with percutaneous Osseointegrated leg-Prosthesis for Rehabilitation Following Lower Limb Amputation"?
- AGM
- Developing a Tool to Predict Rehabilitation Outcomes
- Bariatric Patient Management.

http://bacpar.csp.org.uk

WCPT 2015 – A personal reflection

Travelling to Singapore for the World Confederation of Physical Therapy (WCPT) Congress in May 2015 was a culmination of many many hours work, both in relation to my doctoral work on physical function outcome measures used with lower limb amputees and also the BACPAR outcome measures group. My journey was made possible by three financial awards: i) a bursary from BACPAR, ii) a grant from the Santander University Research Grant Fund and iii) a Robert Williams International Travel award (RWTA) granted by the Chartered Society of Physiotherapy.

The RWTA I received was one of ten awarded across the UK to enable Physiotherapists to travel to the WCPT 2015 Congress and the abstract I won the award for was "Minimal Detectable Change (MDC) Values of Common Outcome Measures used in Lower Limb Prosthetic Rehabilitation in the UK". I presented a poster on this as well as presenting results from my Systematic Review which looked at the "Psychometric Properties of Outcome Measures of Physical Function used with Lower Limb Amputees During Prosthetic Rehabilitation". This presentation was in a 'rapid 5' session and was quite a challenge, presenting in no more than 5 minutes and using a maximum of 5 slides really focuses the mind on what your main messages. I was interested to hear other researchers presenting results of similar reviews in different specialist areas. They appeared to reach similar conclusions i.e. there is limited good quality evidence published on the psychometric properties of the outcome measures we use.

I also presented a poster on behalf of BACPAR detailing the work that was done to produce the Outcome Measures Toolbox. The poster generated much interest with many people wishing to know how to access the toolbox as they wanted to use it. There does not seem to be anything similar published that is readily available, advising on the use of outcome measure with lower limb amputees. There was also some interest voiced about the inclusion of outcome measures in the Toolbox that could be recommended for upper limb amputees, but that will have to wait until the next version. The British Association of Prosthetists and Orthotists (BAPO) have recently produced a similar document, but there is a cost to non BAPO members. The BACPAR poster presented at WCPT will be displayed at the BACPAR Annual Conference 2015.

This was the first time I had attended a WCPT Congress and was the largest gathering of Physiotherapists I have ever seen. Two things struck me (apart from the length of time it took to get there); one was the sheer scale of the Congress and the breadth of topics that were represented and the other was the high level of interest in Amputee Rehabilitation and the number of topics that related to this specialist area.

The scale of the meeting was impressive with over 3,500 delegates attending across the three days. There were often up to 10 plenary sessions available each day so there were some tough choices to make about what to attend. There were also pre-and post-Congress courses, meetings and visits available should you wish to extend your stay. The Congress App was invaluable when searching what was on offer and planning what to attend. Abstracts and details of all the posters and presentations are now available on-line at the WCPT website http://www.abstractstosubmit.com/wpt2015/abstracts/ and gives an idea of the type and scope of topics that were presented, discussed and debated.

I attended one of the pre-Congress courses on "How to Run a MOOC" (multiple open on-line course). We had good hands-on experience of contributing on-line in real time to a learning module during the course. It also gave me the

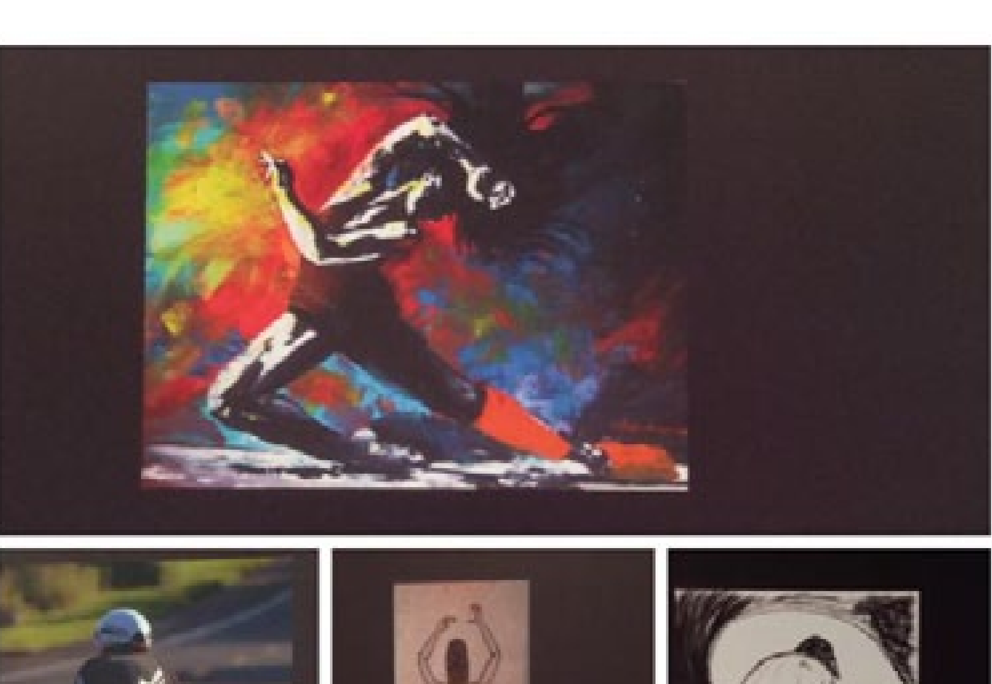
opportunity to meet face-to face with Rachel Lowe of Physiopedia (one of the organisers of the MOOC course) and Barbara Rau of the International Committee of the Red Cross (ICRC) who were the course co-ordinators of the Lower Limb Amputee Rehabilitation Course that recently ran on Physiopedia. It was fascinating to talk to them just before the amputee course was going live about all the preparations. They weren't sure what the response would be, but we now know it was huge with over 3,000 active participants. This demonstrates the sizeable interest in the subject area internationally and it was noted that BACPAR members contributed greatly to this international educational resource.

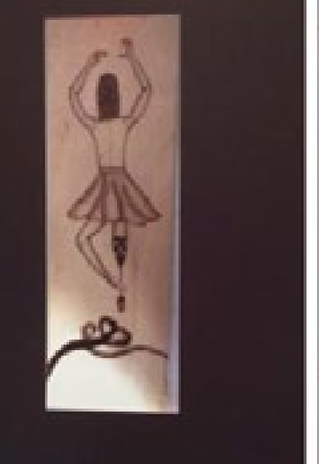
The congress also hosted the first WCPT Amputee Rehabilitation (AR) Network meeting; with over 50 participants attending (see photo), the interest in amputee rehabilitation was obvious. It was wonderful to meet like-minded people and share examples of best practice from around the world. In the absence of face-to-face meetings the group is facilitated through the Linkedin network and I would encourage everyone to join to share experiences and opinions on the discussion boards in the network.

Several people who attended this first network meeting were also at ISPO 2015 in Lyon where I was presenting some more of my research work and the international friendships I made through the AR network were cemented in France. The Focused Symposium on Amputee Rehabilitation at WCPT, chaired by Gillian Johnson from New Zealand, entitled "Integrating Evidence into Lower Limb Prosthetic Rehabilitation in Today's World" was a fascinating insight to research and practice from around the world. The focus was on the impact and level of participation for the amputee after surgery with patient stories from different geographical and clinical situations.

While there was lots of networking going on related to amputee rehabilitation I also took the opportunity to meet other researchers who were looking into outcome measurement, in other patient populations. It is inspiring and motivating to listen to and speak with other people doing similar work as it can be a lonely existence as a researcher.

Aside from the research, clinical practice and professional discussions there was time to take in the art exhibition at WCPT which consisted of pictures and sculptures all painted and made by Physiotherapists. It was great to see so many inspired by or depicting amputees, here are some of my favourites.





I thoroughly enjoyed my time at a WCPT International Congress and will definitely try to make the next one which is being held in Cape Town 2nd - 4th July 2017. Though you don't need to wait that long to experience a WCPT Congress as The Chartered Society of Physiotherapy are hosting the 4th European Congress of the European Region of the World Confederation of Physical Therapy (ER-WCPT) for more details see: http://www.liverpool2016.com/
I haven't talked about all the other opportunities that are available when attending an international conference, for example; experiencing the culture (on show at the opening ceremony) and tastes (eating out every night) of a different country, or the unexpected connections made with colleagues (and colleagues of colleagues) on the other side of the world. It would take too much room to list all the fabulous experiences that I have reflected on since coming home, I would recommend you try it for yourself.

Judy Scopes, HCPC, MPhil, AFHEA. PhD Candidate, Queen Margaret University, Edinburgh

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The Influence of Power and Hope on the Post-Amputation Rehabilitation

Physiotherapists working in the field of amputee rehabilitation will be familiar with making decisions regarding the future care and rehabilitation of their patients, based on a number of clinical factors such as comorbidity, and rehabilitation milestones. There are 2 significant factors, however, which influence clinical practice yet have little acknowledgement from clinicians. To consider these it is relevant to evaluate best practice guidelines, the power relationships between professionals and service users, and how hope impacts rehabilitation. This will be in the context of a complex rehabilitation case study, Mrs C (all names changed to preserve anonymity), in the acute hospital care setting.

Firstly, it is important to consider the concepts of both rehabilitation and disability.

The terms 'rehabilitation' and 'disability' have many definitions and interpretations across health and social care. They mean unique things to each individual depending on their own experience and professional background, or as a service user or provider. The Department of Health (2007) refers to rehabilitation as 'Restoration of an individual to optimal physical, cognitive, psychological and social function following injury' (p.12), however this definition does not consider the importance of engagement, participation or what is meaningful for the individual (Nieuwenhuijsen, 2009). This definition further excludes the possibility that rehabilitation may not be aimed at restoring but 'redefining normality' (Whalley Hammell, 2006, p.50). Perhaps, therefore, it is more pertinent to consider the view of Ellis-Hill et al. (2008) who state 'Through rehabilitation, involving engagement in physical, psychological and social processes, people can learn how to live a life that is not dominated by their disability' (p.155) as a more encompassing definition.

The Equality Act (2010) considers a person disabled if they have a 'physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities'. This definition relates to the legality of discrimination and inequality. However the World Health Organisation (2014) considers disability to be more than a health issue 'It is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives'. Oliver and Barnes (2012) alternative view argues that disability is based on the ideology of 'normality' imposed by a medical model, with the pressure to conform to 'normality' leading to oppression and alienation rather than the impairment itself. It is therefore important to understand these theories and definitions when considering Mrs C.

Mrs C is a 67 year-old lady who underwent a unilateral transtibial amputation secondary to gangrene and diabetes. She was admitted to a specialist renal unit as she also has end stage renal failure, secondary to hypertensive nephropathy and is haemodialysis dependent following the failure of her renal transplant in 2013. Prior to the acute deterioration of her left foot, she was independently mobile, living independently in a second floor flat, with her son. She was able to access the community and attended haemodialysis at a satellite clinic three times a week. Mrs C's acute management was influenced by a number of factors. Her rehabilitation followed the pathway recommended in the 'Clinical Guidelines for the Pre and Post-Operative Physiotherapy Management of Adults with Lower Limb Amputation' (Broomhead et al., 2006) commissioned and endorsed by the British Association of Chartered Physiotherapists in Amputee Rehabilitation (BACPAR). This document outlines what is considered best physiotherapy practice from pre-amputation to completion of rehabilitation in the acute setting for non-prosthetic users or until receipt of the first prosthesis.

The BACPAR guidelines (Broomhead et al., 2006), in conjunction with a number of other publications (Blundell et al., 2008, Bouch et al., 2012 and Broomhead et al., 2012), aspire to offer recommendations for care based on

a bio-psychosocial model. Dean et al. (2012) describes this model in context of the International Classification of Functioning, Disability and Health as 'it considers disability not only from a physical, but also from an individual and societal perspective, and importantly includes the environmental and personal context of the individual' (p.12). When considering this with reference to Mrs C, recommendations highlight the importance of considering her physical needs, particularly with reference to function and pain management, a patient-centred approach considering her psychosocial and socioeconomic needs and with consideration of her previous abilities, activities and participation. An important issue for Mrs C was to be able to use the stairs independently. This allowed her the freedom to make choices about her activities of daily living such as shopping and cooking, on her non-dialysis days. It also reduced wasted time between haemodialysis sessions, enabling her to access more flexible transport, and shorter journey times by being able to use a local satellite clinic, otherwise inaccessible to her.

However, there are a number of aspects more consistent with a biomedical model which highlight how power is used to justify health provision (French and Swain, 2001). For example, recommendation 1.14 'The physiotherapist, as part of the MDT, should be involved in making the decision to refer the patient for a prosthetic limb' (Broomhead et al., 2006, p.18), fails to acknowledge the patient at the centre and places the power and future rehabilitation possibilities entirely with the professional. Whalley Hammell (2006) explores the use of power, which is often justified as professional altruism, and acknowledges that despite best intentions, patients may become powerless and oppressed. Whalley Hammell (2006) also states 'Ideologies of professionalism justify, legitimate and privilege professional knowledge and authority in ways that assert the domination of professionals and reinforce their power' (p.149). This is evident throughout the guidelines, which refer repeatedly to the decisions that physiotherapists should make, all of which were formulated from professional consensus rather than clinical research. This is further highlighted by Brechin (2000) who states 'the concept of empowerment is the second pillar of critical practice' (p.37) but demonstrates that professionals find themselves in a juxtaposition, constantly being pushed for efficiency, specialist knowledge and improved services but also to relinquish the idea that knowledge gives them power to 'define problems and solutions for others' (Finlay, 2000, p.92). Mrs C was offered the choice of whether she wished to be referred for prosthetic rehabilitation but was then informed of the expected level of achievement required in order for the therapists to complete this process, perhaps a form of rationing or gatekeeping of resources and services (Allen et al., 2004, Lipsky, 2010), that returns power back to the professionals. Livingstone et al. (2011), in a grounded theory study for diabetes related amputation, also describes the concept of 'imposed powerlessness' for patients, due to a lack of 'condition' education, mistrust in professionals following failure of treatment options and a lack of empathy of professionals who fail to recognise this state. This is further supported by Ellis-Hill et al. (2008) who highlight that personal and professional realities must be balanced in order for successful rehabilitation to take place.

Another significant issue for Mrs C is the concept of hope. Mrs C expressed at the pre-operative stage that she hoped her amputation would allow her to become pain free and enable her to return to her previous level of mobility and function, to fulfil her social roles as a mother and grandmother and to not be a burden to her son. This is a reasonable and familiar concept for Mrs C as she has previously experienced life changing renal transplant surgery 24 years ago. A qualitative study by Boaz and Morgan (2013) looked at re-established 'normality' post renal transplant. Prior to transplant participants hoped for a return to good health, and, following surgery, they worked hard to re-establish normality, in a reset form, giving careful attention to compliance to all regimens due to the fear of complications and rejection. Mrs C's experience of this allows her the advantage of both robust adjustment strategies and compliance to treatment to achieve a return to 'normality'. The BACPAR guidelines (Broomhead et al., 2006) however, fail to acknowledge hope as an important aspect of rehabilitation. This is evident in recommendation 4.2.2 'Patients/ carers should be made aware that they will experience lower levels of function than bipedal subjects' (p.25). This recommendation is based on a body of evidence related to a number of outcomes based case series, as justification within the 'informed goal setting' section.

Mrs C was able to understand how the surgery would impact her from a physical perspective but her hopes and goals remained. Under a biomedical model we would perceive this to be 'unrealistic' or 'inappropriate'. However the concept of hope within the rehabilitation setting has been widely debated. A literature review by Wiles et al. (2008) highlights a lack of clarity in the evidence, at this time, about the particular dimensions of hope in rehabilitation, as there is a discrepancy in understanding between hope-as a wish and hope-as an expectation. None of the 7 studies reviewed made a clear distinction but many of them discussed the concept of 'realistic' and 'unrealistic' hopes. This may add weight to the 'informed goal setting' element of the BACPAR guidelines (Broomhead et al., 2006), but also demonstrates the importance of therapeutic understanding of hope.

Soundy et al. (2010) supports this further in a qualitative study of 9 physiotherapists working in neuro-rehab. Through semi-structured interviews they discussed the relevance of Physiotherapists understanding the concept of hope and the consequences of each stage within the rehabilitation process.

A number of articles further discuss the importance of developing a new sense of self (Ellis-Hill et al., 2008, Cotter, 2009, Livingstone et al., 2011, Kortte et al., 2012, Soundy et al., 2012, Boaz and Morgan, 2013). Ellis-Hill et al. (2008) discuss this in context of the life threads model within stroke rehabilitation, and Soundy et al. (2012) discuss the progression from defiance, a process of active resistance to a situation fortified by external hope, acceptance and hopelessness, and to the re-establishment of a sense of purpose and hope. This study looked at patients (n=11) with Multiple Sclerosis undergoing rehabilitation.

A concept analysis by Cotter (2009) reviews 27 papers relating to hope in early stage dementia. It identifies the relevance and importance of hope in maintaining normality, adjustment and coping strategies, reconstruction of selfhood and remaining engaged with a social network which reduces feelings of hopelessness. These issues are particularly pertinent to Mrs C as several studies have documented feelings of hopelessness post amputation, especially in diabetes populations (Livingstone et al., 2011, Murray and Forshaw, 2013, Spiess et al., 2014).

Furthermore, a cohort study of 174 patients undergoing inpatient rehabilitation for a number of conditions including amputation (n=22) by Kortte et al. (2012) measured Hope (Hope Scale), positive affect and functional ability and participation at the start of the programme and 3 months post discharge. They found that the level of hope at the acute phase was predictive of the level of functional skill, role participation and engagement in occupational activities, including social integration at follow-up, and that, while positive affect does not contribute to participation levels, it is shown to significantly improve physical independence and mobility. Whilst the size of the cohort makes generalisation difficult, the diversity of patients allows the consideration of the concept of hope after amputation alongside other long-term conditions.

Hope is further explored in a concept analysis by Bright et al. (2011). Whilst the systematic review is based on hope after stroke, as the above studies demonstrate, the concepts may also be applied to other conditions. They discuss the association between persistent hopelessness, lower survival rates and depression and that health professionals may also be responsible for both building and destroying hope. Bright et al. (2011) go on to describe 3 interrelated attributes of hope: hope as an internal state of being, being outcome orientated and also an active process. Where patients experience hope as an internal state, they are able to maintain hope, as a sense of self belief and also belief in the ongoing process of rehabilitation.

Where hope is outcome orientated it allows a process of adjustment, coping and re-alignment of outcomes for the future. This active element is also associated with improved participation and motivation and a more positive perception of quality of life. Mrs C demonstrated a strong sense of self belief throughout her acute rehabilitation and was able to independently re-align her expectations for her future by demonstrating her understanding of her progress and the next phase of her rehabilitation.

In conclusion, Mrs C followed a standard rehabilitation pathway within an acute hospital setting, guided by the embedded BACPAR (Broomhead et al., 2006) best practice guidelines for physiotherapy management for lower limb amputees. However, these guidelines fail to consider the significance of two key factors within the rehabilitation setting: power and hope. Whilst they recommend a patient-centred approach in assessment, treatment and discharge planning, the guidelines maintain the power balance in favour of the healthcare professional, by making us the 'gatekeepers' of knowledge and onward referrals. This imposed powerlessness can have a profound effect. The guidelines also discourage the acknowledgment of hope by recommending physiotherapists inform patients of reduced functional expectations. As the evidence highlights, hope is a pivotal part of the rehabilitation process for both improving outcomes and quality of life. Mrs C, demonstrated a robust sense of self belief and active hope throughout her rehabilitation. However many patients may find themselves in a professional-induced state of hopelessness which should be considered in future pathway planning and guideline development to enable improved patient outcomes.

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Trent BACPAR Regional Study Day

On Wednesday June 10th 2015, the new Trent Regional representatives, R. A. (Shep) Shepherd and Chris Walker held a regional Study day, hosted by REHAB Prosthetics at their clinic in Coalville.

Of the 14 paid-up Trent BACPAR members, 8 were able to attend, along with one non-BACPAR member and one physiotherapy student.

To avoid child-care issues, and to mitigate the always problematic "granting" of Study Leave, the meeting was held during the afternoon.

Following lunch, kindly provided by REHAB Prosthetics, Shep fed back on the minutes of the latest meeting of the BACPAR Executive.

Nigel Davies of OrthoEurope had agreed to "show and tell" the new and improved PPAM Aids.
Lively discussion ensued as to further developments that would also make the PPAM Aid more user-friendly.
Although Nigel was given something of a verbal battering, he did agree to attend the BACPAR Conference in November to repeat his talk, as requested by the Conference Organizing Committee.

Gordon Wilson, Lead Prosthetist at REHAB Prosthetics, then gave a very useful talk on Socket Management. Some of our members had asked to be educated in how to identify socket problems and perhaps more importantly, how to relay the information back to the Prosthetic Centre when they are unable to attend with the patient.
This proved to be very useful to all the delegates, including those experienced prosthetic physiotherapists, and Gordon was persuaded to repeat and extend the talk at the next Regional Study day.

R.A. (Shep) Shepherd Chris Walker BACPAR Trent Region representatives

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MDT Approach to Reducing Falls at the Amputee Rehabilitation Unit (ARU)

Claire Rutherford: Highly Specialist Amputee Occupational Therapist | **Jodie Georgiou:** Highly Specialist Amputee Physiotherapist | **Patricia Willis:** Sister/Ward Manager

1 Objective

The Amputee Rehabilitation Unit (ARU) opened in June 2013. Due to our complex patient population of amputee patients with complex co-morbidities, we were expecting falls to be more frequent than on other wards. The consequences of having a fall for the amputee can have a significant impact both physically and psychologically.

This can include damage to the recovering stump resulting in prolonged admissions to hospital, damage to the contra lateral limb, compromised tissue viability, reduced confidence and increased anxiety and reliance on others. Not only can this have a cost impact to health and social care it can have a lasting impact on the patient. On initial review of falls at the ARU it was clear we had an increased number of falls even for the patient population. This was due to a number of contributing factors and further action was required.

2 Guidelines

BACPAR guidelines 2006 state that "all parties involved with the patient should be made aware that the risk of falling is increased following lower limb amputation. Rehabilitation programmes should include education on preventing falls and coping strategies should a fall occur. Instruction should be given on how to get up from the floor. Advice should be given in the event the patient is unable to get up from the floor".

COT Amputee Guidelines 2011 state that "Occupational Therapists need to identify falls risk factors and provide appropriate individual interventions in collaboration with the Multidisciplinary Team".

3 Initial review

The initial review highlighted the following themes:

- Patients falling in the toilets
- Patients not adhering to transfer technique – patient compliance and staff compliance noted as contributing factors
- Phantom limb sensations
- Over reaching from wheelchair
- Cognition
- Staff education
- Falls happening in the first week of admission to the ARU

4 What was implemented to reduce falls?

SENIOR TEAM
- Senior MDT meeting to review every fall at the ARU and implement action plan as appropriate, MDT met every quarter
- Falls Audit

STAFF TRAINING
- Educational programme completed to all staff members to up skill

FUNCTIONAL TRANSFERS/ INITIAL INFORMATION
- Transfers Assessment completed on the day of admission, this includes assessment from bed -wheelchair, wheelchair-toilet/commode. The patient and nursing team informed. Information on patient board above bed
- Patient allocated a specific toilet with appropriate equipment for his/her needs
- Every patient provided with a fall information leaflet/discussed and provided with appropriate footwear

COGNITION
- Montreal Cognitive Assessment (MOCA) completed within the first week of admission

PATIENT EDUCATION
- Falls Group- patient and family welcome
- Phantom limb/sensation posters in appropriate places at the ARU- "Be Aware Missing Leg"
- Practise getting up off the floor

WHEELCHAIR
- Each patient issued with a wheelchair at the ARU completed a safety checklist, to address how to use the wheelchair safely including safe use of stump board, brake, education on not to over reach
- A wheelchair skills group runs. This supports with safely using wheelchair in different environments and for safe transfers

ENVIRONMENT
- Risk assessment of the toilets and work with Facilities to make more appropriate for the amputee wheelchair user- recommendations made include, relocating call bells and sensor bins rather then pedal bins

5 Key findings

Falls Data
Reviewing the falls in Jan - April 2014 compared to Sept - Dec 2014 Falls have reduced by 46.6%.

There has been a:
- 100% reduction in falls resulting in bed brakes and from the toilet environment
- 75% reduction in falls from those who have a cognitive impairment
- 50% reduction in falls from phantom pain/sensations

From Sept - Dec 2014, we had no falls from toilet environment, bed brakes, phantom pain, and medially unwell patients.

From Sept - Dec 2014, we experienced more falls in therapy, over reaching, transfers and from wheelchairs. We noticed a shift in the time when falls happened; initially falls occured in the first week of admission. From Sept - Dec 2014 this shifted to day 13. We feel a contributing factor is that the patients are becoming more confident and engaging in risky behaviours such as transferring alone or becoming complacent.

Falls Audit
In addition to the above reductions, during the last audit of falls at the ARU we achieved 100% in 5/6 areas. The area we are not 100% is patients attending the ARU therapy falls group; we are continuing to improve on this.

Number of Falls per 4 Month Period

16
14
12
10
8
6
4
2
0

Jan - Apr 2014 | May - Aug | Sept - Dec | Jan - Apr Forecast 2015

6 Future

- Capturing all patients in the falls group- completing this on an individual basis if patients are unable to attend group to achieve 100% compliance with the audit
- New OT falls guidelines introduced in Jan2015- OT team to review these and implement recommendations as appropriate
- Review falls risk again on an individual basis after 1 week post admission to aim to prevent falls at approx. day 13
- Continuous falls review
- Continue Education Programme to ensure all staff are aware of how to reduce falls, risk assess appropriately and contributing factors
- Share practice via professional networks locally and nationally to inform and influence teams providing amputee rehabilitation

The Physiotherapy Research Society – still relevant two decades on

The Physiotherapy Research Society (PRS) is a professional network of the Chartered Society of Physiotherapy (CSP). It was formed approximately 20 years ago with the aim to promote and encourage physiotherapy research. It was formed at a time when physiotherapy research was still in its infancy in the UK and the opportunity to network with other like-minded physiotherapists at research meetings was limited. Thus, the PRS through its annual scientific meeting (in some years there were two meetings per year) provided an opportunity for physiotherapists to disseminate and discuss their research and to communicate this research to their target audience – clinicians.

Today's world of evidence based practice is a very different world. While research within the field of Physiotherapy is still relatively young compared to many other disciplines, it is beginning to find its feet and there are examples of physiotherapists in the UK and across the world who are leading multidisciplinary world leading research teams. In conjunction with this there exist many different research forums where therapists can disseminate their findings whether these are physiotherapy specific such as PHYSIOTHERAPY UK (annual) or the World Congress of Physical Therapy (Now biannual) or more multidisciplinary conferences. Now that these bodies and research conferences exist one must ask the question – is there still a need for the PRS?

I would strongly argue that there is a place for the PRS in the modern world of UK physiotherapy. The conferences described above are excellent but they are geared towards high-end research being carried out by world leaders. I am not saying that they should be not be focussed in this way, but rather that one could argue that they may not provide the ideal platform for novice researchers to disseminate their work. Novice researchers may find large conferences with 500+ delegates quite daunting and the audience engagement encountered can sometimes be quite critical rather than constructive. In contrast to this the PRS annual scientific meeting is specifically focussed on the novice researcher. That does not mean that the quality of the work or its potential impact on clinical practice is any less but rather that the spirit in which the conference is run is about encouragement and constructive discourse which seeks to empower and enable the novice researcher as well as to inform clinicians of ongoing research. Nor does this mean that only novice researchers are invited to submit their research to the conference. On the contrary the PRS scientific meetings involve presentations from novice to expert and this produces a wonderful environment for presenters and attendees alike. Another advantage to novice researchers is that abstracts that are accepted for the conference may be published as research summaries in the International Journal of Therapy Research which gives an additional opportunity to disseminate their findings.

A core component of the PRS scientific meetings is the inclusion of Key note speakers. These individuals are often world leaders in their field. In keeping with the spirit of the meetings their role is not just to disseminate their researcher to clinicians but to inspire - Inspire clinicians to become more actively involved in research and inspire novice researchers to persist with their research endeavours. Furthermore, networking is an important part of the PRS scientific meeting. It is the ideal conference for like-minded novice researchers to get together for peer support while at same time getting the opportunity to network and discuss their ideas with internationally recognised researchers.

The PRS scientific meetings attempt to have a broad clinical focus, similar to that of PHYSIOTHERAPY UK so that all specialities within the profession are included. Indeed while the PRS is a physiotherapy professional network the meetings often have a multidisciplinary feel to them, this is emphasised through our links with the Council for Allied Health Professions Research (CAHPR) a research organisation representing all AHPs in the UK. To facilitate this each year there tends to be a slightly different clinical focus within the constant background of a broad clinical programme. This year's conference entitled Improving quality-of-life for people with chronic conditions may be of particular interest to BACPAR members as the pre-conference workshop will be focused on chronic pain with a key section on phantom limb pain and the use of mirror therapy for this condition. The conference will take place at the University of Leicester on the 16th of April 2016 with the pre-conference workshop the day before on the 15th of April. All are welcome whether you are clinician who simply wants to stay up to date with the latest evidence or if you yourself are a researcher (novice or expert) and wish to present your findings to an engaged enthusiastic and supportive audience. I look forward to seeing you there.

Dr Cormac Ryan PhD Chair of the Physiotherapy Research Society Reader in Physiotherapy
Health and Social Care Institute Teesside University Middlesbrough, UK. TS1 3BA Telephone: 0044 (0)1642 73 8253
Email: c.ryan@tees.ac.uk

The 35th Scientific Meeting of the Physiotherapy Research Society

Conference Title: Improving quality-of-life for people with chronic conditions

When: April 16th 2016

Location: University of Leicester

Call for abstract submissions will be open in October 2015

The theme of the conference will focus on how healthcare professionals can help to improve the quality of life of individuals with chronic conditions across the musculoskeletal, cardiovascular, neurological and pain spectrum. The conference will be multidisciplinary in nature and open to all health care professionals. The conference will host a mixture of free papers and keynote speakers. Successful abstracts may be published in the International Journal of Therapy Research.
There will be a workshop the day before the conference, on April the 15th on the topic of pain management which will include a practical session on mirror therapy for phantom limb pain.

For more information please see our website: http://prs.csp.org.uk/

500 miles

I lost my limbs after contracting meningococcal septicaemia in February 2002. I enjoyed a text-book rehabilitation in Edinburgh and the best part of that was being fitted with my first prosthetic legs and learning to walk on them with invaluable support and encouragement from my physiotherapists.

In no small part out of gratitude for the first class care I received from the prosthetic services of the Scottish NHS, I set up 500 miles (www.500miles.co.uk) in 2008. We promote the development and delivery of prosthetic and orthotic services in Zambia and Zanzibar but principally in Malawi where we have built and run the two 500 miles Prosthetic and Orthotic Centres in the grounds of the main tertiary care hospitals for central and northern region, one in Lilongwe and one in Mzuzu.

The staff is Malawian but the Centres are managed by expatriate prosthetists/orthotists or physiotherapists who liaise with me direct. 500 miles is always on the lookout for prosthestists/orthotists who will have at least 3 years PQE and who would like to run one of our Centres in the future. These positions are paid but we would ideally like to take someone on secondment from a job in the UK. We're looking for a commitment of at least 14 months.
The current manager in Mzuzu is Samuel Walker from Nottingham. I hope you'll be inspired by what Sam has achieved for which he has earned our deepest gratitude and respect.

Please send an email to olivia@500miles.co.uk if you are interested?

Name:	Samuel Walker
Age:	28
Profession:	Physiotherapist MCSP BSc (Hons)
Home town:	Kirkby In Ashfield, Nottingham
Work History:	Manager at 500 miles P&O centre, Mzuzu, Malawi for 3 years NHS Physiotherapist at Sherwood Forest Hospitals NHS Trust for 4 years. Physiotherapist in Tanzania 3 months and in Albania 4 months.

Back in July 2012 I, Sam Walker, started my walk with 500 miles; how time has flown and the amount exciting things that has happened over that same period of time! I had been working in the UK for about 4 years as a NHS physiotherapist when I saw the opportunity to work with 500 miles in helping to set up and develop a Prosthetic and Orthotic service in the northern region of Malawi.

Since graduating I started to set my eyes on using my skills further afield than the roots of my homeland. After about 8 trips to different developing countries, each between 2 weeks to 4 months, either with physiotherapy work or healthcare development as a focus for the trips mostly in Africa I discovered this was also where I eventually wanted to be using my skills. So when saw the opportunity to work with 500 miles in Malawi my heart leaped.

In August 2012, following a month's training with the previous manager of 500 miles P&O centre in Lilongwe Joanna Cole-Hamilton, I arrived in Mzuzu the biggest settlement in the Northern region. Even though it is named an up and coming city it still has kept its town-like feel with its open vibrate markets and more bicycles to cars ratio. I have been told the air is a bit thinner here as Mzuzu sits on a plateau that is apparently as high as Ben Nevis, this probably a small factor to the relaxed and less hectic vibs that are evident here.

The first task I had as manager when arriving was to help manage the building site of the new P&O 500 miles centre and help get the centre geared up for opening, which happened in November 2012. This challenging time was also a fruitful time of understanding the hospital systems and developing firm foundations for good relationship with the hospital. I love that the building is made with the same design of the rest of the hospital, and I do believe clients and hospital staff feel it is an established part of the hospital, that 500 miles is here to stay and being welcomed to graft into itself into the healthcare system of Malawi.

Some of the first clients that came to the new 500 miles centre at Mzuzu Central Hospital were in fact old clients (website Examples Susan Banda and Robert Kamanga) that had previously been delivered a device from 500 miles in Lilongwe. They were excited to hear the new centre was opening as it meant they would not have to travel so far to get the specialised service. There lots of exciting stories also about new individuals who have been struggling for decades without assistance either because they did not know there was a service that could help them or that it was just too far and expensive to go to Lilongwe.

It is amazing to see the 500 miles staff find a long-standing problem that has been with that individual for years and fitting a new device that corrects the deformity, relives some pain and improves mobility almost instantly! For example an 83 year old gentleman who is a village headman came to the centre and had a deformed limb which was weak and shortened limb from polio at age 4. Therefore for about 80 years he had walked struggling, but now fitted with a KAFO with a joint orthosis he is able to mobilise much easier and with a lot more comfort. The number of new clients with similar stories is growing as the message of 500 miles in the northern region expands its reach. To date we have been able to assist over 750 new clients with new devices to improve their mobility and give them hope that they have not been forgotten!

One of parts of the job which I have enjoyed over the last year and half is developing partnerships with other services or organisations that are also involved in assisting the disabled in Malawi. We are always in whatever setting in life stronger and more effective when we work together! It is exciting to hear about other groups of people's hearts for the disabled in the communities around us and that same heart and desire beats at 500 miles to help disabled become restored and valued. It has been amazing to see how this side of developing the service has taken off in the north, sometimes the organisation has just come to the door of 500 miles and say 'we have these people we would like to help more but can't, we are happy this 500 miles P&O service is now available in the northern region to help these individuals how can we help them?'.

Another aspect that has been interesting to watch develop is how physiotherapy can be integrated into the service to benefit 500 miles clients. We were very blessed in April 2013 that the amputee rehabilitation team from my old NHS trust wanted to give their old set of PPAM aid early walking aid equipment to 500 miles. I can see that this new aspect to the 500 miles service will be a very important step in assisting amputees here in Malawi as normally for the CRE technique used to make a prosthetic limb a client has to wait for 3-4 months from surgery before using a new limb, due to stump healing and swelling. Now with this equipment we have been starting the rehabilitation process earlier with clients when they are still even on the surgical wards, so promoting their overall mobility and confidence in becoming a potential limb wearer.

In 2013 we embarked on a comprehensive sensitisation and outreach assessment programme for the whole of the northern region where the service should reach. We started this in Mzimba North and South districts which are closest to Mzuzu but still very rural settings. The response has been overwhelming! In just certain parts of these 2 districts, Northern region having a total 7 districts, over 750 physically disabled individuals have been assessed by the 500 miles staff on Outreach Clinics and this revealed over 350 of these individuals being appropriate for the P&O service and booked appointments. The need here is great, people in the villages rarely move far and often don't know about specialised services or where to get assistance. Also there can be a lot of discrimination towards disabled individuals particularly in the more remote and less educated areas; this always causes people to lose hope and feel rejected by their society. Our hope is that as we continue to reach out with the information about the new 500 miles service and create access for those who really need it, we will continue to find those individuals that have been struggling along on their own and give them the assistance the service can offer.

I have thoroughly enjoyed my time as manager of 500 miles in Mzuzu over the past 3 years and have learnt so much from the challenges and the successes that have sprouted up along the way. Looking back I can see how I have been stretched in my thinking and approaches in how to develop a service in a completely new culture and setting. Learning how to manage and support a dynamic team of staff who possess different levels of skills and aspire to get the best out of everyone. This role and location has exposed my professional skills to many rarer and more challenging cases, both in amputee and neuro rehabilitation. My view of healthcare and service development within society has also been heightened, helping me to view not only managerial aspects to a service holistically but also to see how these aspects directly impact on patient care. Finally working with inspiring individuals everyday who, despite what life has thrown at them, push on through with an inner strength and desire to keep going, has enriched both my professional and personal life.

Please send an email to olivia@500miles.co.uk if you are interested.

BACPAR Journal Issue 44, Autumn 2015

WCPT Network for Physical Therapists working with Individuals with Limb Loss or Limb Absence

WCPT AR Network for physical therapists working with individuals with limb loss or limb absence

At the time of writing this article (August 2015), there are 103 members of the WCPT AR network including (in no particular order) those from the UK, USA, Australia, Portugal, Denmark, South Africa, Malta, Nepal, New Zealand, Norway, Spain, Canada, Serbia, Singapore, Ireland, and Sweden.

Established in Autumn 2013 with BACPAR's support, the Network is free to join; the only pre-requisites are that you are a member of your country's Physiotherapy membership society and that it in turn is a member of the World Confederation of Physical Therapy (WCPT) - the CSP is. For those reading this from outside of the UK there is a list of WCPT member organisations - http://www.wcpt.org/members and that you have an interest in the rehabilitation of Individuals with Limb Loss or Limb Absence.

At its heart the Network's discussion forum, sharing good practice over a wider net than the UK alone but perhaps also for asking that question that can only be partially answered within the UK, and giving support to those working in isolation. The homepage of the network http://www.wcpt.org/ar , a resource for Guidelines and links to individual country's amputee rehabilitation organisations.

The aims of the network are:

- To encourage, promote and facilitate the interchange of ideas, research, knowledge and skills in amputee rehabilitation for education and practice:
    - sharing clinical guidelines;
    - discussing and promoting the use of outcome measures;
    - support pre-registration education.
- To develop post registration education in amputee rehabilitation.
- To provide support and information between members of the network

To join the network and thereby gain access to the Discussion Forum you need to register on LinkedIn, if you are not already registered, and then submit a request to join the AR group at http://www.linkedin.com/groups/WCPT-Network-Amputee-Rehabilitation-AR-5140337/about.

As one of the network facilitators with Helen Scott from the UK and with Kajsa Lindberg in Denmark, Alexandre Coelho in Portugal and Heather Curtis in Australia, the first opportunity for us all (pictured) to meet in person came when we all attended World ISPO Congress in Lyon. Sharing poster space with BACPAR (thank you) and SPARG, in the International Community Lounge (close to the Ortho Europe stand- thanks OrthoEurope for refreshments and seating) this acted as a meet up point for WCPT AR/ BACPAR and SPARG members alike. My attendance was enabled by both a BACPAR and ISPO bursary as well as support from my own NHS Trust.

Some WCPT AR members (including 2 facilitators; Alex and Kajsa) were able to meet at the WCPT Congress in Singapore in May. The first networking meeting for amputee rehabilitation was chaired at the Congress by Kajsa and Alex and was attended by 50 people and there was also an Amputee Rehabilitation Focused Symposium in the programme, the recording for which is available here http://www.wcpt.org/congress/fs/69

The next European meet up opportunity with be at the 4th European Congress of the European Region of the World Confederation for Physical Therapy, 11-12 November 2016 which is being hosted by the CSP in Liverpool.
Both WCPT and ISPO Congresses will be held in South Africa in 2017 so hopefully an opportunity for the wider amputee rehabilitation Physical Therapy community to meet up again.

So in anticipation of these meetings, join the Network and make new friends and colleagues around the world as I have.

Louise Tisdale Network Facilitator WCPT AR

Time for a change

Since the early nineties (I can't even remember exactly when) and ever since BACPAR was formed I have been on the executive committee. I've done most things; chair, PRO, journal editor, education officer, conference organiser, research officer and guidelines co-ordinator…all except treasurer, but who would trust me with the money?

I have seen BACPAR develop into the influential, respected and innovative organisation it is today. BACPAR was the first clinical interest group (now professional network) to embrace iCSP, realising the potential for communication, the amputee rehab site was one of the original pilots (moderated by BACPAR) and ours was the first closed network for a committee. We continue to work with other stakeholders in amputee rehabilitation, especially SPARG as well as the CSP, ISPO, BAPO & the patient groups such as APPLG & the Limbless Association. We have contributed to the National Service Framework on Diabetes, The Quality Service Framework for Major Amputation Surgery, and more recently the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the list goes on.

I believe BACPAR has had a major influence on physiotherapy for amputees and prosthetic users in the UK. It provides a network for the few of us working in this specialist area and through the regional study days and now the two day conference, provides the opportunity for us to meet, moan, enthuse and develop our knowledge. The collaboration with Bradford University and now Southampton University has pushed knowledge and skills even further. And then there are the guidelines. I've said before how proud I am of them, they really have made a difference and they remain the only CSP guidelines that have been expanded and updated.

Now BACPAR is starting to make a difference worldwide too. The original guidelines were adopted by the International Red Cross but just in the last year BACPAR has had a major role in the training of physiotherapists on the UK trauma register, which has resulted in physios working with Handicap International being supported in difficult places such as Gaza, Nepal & the Ukraine. The massive open on-line course (MOOC) from Physiopedia was developed with help from BACPAR members, 7639 (mostly physios) enrolled for the course from 153 countries!

In just under 25 years BACPAR has achieved a lot and I am proud to have been involved. I've met and worked with some amazing people and I've learnt a lot too, but now it's time for me to move on. There is still plenty for BACPAR to do and it has never been more necessary to have an advocate for patients undergoing amputation and their physiotherapists. I am keen to see how BACPAR rises to the challenges with the help of new enthusiastic (younger) members.

I don't want this to sound like an Oscars acceptance speech but I will just finish with; Thank you!

Penny Broomhead

Guidelines for Journal Article Submission

Submitting a document:
- Please send the article as a Word or PDF file.

- If your article includes pictures please also send these as separate files (JPEG, BMP, GIF, PNG etc format) at the highest quality you have.

- If your article includes graphs please also send these as separate Excel files and name these the same as your article followed by a number in the sequence that they appear in the article (as with pictures). If all the graphs are in one Excel file this is fine.

Please use the email address bacpar@flutefamily.me.uk for your submissions and any queries

DEADLINE for Spring edition Friday 12th February 2016

New and Exciting Professional Development Opportunities in Amputee Rehabilitation and Prosthetic Use

Background

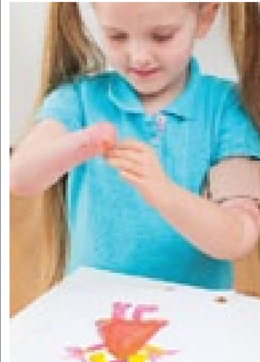
The University of Bradford hosted and delivered the first Post Graduate Certificate in Amputee Rehab with three cohorts successfully completing – simultaneously developing and publishing several excellent and valued evidence based guidelines and guidance for best practice in the field. Unfortunately the university was unable to continue hosting the course.

A survey of the BACPAR membership highlighted the desire to continue with this level of professional development. Consequently, in spring 2014, BACPAR invited all Higher Education Institutions (HEIs) in the UK to submit a proposal for such learning. Over ten HEIs expressed interest, five of which subsequently submitted more detailed outlines of potential content and delivery. The BACPAR education working group robustly scrutinised each of the proposals resulting in a final shortlist of three very commendable and thorough proposals. After yet more evaluation, the University of Southampton was selected to deliver a range of new and exciting learning opportunities in 'Amputee Rehabilitation and Prosthetic Use'.

What can the new courses offer me?

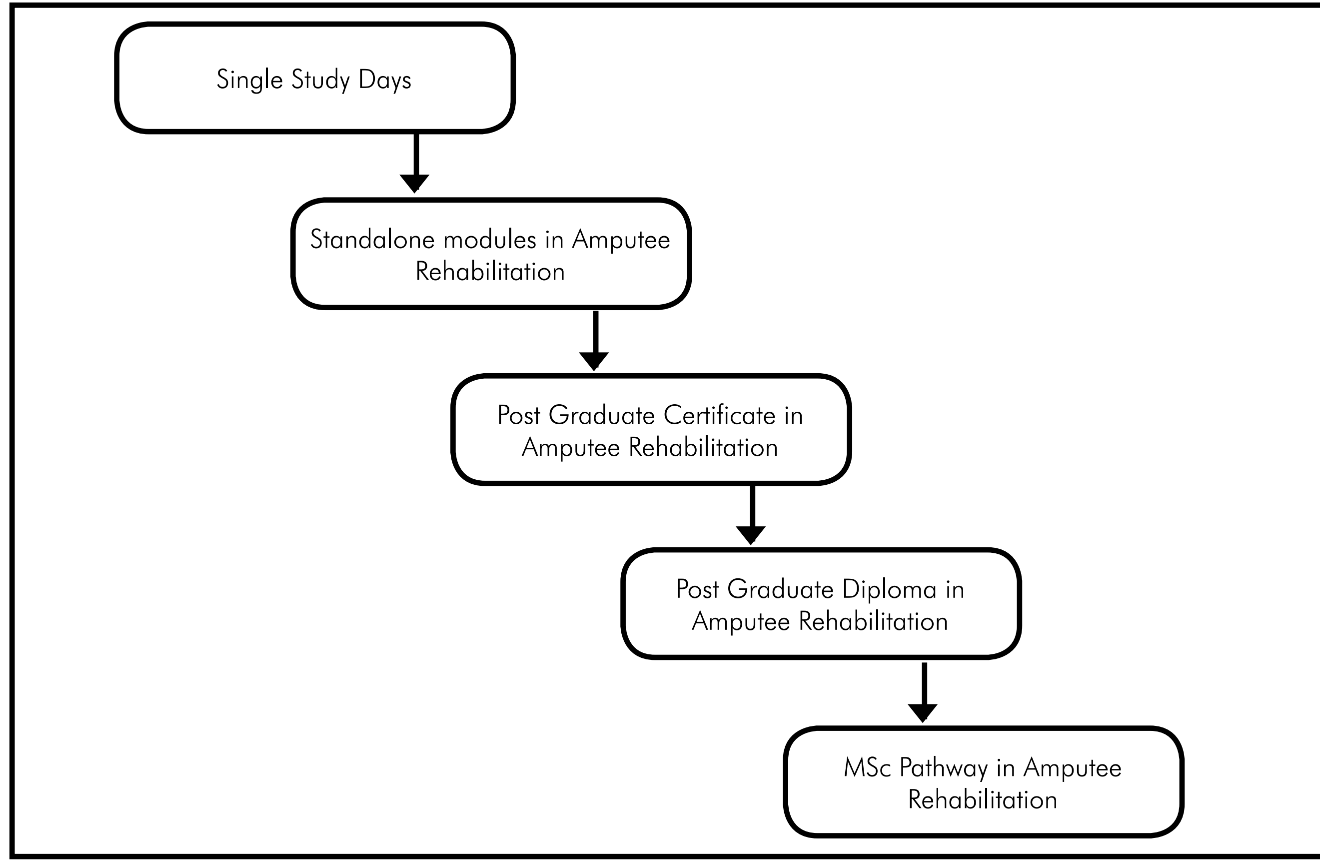
Maggie Donovan-Hall and Cheryl Metcalf from the Faculty of Health Sciences at the University of Southampton and members of the BACPAR Executive Committee education working group have worked together to design a range of flexible learning opportunities for healthcare professionals currently working in amputee rehabilitation or who would like to move into this area. This will enable students to gain an in depth understanding of the patient journey from pre-amputation to prosthetic rehabilitation within a holistic framework, exploring both the physical and psychological aspects of patient care.

This has involved the development of two exciting new modules that provide the opportunity to offer flexible CPD opportunities ranging from a single study day to an MSc pathway in Amputee Rehabilitation.

	Module 1: 'Amputee Rehabilitation and Prosthetic' (20 ECTS credits) This module provides an in depth understanding of the amputee and prosthetic rehabilitation journey. This will involve exploring key issues related to the causes of limb loss or deficiency (in both children and adults), clinical decision making, psychological and social responses, coping with pain, recovery outcomes and assessment, and quality of life issues. The module is embedded in current clinical and industrial practice and will include clinical skills sessions and a student conference and industry day.
	**Module 2: 'Contemporary Issues in Limb Loss' (10 ECTS credits)** This module addresses the wider issues relating to a contemporary view of limb loss and amputee rehabilitation, such as children and limb loss, multiple limb loss, the management of pain, skin health and infection prevention, and amputee sports, etc. Sessions will be taught in partnership with leading researchers and a wide range of professional bodies (this module is subject to validation). Sessions with both of these modules can be offered as 'study days' and we will negotiate with Professional bodies regarding CPD credits.

Flexible COD opportunities at different levels

This is an outline of the different levels flexible opportunities that can be tailored to you own leaning needs:



When will these courses start and how do I get more information?

Module 1 will start in February 2016 and to make things easier for busy clinicians, it will be taught in two blocks of four days incorporating the week-end. Module two will run in November 2016 and is likely to be taught in one four day block. To find out about any of these learning opportunities, please contact the programme leads:

Dr Maggie Donovan-Hall - Email: mh699@soton.ac.uk or Dr Cheryl Metcalf - Email: C.D.Metcalf@soton.ac.uk

Maggie and Cheryl will be presenting more details about the courses at the BACPAR Conference on the 5th and 6th November 2015 and will be hosting a stand with more information.

Mary Jane Cole MSc MSCP (Hon. Education Officer BACPAR) and Maggie Donovan-Hall (PhD, Associate Professor)

Nepal smiles again…deployment to Nepal post earthquake 2015

Nepal is a beautiful country in South Asia, landlocked between India to the south and China to the north. It has a population of approximately 29 million; while one million live in the capital Kathmandu, most live in its remote mountainous regions. Politically unsettled since the recent civil war, the United Nations estimates that 40% of the population live in poverty. Agriculture is its main source of income and tourism is a growing industry; many of us associate Nepal with Everest, the word's highest mountain at over 29,000 feet (8,846 m). Compare this to Ben Nevis, the highest mountain in the UK at 4,406ft (1,344m)!

On Saturday the 25th April this year, a massive earthquake (7.5 on the Richter Scale) struck the country about 50 miles west of Kathmandu, the worst earthquake in 80 years. The earthquake was felt as far away as Delhi in India. After-shocks continued with a huge one on the 12th of May to the east of the city.
The damage and destruction was immense. Over 8 million people were affected, up to 9,000 died and over 22,000 were injured. Half a million Nepalese were made homeless with whole villages being completely flattened. It will take many years to rebuild the country's fragile economy.

With its geological history Nepal had plans and protocols in place to respond to an earthquake. Nonetheless co-ordinated international support was essential. Part of the UK's response was through the UK Emergency Medical Team, a collaboration between UK-Med, Save the Children and Handicap International, funded by the UK government. Surgeons, nurses and allied health professionals were deployed from the UKIETR (UK International Emergency Trauma Register) at short notice from their work, mostly in the NHS. The first UK EMT (emergency medical team) left the UK for Nepal on the day of the earthquake.

© Mary Jane Cole

I have been associated with the UKIETR through the work BACPAR is currently undertaking with Handicap International UK supporting the training of therapists on the register in preparation for deployment after sudden onset disasters. With the support of my employer Kingston and St George's University of London, I had a timely period of availability to support the aid effort. I was given a clear brief to provide clinical and educational support in amputee rehabilitation. Fortunately the number of amputees was relatively small with amputations making up approximately 4% of the initial serious earthquake injuries.

I was a member of the second UK EMT, arriving about 3 weeks after the first earthquake. We were 2 physiotherapists, one OT and 2 nurses. We joined 2 other physiotherapists who between them were our team leaders and who remained in Nepal for all of the three 2 – 3 week deployments.

All of 'Team Two' – apart from me – supported survivors with spinal injuries. I was the only amputee specialist. One of my main roles was working with various members of a team of 24 Nepalese therapists – mostly physiotherapists (there is one school of physiotherapy in Nepal; the few OTs in the country train abroad) in the hospitals in Kathmandu or in 'step-down' facilities – temporary accommodation following discharge from hospital. Alongside this I provided workshops in early and pre-prosthetic management. The therapists were fantastic, incredibly hard working, receptive to teaching and work-based learning and exceptionally proactive with suggestions for practice. Their understanding of English was good making teaching easier and time efficient, and their therapeutic skills commendable.

The amputees I met were mostly young and previously fit and well, however several had multiple limb loss with a proportionately high number of upper limb amputations. A few had additional complications but for the most part physical rehabilitation was relatively straightforward particularly as the treating therapists were so proactive. It was gratifying to observe residual limbs that were mostly of good shape, length and healing well despite the need for plastic surgery in some instances. As is common practice beyond the UK, oedema control was helped by compression bandaging – a skill that the therapists and many of the amputees quickly became very proficient with. I came across one amputee with a POP rigid post amputation dressing; when we suspected a wound infection the surgeon was very receptive to the therapist's advice to remove it to examine the residuum and reapply – a great example of effective team work and best practice. Assisted devices such as crutches and wheelchairs for multiple amputees were available and once reassured and encouraged, most amputees were 'up and about' as their individual situation allowed.

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But what was overwhelmingly clear was the uncertainty about the future – many livelihoods were threatened by the earthquake. Most of the amputees and their families were poor; would they be able to afford a prosthesis? The majority of amputees came from villages with no home to return to and where subsistence was often through farming. Would they be able to walk again? More relevantly, would they be able to walk up and down steep hills and manage rough terrain? Added to this was the stigma associated with disability, for example problems returning to school were anticipated with the younger amputees, let alone those seeking employment.

The Nepal government agreed that all earthquake survivors were entitled to free healthcare – and this included prosthetics. This at least was of some reassurance. But would existing prosthetic services cope with the demand post earthquake? This important question was addressed through the formation of a Prosthetics and Orthotics Working Group, as part of the Ministry of Health Injury and Rehabilitation sub cluster. I was privileged to work with Amit Ratna Bajracharya, one of few P & Os in Nepal. Together we liaised with government funded and private P & O providers in Kathmandu (and further afield via the working group), visiting centres to meet with personnel, to scope current capacity and identify needs to support an ongoing sustainable prosthetic rehab service. We made good progress in a short period of time and were able to make initial recommendations to prosthetic centres and the Ministry of Health, for example referral pathways were provided to all amputees and health care professionals. Amit continues to work closely with all relevant parties to ensure all earthquake amputees are informed of available appropriate services and I understand that prosthetic rehabilitation is now underway.

The Nepal Earthquake was the focus of a symposium at ISPO World Congress in Lyon, France in June. Eminent speakers such as Dr Ian Norton of the World Health Organisation and Dr Wesley Pryor, Handicap International Adviser for Rehabilitation in Asia, spoke passionately about the situation, referring to the importance of timely co-ordination of appropriate aid efforts and how further lessons on how to best manage sudden onset disasters have been learned. Amit also joined us and shared his experience of the post earthquake situation highlighting the challenges but also the opportunity that the earthquake situation brings to review existing prosthetic services and build on quality of care and standards of practice through education. Unfortunately Sunil Pokharel a Nepalese physiotherapist I had worked with – one of the local physiotherapy team leads in Kathmandu – was unable to get his visa to visit France but Berengere Gohy a physiotherapist who works for Handicap International (coincidentally HI is based in Lyon) and who had also worked in Nepal post earthquake, stepped in to recount the therapy perspective and outcomes. After the symposium several people said it was the highlight of their congress, such was the concern felt for the Nepalese and the need to learn from these devastating events.

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Personally and professionally I gained a great deal. The resilience of people when faced with catastrophic events is incredible; whether a survivor, a health professional or any other member of the community. I was both humbled and privileged to visit Nepal and help in a modest way.

Please take a look at this link which describes the plight of one earthquake survivor, Nirmala, and her family.
http://www.handicap-international.us/nepal_smiling_again

Nirmala and Khembro have come a long way since I first met them. Khembro was especially afraid but the rapport between the girls and their physiotherapist Sudan was a joy to see and its credit to him and their families that they now illustrate such a positive outlook on what continues to be a very challenging situation.

If you want more information on Handicap International's work in Nepal please visit www.handicap-international.org.uk/nepal

For further information on the UK Emergency Medical Team, please visit www.uk-med.org/trauma or contact peter.skelton@hi-uk.org

Mary Jane Cole MSc MSCP BACPAR Vice-Chair and Hon. Education Officer

SPARG REPORT

A Survey of the Lower Limb Amputee Population in Scotland, 2012

Executive Summary

This is the 20th Annual Report on data collated from lower limb amputees in Scotland by the Scottish Physiotherapy Amputee Research Group (SPARG). All major amputations carried out in 2012 are included, that is, ankle disarticulation (A.D.), transtibial (T.T.), knee disarticulation (K.D.), transfemoral (T.F.), hip disarticulation (H.D.), and transpelvic. Patients having partial amputations of the feet and amputation of the toes are excluded.

All data are entered locally onto the SPARG web-based data base. The data-base has reporting facilities which allow for local data checking and analysis (see Appendix B for the list of available reports).

National and individual hospital data are presented in this report. Individual hospital data are summarised to facilitate comparison of outcomes and the benchmarking of services. The data items or key performance indicators for each hospital were identified by a previous, multidisciplinary benchmarking exercise (Scott and Patel 2009). Each of the larger centre's (n≥10) model of care has been described according to criteria identified in the benchmarking report just mentioned and agreed following consultation with SPARG members. This information has been summarised in Section 6 (see also Appendix H).

Once again, national data are broadly consistent with these from previous years; significant changes and trends of note are reported in this summary. Where possible, comparisons are given in the body of the report for at least the 6 years 2007-2012.

Results

In 2012, there were 708 amputees and 752 amputations, some patients having a re-amputation to a higher level, or a bilateral amputation, during the same episode of care.

The quality management "data checking" system introduced in 2003 continues to be highly successful. The percentage of records which are complete in every respect is 96.75%.

Demographic data remain broadly similar over 5 years. The mean age at amputation is 67.58 years in 2012 and peripheral arterial disease and/or diabetes, accounted for 84% of all amputations. The percentage of amputations due to diabetes has fallen to 42% reversing an apparent trend upwards to 45% in 2010. In this group, males outnumber females by 2.1:1 and the mean age at amputation is 3.4 years less than the group with peripheral arterial disease without diabetes. There has been a decrease in the number of amputations carried out due to orthopaedic conditions, from 40 in 2011 to 26 in 2012.

The percentage of amputations carried out at a T.T. level in 2012 was 53.5%, reduced from a peak of 60% in 2007 but up from 50.2% in 2010. When individual hospital data (centres, n≥10) are examined, the differences are large, varying from 82% to 42%.

41% of all amputees are fitted with a prosthesis. When examined by level, 67% of T.T. and 26% of T.F. amputees are fitted. There is still discrepancy between males and females fitted with a prosthesis with more men being fitted than women in particular at T.F. level (T.T., M:F=69%:61%) (T.F., M:F=34%:13%). When individual hospital data are examined, the differences in percentage of amputees being successfully fitted are large, varying from 90% to 22% (centres, n≥10).

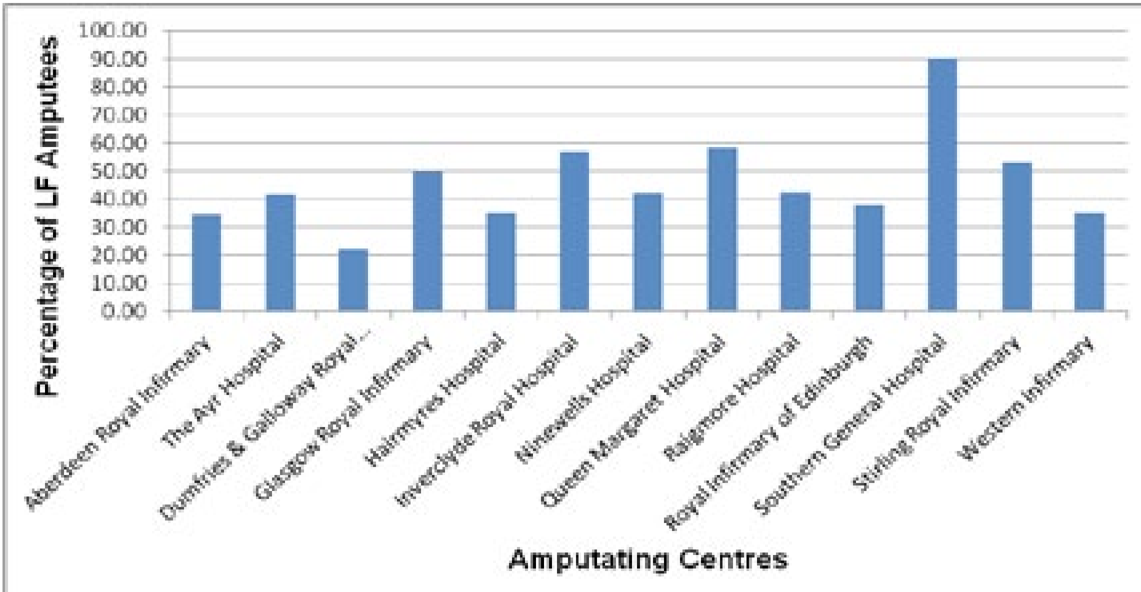

Table 1: Percentage of amputees who were limb fitted in each of the amputating centres (> 5 amputees)

For the seventh year, the figures for prosthetic rehabilitation being abandoned are reported. These are unilateral, TT= 8.56%, unilateral, TF=10.45% and bilateral, 8.85%.
Inpatient length of stay for limb fitted amputees has increased slightly since 2011 (TT, median 51 days, TF, median 49 days), but is still significantly less than 2010 and before.

Discussion and conclusions

Service changes in 2012

Vascular Surgery services in Forth Valley were centralised to Forth Valley Royal Infirmary, Larbert (July 2011, not reported in 2011 report) and surgical services moved from Queen Margaret Hospital to the new Victoria Hospital, Kirkcaldy (January 2012).
A multidisciplinary In-Reach service from Astley Ainslie Hospital to Royal Infirmary of Edinburgh was initiated in March 2012.
New local audit, research and development projects
The SPARG data set has been central to the development of additional pieces of work as follows (see Appendix A for more detail): -
Joanne Hebenton started work on the CSP Funded project 'How do models of care in Scotland impact on the use of the PPAM aid in Scotland?' at the beginning of September. This is a collaborative project with NHS GG&C, SPARG and Caledonian University. It was proposed as a result of the apparent trend in Scotland for fewer amputees to be treated with an early walking aid prior to 10 days after surgery despite the recommendations of current evidence and guidelines (Smith at al 2003, Dawson et al 2008 and Bouch et al 2012).
Fiona Smith is working on her PhD funded by Diabetes UK. The purpose of the project is to investigate the factors which affect rehabilitation outcome following lower extremity amputation in people with diabetes and to use this information to propose a service delivery model to improve outcomes for this patient group (see Appendix A)
The results of a collaborative project linking 3 years of SPARG data (2008 – 2010) to vascular surgery data to investigate factors affecting survival and outcome following major lower limb amputation for PAD with or without Diabetes is written up and is currently submitted for publication (see Appendix A).
Key messages from the 2012 report are: -
There is a reduction in the number of patients undergoing an amputation as a
result of an orthopaedic condition back to pre-2011 levels (see Appendix C for definition of orthopaedic aetiology)
There are more patients being treated with a rigid post-operative dressing.
There are more T.T. amputees being revised to T.F. level.
There are more bilateral T.F. amputations carried out in the same hospital admission.
There was a decrease in time from surgery to casting for first prosthesis by one week for T.T. in 2011 and this has been maintained in 2012.
There is an increase in time to cast for T.F. This may be related to the requirement for patients to achieve certain rehabilitation milestones measured using the Trans-femoral Predictor (Condie et al 2011) prior to being allocated an

appointment at Westmarc, the largest Prosthetic Service in Scotland (initiated in 2012).
Outcomes and milestones continue to vary significantly between hospitals, most importantly, the proportion of amputations carried out at a T.T. level and the proportion of all patients successfully limb fitted.
Proportionally, fewer women continue to be limb fitted compared to men.
Limb abandonment rate for T.T. has increased. This may be related to abandonment rates being reported according to initial amputation level, that is, some of these patient's final level of amputation will be T.F..

Points for action: -
The large variation in the proportion of amputees successfully limb fitted between centres warrants further investigation by the local multidisciplinary teams.
Investigate in more detail the key aspects of services that appear to improve speed and outcomes of rehabilitation after lower limb amputation now a description of each centre's model of care is available.
Ensure all outcomes are reported according to final level of amputation.
Review reporting of aetiology, in particular, how diabetes and orthopaedic conditions are defined.
Include in next report length of stay in acute units as a proportion of overall hospital length of stay.
For the first time this year the final draft of this report was reviewed by a national multidisciplinary group (see Appendix I). This group will advise on the content of the next report and review the data again prior to publication.

Ms H Scott-Team Leader Physiotherapist and SPARG Chairman Westmarc, Southern General Hospital

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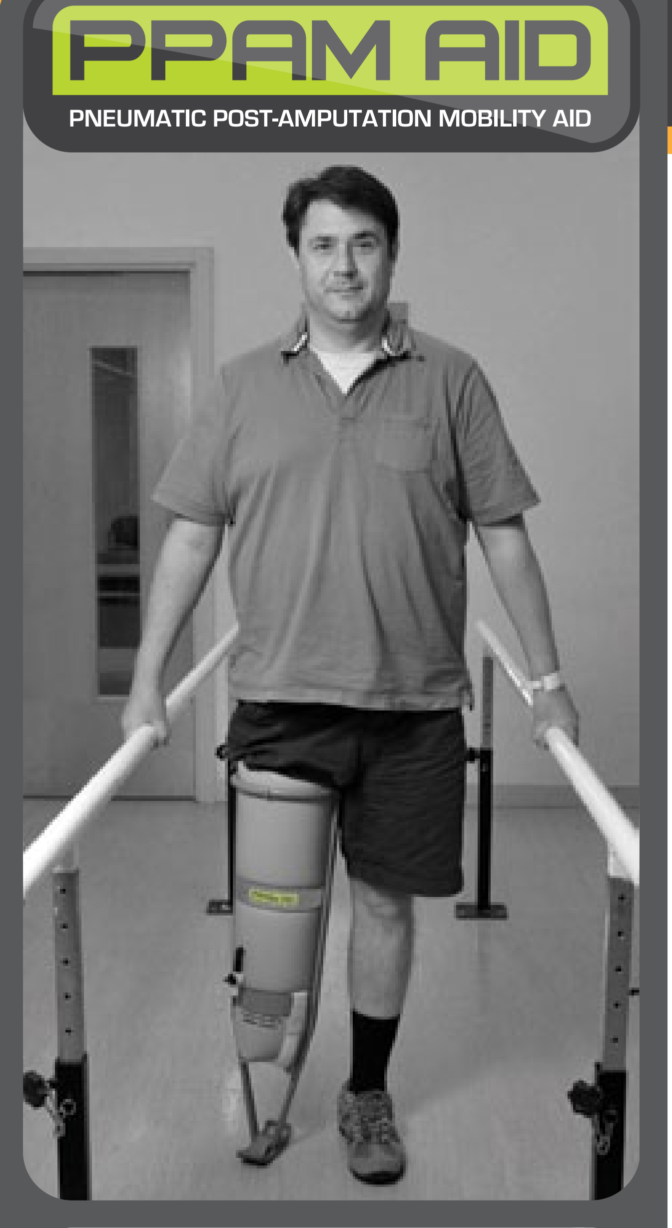

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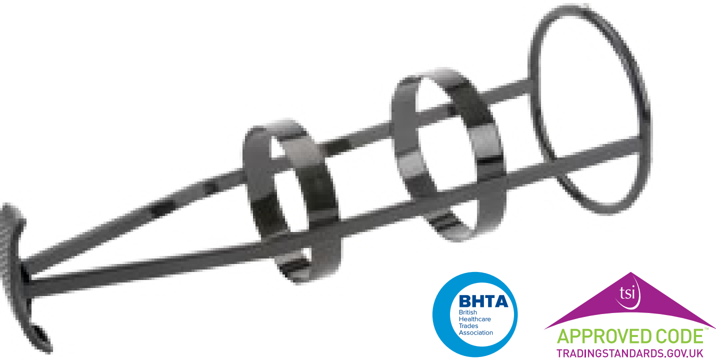

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