EUROPEAN REGION
World Confederation for Physical Therapy

European Core Standards of Physiotherapy Practice

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EUROPEAN CORE STANDARDS OF PHYSIOTHERAPY PRACTICE

European Region of the World Confederation for Physical Therapy (WCPT)

Professional Issues

Background

The World Confederation for Physical Therapy aims to improve the quality of global health care by: encouraging high standards of physiotherapy education and practice. The commitment to ensuring high standards and quality of service is reflected in the Declarations of Principles and position statements (WCPT, 1995). The Declarations of Principle and Position Statements (1995) document outlines Ethical principles that member organisations agree to adhere to by virtue of their membership of WCPT.

The principles state that physiotherapist must:

- Respect the rights and dignity of all individuals;
- Comply with the laws and regulations governing the practice of physiotherapy in the country in which they work;
- Accept responsibility for the exercise of sound judgement;
- Provide an honest, competent and accountable professional service;
- Be committed to providing quality services according to quality policies and objectives defined by their national physiotherapy association;
- Be entitled to a just and fair level of remuneration for their services;
- Provide accurate information to clients, to other agencies and the community about physiotherapy and the services physiotherapists provide;
- Contribute to the planning and development of services which address the health needs of the community

The World Confederation for Physical Therapy recognises the absolute importance of the development and documentation of agreed standards for the practice of physiotherapy. These standards are the means by which the declarations of principle can be measured and evaluated.

These standards are necessary to:

- demonstrate to the public that physiotherapists are concerned with the quality of the services provided and are willing to implement self-regulatory programs to maintain that quality;
- guide the development of professional education;
- guide practitioners in the conduct and evaluation of their practices;
- provide governments, regulatory bodies and other professional groups with background information about the professional nature of physiotherapy.

- Standards should reflect the values, conditions and goals necessary for the continuing advancement of the profession;
- Standards must be based on valid principles and be measurable;
- Standards are designed to assist the profession to meet the changing needs of the community;
- Standards should serve as a means of communication with members of the profession, employers, other health professions, governments and the public.

How have these standards been developed?

In response to the guidance from WCPT the Professional Issues Working Group of the European region of WCPT considered developing a tool which provides an analysis of interaction between the individual physiotherapist or physiotherapy services in order to evaluate and promote high standards of practice.

Practice standards from several countries were reviewed and it was felt that the Core Practice Standards produced by the CSP (Chartered Society of Physiotherapy, UK) were very clear and easily adapted for use by the European Region. Permission was granted by the CSP for use of this tool.

The tool provides clear statements about the expected quality of interaction required to apply the ethical principles outlined by WCPT. The statements are broken down into criteria, which describe how the standards will be achieved. The criteria are measurable so that patients, physiotherapists and others can determine the quality of the interaction.

Who should use the Core Standards?

The Core Standards is a tool that can be used by physiotherapists, patients, members of the public, managers and others who have an interest in providing or receiving high quality physical therapy services.

The term ***patient*** is used in this document as a generic term to refer to individuals and groups of individuals who can benefit from physiotherapy intervention. It includes those who may be called ***clients*** or ***users***.

The standards expressed in this document may apply to physiotherapy students, assistants and physiotherapists. The European Region of WCPT recognises that the professional name "physiotherapist", is the sole preserve of persons who hold qualifications approved by national professional associations which are members of the World Confederation for Physical Therapy. It must be further stated that the European Region in agreement with WCPT acknowledge that physiotherapy is the service only provided by, or under the direction and supervision of a physiotherapist and includes assessment, diagnosis, planning, intervention and evaluation.

The core standards are those that apply to, and are the responsibility of the individual physiotherapist.

The tool includes a patient record audit, a continuing professional development audit, guidance on a peer review process, a patient feedback questionnaire and audit tool for service standards.

Who do the standards apply to?

These standards apply to all physiotherapists, whether newly qualified or highly specialist, in direct or indirect contact with patients, carers and other professional colleagues.

These standards are also applicable to students of physiotherapy and physiotherapy assistants (where they exist). Not all standards will apply to assistants and students, the degree to which they apply will be determined locally, for example by the extent to which tasks and responsibilities are delegated to them by qualified physiotherapist.

What is the status of these standards?

These standards are not minimum standards or standards of excellence but they are considered to be achievable. They are presented as standards that all physiotherapists should aspire to as part of their professional responsibility. Any necessary changes in practice needed to achieve these standards will be the responsibility of the individual practitioner.

There may be organisational barriers to the implementation of theses standards, for example limitation in access to sources of evidence about effective practice for those working in isolated community settings. In these situations the standards should be used to highlight the expectation that all physiotherapists and physiotherapy services, should be able to achieve all the standards and that systems need to be put in place to facilitate this.

(Throughout this document the term physiotherapy is used but it is understood that this term is interchangeable with physical therapist where applicable member organisations may opt to use the alternative term.)

Patient Partnership

Respect for the Individual

a. STANDARD 1

Recognition of the patient as an individual is central to all aspects of the physiotherapeutic relationship and is demonstrated at all times.

Criteria

1.1 The physiotherapist responds to individuals' lifestyle, cultural beliefs and practices and should base their response on fact not assumption.

Guidance: *Physiotherapists need to respect and respond actively to every patient as an individual. The physiotherapist should consider a patient's social, occupational, recreational and economic status, culture, race, gender, sexual orientation, religion, disability, age, beliefs, values, abilities, mental well being as these may impact on a patient's physical and psychological well-being.*

1.2 The physiotherapist is courteous and considerate.

Guidance: *The physiotherapist must be aware of the impact of their own beliefs and values on their practice, and consider this.*

1.3 The patient is addressed by the name of their choice.

Guidance: *Physiotherapists must be aware of the cultural difference in naming systems. Patients should be asked for "first and family name".*

1.4 The patient is informed of the name of the physiotherapist responsible for their episode of care.

1.5 The patient is aware of the role of any member of the physiotherapy team, or other health care professionals involved in their care.

Guidance: *Patients should be informed if a physiotherapy assistant or student is treating them.*

1.6 The patient's privacy and dignity is respected.

Guidance: *Examinations, assessments and treatment require a private environment. Where this is not possible, care should be taken to avoid discussions being*

overheard. Intimate examinations may need greater privacy, and patients should be asked if they would like a family member/friend present to support them. Physiotherapists need to remember that privacy differs across cultures.

1.7 Chaperoning is provided where appropriate.

Guidance: *This will vary according to local policy, the type of examination being performed and when requested by the patient.*

Informed Consent

b. STANDARD 2

Patients are given relevant information about the proposed physiotherapy procedure, taking into account their age, emotional state and cognitive ability, to allow valid/informed consent to be given.

Guidance: *Detailing the nature and purpose of any proposed intervention or treatment is sufficient for the purpose of valid/ informed consent as part of which the .the physiotherapist has a duty to inform the patient of all potential and significant risks, benefits and likely outcomes of treatment. For patients who may not be competent to give informed consent, for example, some children where consent may be obtained from parents/ guardians, unconscious patients, patients with severe mental health problems, confused patients and some patients with learning disabilities, consent is obtained wherever possible, guardians, carers or others designated to act on the patient's behalf. In some countries consent may be obtained from relatives or careres on the patients behalf while in others the decision to treat is made by professionals in the best interest of the patient. Living wills are statements made by the patient when they are capable of giving consent and are binding in the countries who recognise them. Where difficult decisions about consent have to be made, circumstances should be discussed with colleagues and other health professionals involved in the care of the patient, before making a final decision. The WCPT Declarations of Principle (1995) should be read in conjunction with these standards.*

Criteria

The patient's valid/informed consent is obtained before starting any examination / treatment.

2.1 Treatment options, including significant benefits, risks and side effects, are discussed with the patient.

Guidance: *Written information may need to be provided in an appropriate language and format. For example: a physiotherapist considering the use of electrotherapy*

would discuss with the patient the evidence for its effectiveness, but also highlight the very small risk of injury from burns.

2.2 The patient is given the opportunity to ask questions for clarification.

Guidance: *Patients may need time to absorb information and be given opportunities to ask questions on a number of occasions.*

2.3 The patient is informed of their right to decline physiotherapy at any stage without it affecting their future care.

2.4 If the patient declines physiotherapy, this is documented in the patient's record, together with the reasons, if these are known.

2.5 *In those practices that have student placements* the patient is informed that they may be treated by a physiotherapy student, or physiotherapy assistant and given the right to decline this option, and to be treated by a qualified physiotherapist.

2.6 The patient is informed that their treatment may be observed by a Student, and given the right to decline.

2.7 The patient's consent to the treatment plan is documented in the patient's record.

Guidance: *Obtaining consent is an ongoing process throughout the episode of care. Refer to Standard 8, criteria 8.1.*

2.8 Physiotherapists must uses his/her judgement in deciding when written consent is needed e.g. in the case of invasive or high risk procedures.

2.9 Where written consent forms are used a copy is retained in the patients record.

2.10 Patient information leaflets should be given where possible; to assist in the consent process and a note of the information given should be kept in the patients' record.

Confidentiality

c. STANDARD 3

Information which the patient gives to the physiotherapist is treated in the strictest confidence.

Guidance: *Rules of Professional Conduct from the Member Organisation should be read in conjunction with these standards as it provides more detailed guidance on this matter.*

Criteria

3.1 There is privacy when discussing personal details.

Guidance: *This applies during "face to face" contact with patients, carers or other health professionals. Care should be taken whenever discussing patient details, for example when using the telephone.*

3.2 The written consent of patients is obtained before using identifiable clinical information, photographs, videos etc. for teaching, publication or other purposes.

3.3 In discussion with the patient, the physiotherapist may allow other healthcare workers access to patients' physiotherapy records when it is of benefit to the patient.

Guidance: *Patient's confidential information still remains confidential after a person's death. In these cases, permission must be obtained from the executor or next of kin (closest relative).*

3.4 Physiotherapy information is only released to sources other than those immediately involved in the patient's care when there is a signed patient consent form to allow this.

Guidance: *This is particularly important when information is sought from an employer wishing to obtain details about an employee. For legal reports, written consent from the patient must be obtained before releasing any information. Patients should be made fully aware of the extent of the information requested and subsequently released.*

3.5 Patient identifiable information is transmitted securely.

3.6 Steps are taken to ensure the confidentiality of patient identifiable data held, or transmitted in electronic formats.

3.7 Where confidentiality cannot be guaranteed, the patient should be informed of this, and given the option to decline giving information.

3.8 Steps are taken to ensure the confidentiality of patient identifiable data seen by physiotherapists but intended for other professional staff.

Assessment and Treatment Cycle

Assessment

d. STANDARD 4

In order to deliver effective physiotherapy intervention, information relating to treatment options is identified, based on the best available evidence.

Guidance: *There will be a range of different sources for obtaining this information including the patient, relatives/carers, other health care professionals, library facilities, electronic sources, journals, local policies.*

Criteria

4.1 The physiotherapist considers and critically evaluates information about effective interventions relating to the patient's condition.

Guidance: sources may include:

- **a.** research
- **b.** clinical guidelines, and other summaries of evidence of effectiveness
- **c.** special interest groups
- **d.** national guidance
- **e.** local standards and protocols
- **f.** information derived from the use of outcome measures
- **g.** patient organisations/groups
- **h.** expert opinion
- **i.** reflection on own practice

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Section 1.02

STANDARD 5

Information relating to the patient and his/her presenting problem is collected.
Guidance: *Where appropriate, information collected should reflect the values and needs of the patient and their main carers. Background information collected regarding the patient's presenting problem may come from published research findings or evidence.*

Criteria

5.1 There is written evidence of a gathering together of data. ~~consisting of:~~

This includes:

a. the patient's perceptions of his/hers needs
b. the patient's expectations of physiotherapy intervention
c. the patient's demographic details
d. presenting condition/problems
e. past medical history
f. current medication/treatment
g. contra-indications/precautions/allergies
h. social and family history/lifestyle

Guidance: *This will include the effects of impaired activity and participation according to ICF*

i. relevant investigations

5.2 There is written evidence of a physical examination carried out to obtain measurable data with which to analyse the patient's physiotherapeutic needs.
Guidance: *The extent of the physical examination may be determined by the clinical speciality or by the patient's presenting condition at the time of examination.*

This includes:

a. observation
b. use of specific assessment tools/techniques including standardised outcome measures
c. palpation/handling

5.3 The findings of the clinical assessment are explained to the patient.

5.4 If any of the required information is missing or unavailable, reasons for this are documented.

Section 1.03

STANDARD 6

Taking account of the patient's problems, a published, standardised, valid, reliable and responsive outcome measure is used to evaluate the change in the patient's health status.

Guidance: *The CSP database of outcome measures can be used as a resource. (www.csp.org.uk)*

Criteria

6.1 The physiotherapist selects an outcome measure that is relevant to the patient's problems.

Guidance: *The outcome measure selected should capture the components of rehabilitation that need to be evaluated. The physiotherapist chooses an outcome measure that is most likely to be impacted by treatment.*

6.2 The physiotherapist ensures the outcome measure is acceptable to the patient.

Guidance: *The outcome measure should be explained to the patient (refer to standard 2).*

6.3 The physiotherapist selects an outcome measure which he/she has the necessary skill and experience to use, administer and interpret.

6.4 The physiotherapist takes account of the patient's well being during the administration of the measure.

6.5 Written instructions in the manufacturer's manual, test designer's manual or service guidelines are followed during the administration and scoring of the measure.

6.6 The result of the measurement is recorded immediately.

6.7 The same measure is used at the end of the episode of care and at periods during the episode of care as appropriate.

Section 1.04

Section 1.05 ***Analysis***

STANDARD 7

Following information gathering and assessment, analysis will be undertaken in order to formulate a treatment plan.

Criteria

7.1 There is evidence of a clinical reasoning process.

Guidance: *The peer review process (see audit tool document) provides the opportunity to evaluate the clinical reasoning process.*

7.2 There is written evidence of identified needs/problems, formulated from the information gathered (refer to standards 4 and 5).

Guidance: *The WHO International Classification of Functioning, Disability and Health (ICF) may be used.*

7.3 Subjective measures are identified recorded and evaluated

Guidance: *These measures may include patient descriptions such as pain, severity, nature, location and diurnal variation of the presenting complaint.*

7.4 Objective measures are identified, recorded and evaluated.

Guidance: *Quantifiable measures such as range of movement and limb girth are included.*

7.5 A physiotherapy diagnosis with relevant signs and symptoms is recorded.

Guidance: *A medical diagnosis is a clinical decision arrived at as a result of assessing the patient's signs and symptoms. It generally labels the pathology present, but makes no assumption regarding the effect the pathology has on function.*

The term 'physiotherapy diagnosis' is arrived at either independently of or in conjunction with a medical diagnosis. Physiotherapy diagnosis' refers to the presenting physiotherapy problem. It is generally expressed in terms of how a condition compromises the functioning of a patient.

7.6 If the patient and physiotherapist decide no treatment is to be given, this information is relayed to the referrer, where there is one.

7.7 Relevant clinical investigations / results to assist the diagnosis and management process are documented and evaluated.

Guidance: *These tests may be requested by a physiotherapist or other health care professional.*

7.8 Patient expectations should be elicted and documented

Guidance: *The WHO International Classification of Functioning, Disability and Health (ICF) may be used. (patients find goals very difficult to formulate. The importance of patient expectations is strongly supported by evidence.)*

Section 1.06 *Treatment Planning*

STANDARD 8

A treatment plan is formulated in partnership with the patient.

General Guidance

The treatment plan should be based on the best available evidence. Evidence is likely to be a combination of research based evidence, clinical reasoning and consideration of the unique presentation of the patient.

Criteria

8.1 The physiotherapist ensures that the patient is fully involved in any decision-making process during treatment planning.

Guidance: *The physiotherapist should take account of the goals and aspirations of the patient and ensure that they have sufficient information in order to participate in the decision making process where able.*

8.2 The physiotherapist demonstrates that they have considered the patient's and/or carer's needs within their social context.

Guidance: *The plan will be based on the information gathered during the assessment process relating to social and family history (e.g. work, sport and lifestyle) and reflect cultural and religious beliefs .Consideration is given to things that may impact on treatment . The WHO International Classification of Functioning, Disability and Health~(ICF) may be used.*

8.3 The treatment plan clearly documents the chosen interventions including:

- **a.** time scales for implementation and/or review
- **b.** goals
- **c.** outcome measures
- **d.** the identification of those who will deliver the *treatment* plan including collaborative and multi-professional team working
- **e.** relevant risk assessments
- **f.** delegation of activities to assistants or carers

8.4 If clinical guidelines or local protocols are used, the date, version, and source of the document are recorded in the patient's record.

Guidance: *This is to ensure that in the case of a retrospective examination, the case notes are judged against the accepted practice at the time. The physiotherapist may wish to keep a copy of the relevant document with the patient's notes.*

Section 1.07 *Implementation*

STANDARD 9

The treatment plan is delivered in a way that benefits the patient.

Criteria

9.1 All interventions are implemented according to the treatment plan.

Guidance: *Where there is delegation to assistants or students, responsibility remains with the person who delegated the task. The person delegating has a duty to ensure that the activity is suitable to be delegated, and the person accepting the delegated activity, has a duty to ensure that they are competent to perform the task.*

9.2 All advice/information given to the patient is recorded, signed and dated.

Guidance: *This includes written and verbal information. The physiotherapist must ensure that any information given to the patient has been understood.*

9.3 A record is made of equipment loaned or issued to the patient.

9.4 Any deviations from the intended treatment plan are recorded in the patient's record with the reasons given.

Guidance: *This is particularly important where there may be more than one person involved in the patient's care, and these health professionals may be from different professional backgrounds. It must be clear why any changes to the intended plan have occurred*. The patient must consent to any change in treatment and this recorded in their notes.

Evaluation

STANDARD 10

The treatment plan is constantly evaluated to ensure that it is effective and relevant to the patient's changing circumstances and health status.

Criteria

10.1 There is written evidence that at each treatment session there is a review of:

- **a.** the treatment plan
- **b.** subjective measures
- **c.** objective measures
- **d.** relevant investigation results

10.2 All changes, subjective and objective, are documented.

10.3 Any changes to the treatment plan are documented.

10.4 Outcome is measured at the end of the treatment plan to assess its impact.

10.5 Information derived from the use of the outcome measure is shared with the patient.

10.6 Adverse and unexpected effects occurring during treatment are reported and evaluated using relevant processes.

Section 1.08 *Transfer of Care/Discharge*

STANDARD 11

On completion of the treatment plan, arrangements are made for the transfer of care/discharge.

Guidance: *"Transfer of care" relates to transfer of care between professionals, between hospital, rehabilitation centres, and home settings also the transfer of care to carers or community rehabilitation teams. "Discharge" relates to the termination of care. For example; a person with a stroke (CVA) may be admitted to hospital, then transferred to a rehabilitation stetting and then to the home setting.*

Criteria

11.1 The patient is involved with the arrangements for their transfer of care/discharge.

11.2 Arrangements for the transfer of care/discharge are recorded in the patient's record.

Guidance: *A discharge or transfer letter should be sent if the referral was received ~~form~~ from another health professional. Discharge reports may be uni-professional or multi-professional to reflect where the patient was treated.*

11.3 When the care of a patient is transferred, information is relayed to those involved in their on-going care.

Guidance: *This should include the results of any outcome measures used, with a clear explanation of the scoring used and interpretation. We think this is over the top Information should be relayed within locally agreed timescales. The language used should be understood by the recipients.*

11.4 A discharge summary is sent to the referrer upon completion of the episode of care, in keeping with agreed local policies.

11.5 Appropriate discharge information is sent to the patient's doctor for all patients

Guidance: *If the patient has self-referred, the physiotherapist should discuss with the patient which health professional e.g. the patient's Doctor, will receive information.*

The patient has the right to refuse the sharing of such information, but the implications of refusal should be discussed and documented in the patient's record.

11.6 Transfer of patient information should respect the requirement of patient consent and confidentiality.

Communication

Section 1.09 Communication with patients and carers

STANDARD 12

Physiotherapists communicate effectively with patients and/or their carers/relatives.

General Guidance

Physiotherapists should access interpreting services where necessary and practical.

Criteria

12.1 The physiotherapist uses active listening skills, providing opportunities for the patient to communicate effectively.

Guidance: *Particular care should be taken with non-verbal communication that can affect the interaction.*

12.2 Physiotherapists communicate openly and honestly with patients.

Guidance: *In some circumstances, for example terminal care, an approach to communication may need to be agreed within the team.*

12.3 All communication, written and verbal, is clear, unambiguous and easily understood by the recipient and is available in a variety of formats.

Guidance: *Abbreviations and jargon should be avoided. Interpreters should be available for those who require them. When identifying a suitable interpreter the physiotherapist should be aware of cultural requirements, age and relationship of the interpreter to the patient. Where there is no alternative to the use of a family member, the patient should consent to this.*

12.4 Methods of communication are modified to meet the needs of the patient.

Guidance: *Communication should take account of an individual's culture and language and physical and cognitive needs. The use of alternative forms of communication such as signing, video/audio cassettes and pictures should be considered.*

12.5 The physiotherapist assesses the recipient's understanding of the information given.

12.6 Communication of a sensitive nature is undertaken in a private environment.

12.7 Information is available on condition-specific support groups and networks.

Guidance: *The physiotherapist should know how the information can be obtained if it is not readily available.*

12.8 Permission is sought from the patient before discussing confidential details with carers, friends or relatives.

12.9 The patient is offered a copy of any discharge/transfer letter.

Communication with other Professionals

STANDARD 13

Physiotherapists **communicate effectively with health professionals and other relevant professionals to provide an effective and efficient service to the patient.**

General guidance: *This standard applies to communication with other healthcare workers and those who have a clinical interest in the patient's care. This could, for example, include immediate multidisciplinary team members, teachers, social care workers or occupational health staff, who may work within or outside the healthcare environment. The WCPT Declarations of Principle (1995) section on "relationships with medical practitioners and relationships with other health professionals" should be read in conjunction with this.*

Criteria

13.1 Physiotherapists follow locally agreed systems for referral.

Guidance: *These systems define procedures used for accepting referrals and also referring to other professionals.*

13.2 Physiotherapists provide information for multidisciplinary assessments, planned transfers and discharges.

13.3 Physiotherapists agree common goals with the patient, multidisciplinary team, carers and family.

Guidance: *There should be a written record of communication with other health professionals involved in the patient's care; evidence could include letters, records of telephone calls, case conferences, multidisciplinary meetings and onward referral.*

13.4 Physiotherapists are aware of the roles of the other members of the multidisciplinary team.

13.5 Physiotherapists contribute to multi-professional record keeping and patient-held records where used.

13.6 Physiotherapists inform others of their own specific role.

Guidance: *This may be verbal, written or electronic.*

13.7 Information supplied to other professionals is directly relevant to their role with the patient.

Guidance: *See also core standard 3.3 and 11.4.*

13.8 Physiotherapists communicate with health professionals and other relevant professionals involved in the patient's care.

13.9 Physiotherapists communicate relevant information promptly.

13.10 The physiotherapist selects the most appropriate means of communication.

13.11 Language used should be easily understood by the person receiving it.

13.12 Where electronic communication is used e.g. for sending/receiving referrals, measures must be in place to ensure that such communications are secure and confidential.

Section 1.10 *Documentation*

STANDARD 14

To facilitate patient management and satisfy legal requirements, every patient who receives physiotherapy must have a record.

General guidance: *Records should include information associated with each episode of care/intervention. Records may be uni-professional, multi-professional, electronic or paper based.*

Criteria

14.1 Patient records are started from the time of the initial contact.

14.2 Patient records are written immediately after the contact with the physiotherapist or before the end of the day of the contact.

14.3 Patient records are contemporaneous.

Guidance: *In some circumstances, to be determined locally, it will also be important to record the time treatment was given. In these circumstances, the audit of the standards should include this. Records are not added to after the time of writing. Any genuine omissions should be recorded at the time the omission is identified.*

14.4 Patient records conform to the following requirements:

- **a.** concise
- **b.** legible
- **c.** logical sequence
- **d.** dated
- **e.** accurate
- **f.** provide adequate details of the intervention given
- **g.** signed after each entry/attendance

Guidance: *Where students are carrying out assessment and/or treatment, both the student and supervisor should sign the record.*

- **h.** name is printed after each entry/attendance

Guidance: *This is necessary so that the physiotherapist can be traced easily when the signature is not legible. Records may need to be traced some time later and the treating physiotherapist may have left the employer. Where patients are treated by*

the same physiotherapist throughout, it is sufficient for a printed name to appear once on each side of each page of the record. An equivalent system for the identification of the author must be in place for electronic records.

i. no correction fluid is used
j. written in permanent ink that will remain legible with photocopying.
k. any errors are crossed with a single line and initialled
l. each side of each page of the record is numbered
m. the name of the patient and either date of birth, record/archive number, or personal id number are recorded on each page of the record
n. abbreviations are used only within the context of any locally agreed abbreviations glossary.

14.5 Records are appropriately countersigned

Guidance: *The qualified physiotherapist remains responsible for the patient's management at all times, although some activities may be delegated to an assistant. If the physiotherapist is supervising activities undertaken by assistants or students, each entry must be countersigned by the physiotherapist.*

14.6 If Dictaphones are used to store information, the transcriptions of such records must include a date/time reference and a clinician/typist reference. Dictated notes must cover the same details as a written record or manuscript.

STANDARD 15

Patient records are retained in accordance with existing policies and current legislation.

General Guidance

Keeping records is an essential part of a physiotherapist's duty of care to the patient. Records should include information associated with each episode of care/intervention. Records may be uni-professional or multi-professional. The format may be electronic or paper based.

Criteria

15.1 Patient records are kept securely

Guidance: *This relates to the individual's responsibility in relation to confidentiality. It applies to all patient related information; written, computer records, audiotape, emails, faxes, videotape, photographs and other electronic media. In a community setting, patient records should be taken with the physiotherapist and not left in an unoccupied vehicle.*

15.2 Physiotherapists comply with local Information technology security policies.

Guidance: *If the records need to be kept by the physiotherapist in his/hers home overnight they should be stored in a locked container.*

15.3 Physiotherapists adhere to the local/national policies when asked by the patient to view their patient record.

Guidance: *Any changes made to a computer record should be identifiable by suitably skilled persons.*

15.4 There is a clear statement available identifying who has storage and access rights of patients records.

15.5 Patient records are destroyed in a secure way after a required time period according to local policies and national legislation.

15.6 Clinical records held on audiotape must have hard copy back up.

Article II. *Promotion of a Safe Working/Treatment Environment*

Section 2.01 ***Patient and physiotherapist safety***

STANDARD 16

Patients are treated in an environment that is safe for patients, physiotherapists and carers.

General Guidance: *This standard highlights the areas of practice in which physiotherapists have a duty of care towards their patients, colleagues and others in respect of their health and safety. Please read in conjunction with local policies and national legislation in these areas*

Criteria

16.1 A risk assessment is carried out prior to each procedure/treatment for every patient.

Guidance: *This will include a manual handling risk assessment, contra-indications and precautions. It may also include checking for wet floors, etc which might be a hazard to the patients, and ensuring that suitable clothing and footwear is worn. Risk assessments should take into account the patient, the physiotherapist, the technique/treatment proposed and the environment.*

16.2 Action is taken on the results of the risk assessment, to minimise any hazards identified.

16.3 Patients receiving treatment are made aware of how to summon assistance.

16.4 The physiotherapist is able to summon urgent assistance when required.

Guidance: *This will range from systems for summoning colleagues, carers or hospital emergency teams, to dialling the national emergency number in community or private practice settings.*

16.5 Environmental, personal hygiene and infection control procedures are followed.

16.6 Adverse and unexpected events, or events which could have (or did) effect patient safety are reported using appropriate local, national and professional systems.

Section 2.02 *Physiotherapists Working Alone*

STANDARD 17

Physiotherapists **take measures to ensure that the risks of working alone are minimised.**

Guidance: *this should be read in conjunction with local policies and national legislation*

Criteria

17.1 Policies and procedures for *physiotherapists* working alone are followed at all times.

Guidance: *The physiotherapist should have read the policies and procedures and know how to access them should they need to.*

17.2 Communication links are established between the physiotherapist working in the community and their base.

Guidance: *This could be by use of mobile phones, a written list left with a colleague which includes names, addresses and telephone numbers of the patients being visited. Physiotherapists need to ensure that someone is aware of their daily work activities.*

17.3 A personal alarm is carried by staff when the risk assessment requires it.

Guidance: *The risks involved should be assessed and a decision made as to whether an alarm is needed. Examples where an alarm may be required include community working, weekend working, on-call duty and outpatient staff working alone.*

17.4 Where known risks exist, patients' homes are not visited alone.

Guidance: *Known risks may include physical risks such as aggressive patients, animals etc, but there may also be risks relating to unsafe buildings or environments. Every attempt should be made to ensure a risk assessment is made to gather information from other healthcare workers. Where possible, in situations of known risk, visits should coincide with those of other healthcare workers.*

Section 2.03 *Equipment Safety*

STANDARD 18

All equipment is safe, fit for purpose and ensures patient, carer and physiotherapist safety.

Criteria

18.1 Visual and physical safety checks are made of equipment prior to its use or issuing to patients.

Guidance: *This includes routine checks, such as wear and tear on electrodes and ferrules, correct suction pressure, wheelchair tyre pressures, etc. Physiotherapists have a responsibility to report equipment that has not been serviced as planned and withdraw such equipment from use, if necessary.*

18.2 Equipment is used for the purpose according to the manufacturers' instructions.

Guidance: *For example, weight bearing equipment, such as a wheelchair, is used within loading limits*

18.3 Equipment is cleaned according to manufacturer's instructions and infection control policies

Guidance: *This applies to situations where cleaning is required prior to each patient use. Items that are designed for single use, are not reused and should not be modified from the manufacturer's original specification.*

18.4 Any equipment faults identified are reported.

18.5 Faulty equipment is taken out of use immediately

18.6 The physiotherapist acts on new guidance about equipment safety.

Guidance: *This will include information published by the Government or health departments.*

18.7 The risks associated with using electrical equipment in a patient's home are minimised.

Guidance: *Circuit breakers should be available. Battery operated equipment is used where this is available.*

18.8 The patient is given instructions on the safe use of any equipment issued.

Guidance: *Examples include TENS, walking aids, collars and splints. Instructions should be clear, documented and given to the patient in writing where possible.*

18.9 There is a record of all equipment that is loaned to patients.

Guidance: *This record will include details of any action required to maintain the safety of equipment between patients.*

18.10 The physiotherapist acts on any health and safety notices issued locally or nationally.

Section 2.04 *Continuing Professional Development/Lifelong Learning (CPD/LLL)*

STANDARD 19

The physiotherapist assesses his/her learning needs.

Guidance: *Continuing Professional Development (CPD) is the educational process by which physiotherapists maintain and develop their skills, knowledge and competency to provide safe and effective clinical practice. It is a systematic and cyclical process that is undertaken throughout an individual's career to develop and enhance performance at work, and patient care. Assessment of learning needs should normally take place in conjunction with a peer or manager. "Life-long learning and professional development is the hallmark of a competent physical therapist, participation in continuing education contributing to the development and maintenance of quality practice."*

WCPT Declarations of Principle, 1995

Criteria

19.1 The assessment takes account of:

- **a.** development needs related to the enhancement of an individual's current scope of practice/ and or the desire to move into a new clinical area or an area not practiced for a period of time
- **b.** feedback from performance data
- **c.** Guidance: Performance data might include routinely collected statistics, results of audit or an analysis of outcome measures.
- **d.** mandatory requirements
- **e.** Guidance: Examples of this could include fire and cardiopulmonary resuscitation and manual handling training.
- **f.** innovations in practice and technological advances.
- **g.** The needs of the national regulatory/registration authority
- **h.** the needs of the organisation

  Guidance: *The term 'organisation' refers to the whole range of services, from a single handed practice to a large hospital or rehabilitation centre.*

STANDARD 20

The physiotherapist plans his/her CPD/LLL

General guidance

CPD activities should be undertaken by physiotherapists to improve the quality of patient care

Criteria

20.1 There is a written plan based on the assessment of learning needs (core standard 19)

20.2 The plan includes learning objectives.

Guidance: *Learning objectives should be specific, measurable, achievable, relevant and timed (SMART).*

20.3 The plan identifies a range of activities that will lead to the achievement of the learning objectives.

Guidance: *These activities may include:*

- **a.** reflective practice
- **b.** further formal education e.g. Masters Degree/PhD
- **c.** reading relevant professional journals
- **d.** attending educational meetings
- **e.** secondment and shadowing
- **f.** in-service education programmes
- **g.** independent study
- **h.** clinical audit
- **i.** implementing clinical guidelines
- **j.** peer review
- **k.** mentorship
- **l.** contact with other specialist physiotherapy groups, professions or patient organisations
- **m.** research
- **n.** sharing knowledge and skills with others
- **o.** clinical supervision
- **p.** membership of a clinical interest group

STANDARD 21

The CPD/LLL plan is implemented

Criteria

21.1 There is written evidence in a CPD portfolio to show the plan has been implemented.

21.2 The plan is subject to appropriate review.

Guidance: *This will normally take place with a peer or manager within agreed timescales.*

21.3 CPD activity undertaken is evaluated on completion in terms of:

21.3.1 Effect on the physiotherapist's practice

21.3.2 Impact on the service where the physiotherapist works

21.3.3 Impact on the practice of the physiotherapy profession

21.4 There is agreed and protected working time for personal learning activities

21.5 CPD activity is documented as a part of the working conditions.

STANDARD 22

The physiotherapist evaluates the benefit of their CPD/LLL.

Criteria

21.1 There is evidence that the learning objectives have been met.
Guidance: *If learning objectives have not been met, the underlying reasons for this need to be discussed and understood to inform the next assessment of the individual's learning needs.*

22.2 New learning objectives are developed, to continue the cyclical process of CPD/LLL.

22.3 There is evidence that learning objectives are recorded in a portfolio

22.4 The physiotherapist can demonstrate that their learning has enhanced and developed their clinical practice

Article III. *References*

Chartered Society of Physiotherapy (1994), *Health & Safety Handbook: Safety Representatives Information Manual,* Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (1996), *Rules of Professional Conduct,* Chartered Society of Physiotherapy, London.

Chartered Society of Physiotherapy (1998), *Personal Safety for Loneworkers: Health & Safety briefing pack no.7,* Chartered Society of Physiotherapy, London.

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Field MJ, Lohr KN eds (1992), *Guidelines for Clinical Practice: From Development to Use,* Washington DC: National Academy Press.

Mayo N, Cole B, Dowler J, Gowland C, and Finch E, (1993), *Use of outcome measures in physiotherapy: survey of current practice,* Canadian Journal of Rehabilitation, 1981-1982

World Confederation for Physical Therapy (1995)
Declarations of Principle and Position Statements

Article IV. Glossary

Abbreviations glossary

A glossary that includes definitions of all the abbreviations used within the organisation so that misunderstandings do not occur. E.g. PID may be a prolapsed intervertebral disc or pelvic inflammatory disease.

Active listening

Structured method of listening which includes the steps:
1. encouraging, 2. restating, 3. reflecting, 4. summarising.

Assessment/treatment cycle

This is a cyclical process describing the thought process of clinicians from information gathering to analysis and assessment, planning, implementation, evaluation and transfer of care/discharge.

Carers

Carers are people looking after relatives or friends (though not always sharing their home) who, because of disability, illness or the effects of old age cannot manage at home without help.

Clinical audit

A cyclical process involving the identification of a topic, setting standards, comparing practice with the standards, implementing changes and monitoring the effect of those changes.

Clinical effectiveness

The extent to which specific clinical interventions, when deployed in the field for a particular patient or population, do what they are intended to do, i.e. maintain and improve health and secure the greatest possible health gain from the available resources.

Clinical guidelines

'Systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances' (Field MJ, Lohr KN, 1992).

Clinical supervision

Time set aside for formal reflection on clinical practice, usually with a more experienced practitioner, or for senior clinicians, a peer practitioner.

Clinical team

The team is a group of people (healthcare staff, patients and others) that share a common purpose, to achieve the agreed clinical goals.

Criteria

The measurable component of a standard.

Demographic details

Usually refers to the basic details collected by healthcare workers; name, address, age, occupation, religion etc.

Discharge summary

A summary of the episode of care, usually describing the treatment given and the follow-up care needed.

Evaluation

The review and assessment of the quality of care for the purpose of identifying opportunities for improvement.

Goal setting

Desired end points of care. Agreed individual goals should be established by negotiation with each patient and any carers. These should be realistic, include time scales that are subject to on-going review, discussion and modification.

Health Care Workers

Include any medical or other allied health care professional

International Classification of Functioning, Disability and Health (ICF)

Investigations

Clinical investigations refers to physiological/laboratory tests, usually taken to enable diagnosis or monitor progress. Examples are: blood tests, X-rays, scans.

Manual Handling risk assessment

See risk assessment

Medical Diagnosis-

Is a clinical decision arrived at as a result of assessing the patients signs and symptoms .It generally labels the pathology present but makes no assumption regarding the effect the pathology has on function

Non-verbal communication

The use of eyes, smiles, frowns, the tone of voice, the position of your arms and legs, how close you stand, and whether you touch or not, all indicate non-verbal messages to the person whom you are treating.

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Objective measure

A measurement that is not affected by the person making the measurement.

Outcome measure

A physical therapy outcome measure is 'a test or scale administered and interpreted by physical therapists that has been shown to measure accurately a particular attribute of interest to patients and therapists and is expected to be influenced by intervention' (Mayo, 1995).

Outcomes

What happens (or does not happen) in response to care or a service; may be desirable or undesirable. Outcomes are the end result of the care process that can be attributed to the treatment. They may be defined by the patient or the physiotherapist.

Patient record

The patient record refers to any record containing patient details. It includes all media, for example; paper, faxes, videos, photographs, and electronic records. Used

generically to mean the separate physiotherapy record and the physiotherapy record contained within a multiprofessional record or case notes.

Peer review

An assessment of clinical performance undertaken by another physiotherapist who has similar experience and knowledge.

Physiotherapeutic Diagnosis

Is arrived at either independently of or in conjunction with a medical diagnosis. It is generally expressed in terms of how a condition compromises the functioning of a patient

Portfolio

A tool that helps individuals record and evaluate learning activities undertaken for professional development, and that provides a resource for planning future learning.

Primary care team

A team of healthcare professionals working in primary care, usually comprises the general practitioner, practice nurses, district nurses, health visitors etc.

Reflective practice

Professional activity in which the physiotherapist thinks critically about their practice and, as a result, may modify their action or behaviour and/or modify their learning needs.

Reliability

The extent to which a measure produces results that are reproducible and internally consistent. Not a fixed property but dependent on the context and population in which it is used.

Responsiveness

Sensitivity to change. The capacity of a measure to detect clinically important changes over time that matter to patients.

Risk assessment

A formal method of assessing the potential risks for patients, healthcare staff and employees. This includes clinical risk, organisational risk, legal and financial risk.

Sharps

Any clinical material that contains sharp components; needles, glass, scalpels.

Skill mix

The mix of skills held by the healthcare workforce needed to deliver a service. It can refer to the grade mix within one profession, the proportion of professional and assistant staff and/or the combination of multiprofessional staff within the team.

Standard

Statement which describes the range of acceptable care.

Subjective measure

A measurement that requires judgement on behalf of the measurer.

TENS

Transcutaneous Electrical Nerve Stimulation. TENS machines work on the principle of delivering stimulation to nerve endings releasing natural endorphins. Usually used for pain relief.

Transfer of care

The term which describes the process of transferring the responsibility for care from one service (maybe not always a place) to another. It includes secondary referrals, discharges.

Validity

The extent to which a test actually measures what it purports to measure. Not a fixed property but dependent on the context and population in which it is used.