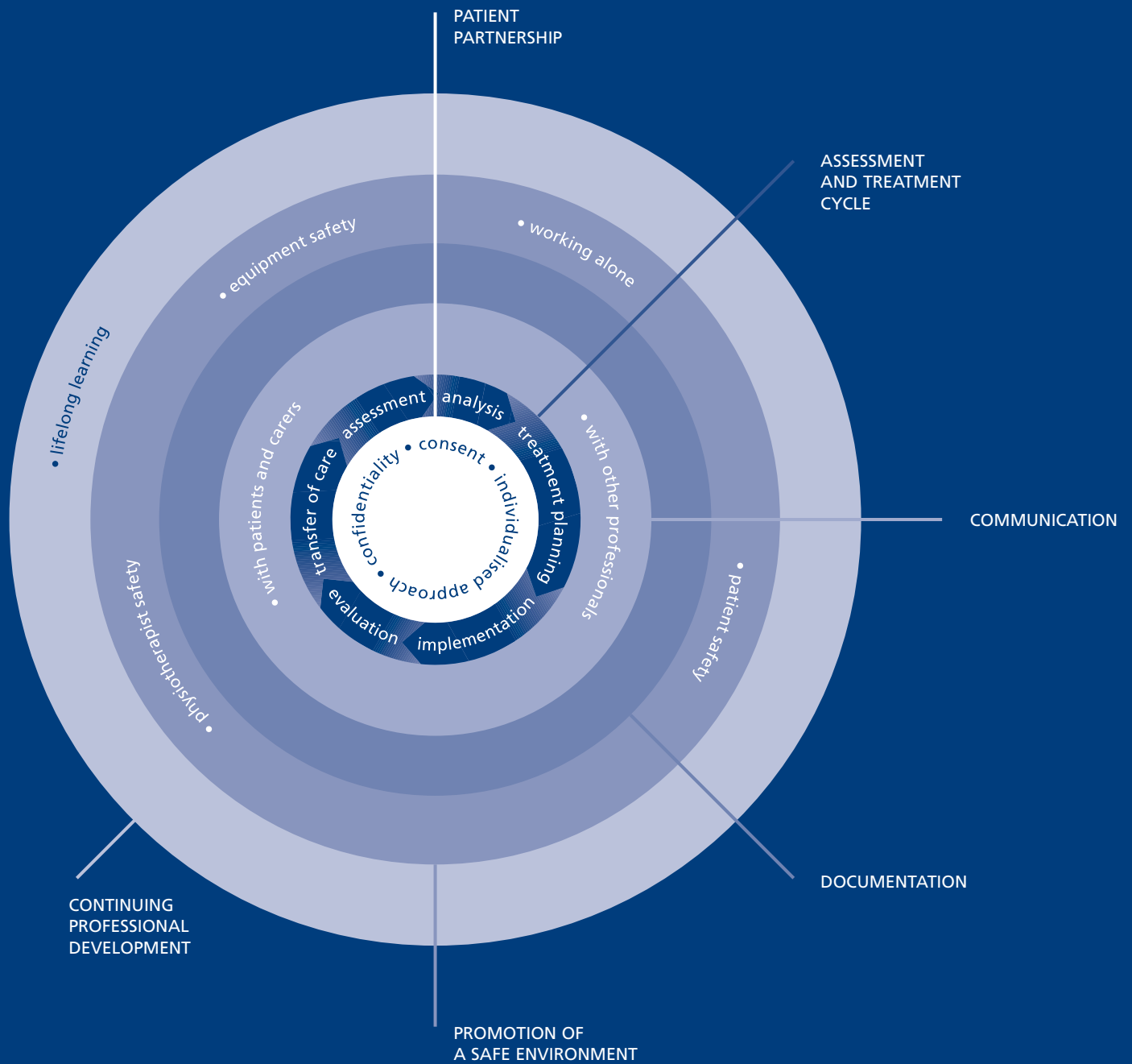


# Core Standards of Physiotherapy Practice 2005



THE CHARTERED SOCIETY OF PHYSIOTHERAPY

Framework for the Core Standards of Physiotherapy Practice  
Figure 1



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## Introduction to revisions to Core Standards of Physiotherapy Practice.

The third edition of the Core Standards of Physiotherapy Practice were launched in 2000 following extensive expansion and modernising. The Core Standards of Physiotherapy Practice brought together the Profession's expectation of all practising members in one document, with the focus being on taking a more patient centred approach to care.

Physiotherapy is a constantly evolving profession and there is currently great change in the health and social care sector with a continued drive towards excellence and consistency in clinical practice. With this in mind, the CSP has been reviewing the content of the 3rd edition of the Standards to ensure that the criteria chosen and the guidance given remains in keeping with current good practice.

This revised version of the Core Standards of Physiotherapy Practice has been up-dated through considerable consultation with clinical interest and occupational groups and individual members.

The 22 standards have remained unchanged as they remain relevant to today's practice. In many cases, these standards have been strengthened by direct reference to the overarching legislation affecting the standard. The focus of the Core Standards is on services to patients and issues around those services, and therefore only legislation that directly relates to the professional duty of a physiotherapist to their patients is quoted. In many cases there are also additions to the criteria and guidance supporting the standards. These additions and changes have occurred to reflect changes in primary legislation or government policy that has been introduced since the 3rd edition of the Standards was published. In many cases, expanded guidance is given to provide members with greater clarity about what is expected of their practice and to give members examples of practical implementation of the standards in the workplace.

The Core Standards are applicable to all members including student physiotherapists, associate members and qualified physiotherapists. Not all the standards will apply to all associates and students, and the degree to which they do will be determined locally, and the extent to which tasks and responsibilities have been delegated to them by qualified physiotherapists. The term 'physiotherapist' is used throughout the document as an all-inclusive term, which encompasses students, assistants, technical instructors and chartered physiotherapists.

Throughout the document the term 'patient' is used to describe the recipient of the services of a physiotherapist in the context of preventative, primary, secondary or tertiary healthcare provision and also social care provision. The standards also apply where a

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physiotherapist provides services to a patient's wider network including family, friends and carers.

These core standards of practice play a central role in the delivery of safe and effective physiotherapy to patients and it is important for members to understand the place of these standards in their everyday clinical practice. First and foremost, members must practice within the law of the country in which they deliver physiotherapy. Secondly, registered members must work within the framework of the regulatory body the Health Professions Council. Finally, members must adhere to the Rules of Professional Conduct of the CSP and strive to implement all aspects of the Standards of Practice. The definitions in the core standards represent a level of practice that all members should achieve.

The requirements of the HPC and the CSP are in harmony. By adhering to the Rules of Professional Conduct and Standards Of Practice members will be discharging their statutory obligations. Employed members also have an additional contractual obligation to follow their employer's requirements, and in general, employer's requirements mirror the statutory and professional requirements already placed on members. If there appears to be a discrepancy between the standards required by an employer and the standards required by the CSP, in terms of the obligation of employee to employer, the employer's standards take precedence over the CSP standards. However, employed members also have to be aware that patients are not governed by employer's standards, and should a patient feel they have cause to complain to the CSP about the standard of care given by a member, both the employer's standards and the CSP's standards will be considered in addressing the patient's complaint.

These standards should be read in conjunction with

- Health Professions Council: Standards of Conduct, Performance and Ethics
- Health Professions Council: Standards of Proficiency – Physiotherapists
- Rules of Professional Conduct or
- Physiotherapy Assistant's Code of Conduct

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## Standard 1

Respect for 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 the individual's lifestyles, cultural beliefs and practices and should base their response on fact not assumption.
- 1.2 The physiotherapist is courteous and considerate.
- 1.3 The patient is addressed by the name of their choice.
- 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 other member of the physiotherapy team, allied health professional, or social services staff involved in their care.
- 1.6 The patient's privacy and dignity is respected.

### 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 commitments, culture, race, gender, sexual orientation, religion, disability and age, beliefs, values, abilities, mental well being, and the impact these may have on the patient's perception of health and illness, and the impact of physiotherapy on a patient's physical and psychological well-being.
- The physiotherapist must be aware of the impact of their own beliefs and values on their practice, and consider this.
- E.g. Mrs [family name] or Joan [family name]. Physiotherapists must be aware of the cultural differences in naming systems. Patients should be asked for 'first and family name' rather than 'Christian name'.
- The physiotherapist should be able to choose the title by which they are addressed e.g. Mr [family name] or Fred [family name]
- Patients should be informed if a physiotherapy assistant/technical instructor or student is treating them. Extended scope practitioners and consultant physiotherapists need to make it clear to patients that they are being treated by physiotherapists, and of the physiotherapist's role within the service. In extended scope services, sufficient information must be provided to the patient in advance of their appointment, to allow the patient to decline treatment if they wish.
- Assessment, examination and treatment require a private environment. In circumstances where this is not possible or practicable e.g. in ward based environments

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## Standard 1

- 1.7 Chaperoning is provided where appropriate.

### Supporting Legislation:

Human Rights Act (1998)  
Disability Discrimination Act (1995)  
Race Relations Act (1976)  
Race Relations (Northern Ireland) Act (1998)  
Race Relations (Amendment) Act (2000)  
Data Protection Act (1998)  
Health and Social Care Act (2001)

or sports arenas, care should be taken to avoid discussions being overheard. Intimate examinations require greater guaranteed privacy and patients should be asked if they would like a family member/friend present to support them. Physiotherapists need to establish the cultural norm by which some patients are accompanied on a regular basis and remember that privacy differs across cultures.

When chaperoning is applied this will vary according to employer policy for employed physiotherapists, the type of examination being performed and when requested by the patient.

### Cross-references:

Rule 2 - Rules of Professional Conduct  
PA 29 - Chartered Physiotherapists Working As Extended Scope Practitioners  
ERUS 24 - Guidance to Members on Chaperoning and Related Issues

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## 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 consent to be given.

### General guidance

Consent is a complex area. The guidance supplied below can only provide a general overview of the topic. Members are advised to seek appropriate advice for clinical situations which are not clearly described if they are concerned about satisfying their professional obligations.

UK law demands that VALID consent is obtained prior to any proposed treatment. For consent to be valid, patients must:

- a) have the capacity to make the particular decision
- b) not be acting under duress [i.e. threat, constraint or coercion] and
- c) have received sufficient information about the nature and purpose of the proposed intervention to make a decision.

Detailing the nature and purpose of any proposed intervention is sufficient for the purpose of valid consent, but does not fulfil the requirements of duty of care which also requires information giving of all 'likely and significant' risks and benefits of treatment.

It is recommended, in order to fulfil the duty of care the patient must be informed of all potential and significant risks, benefits and likely outcomes of treatment. The basis of the information given should be what the 'reasonable practitioner' deems significant for the patient to know. This is known as The Bolam Standard. The Bolitho case refines the Bolam Standard in that practitioners must demonstrate that the body of professional opinion used has a logical basis, and that in advocating its use they have considered the relative risks and benefits to reach a defensible conclusion.

Consent is an ongoing process and the success of consent relies heavily on good communication and good practice, and physiotherapists must be aware that English may not be the first language of their patients. The concept of the patient making their own decisions about proposed treatment i.e. exercising autonomy by giving their own consent, is a Western concept. In some cultures, individuals exercise their autonomy by letting family members make decisions on their behalf. In the UK, the relevant English or Scottish law MUST be upheld and so in some cases a more detailed explanation of consent under UK law will need to be given to the patient.

Members must take great care not to become confused with the American term 'informed consent' that has specific legal meaning in US practice settings only. In the US, US law demands that ALL risks, benefits and outcomes of treatment are shared with the patient.



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As yet there is no case law in the UK to demonstrate that this US meaning applies in the UK setting.

Members should be aware that the wishes of patients who have Advance Directives (Living Wills) must be acted upon. All employed members should seek their employer's policy and guidance for details of how to proceed with patients who possess Advance Directives. Other members are advised to consult the CSP for further information.

### **Members practising in England and Wales:**

Adults (those over 18 years of age):

Members must be aware that under the law in England and Wales, no-one can give consent on behalf of another adult. For adults lacking capacity, no-one may give consent on behalf of that adult. Treatment may only be given without consent providing it is

- a) out of emergency to save life
- b) out of necessity to preserve life and limb and
- c) deemed in the patient's best interests.

However, it is good practice to liaise with other team members, family members and partners to ascertain the previous lifestyle wishes of the patient to inform what really is in the patient's best interest. In extreme cases, the courts can be asked to make a decision.

Please note: an 'enduring power of attorney' does not give rights over the person (only over property and money) and thus another individual cannot give consent to treatment for another adult even if they possess enduring power of attorney.

Children and Young People (those under 18 years of age):

16-17 year olds may give their own consent to medical, dental and surgical procedures without the consent of the parent (Family Law Reform Act 1969). Consent may also be obtained from the person(s) with 'parental responsibility', which may not always be the biological parents. If valid consent is given by the young person then adult consent is not necessary.

Those under 16: Consent can be gained from the person(s) with parental responsibility. The child can give their own consent if they can fully understand the proposed treatment having received sufficient information i.e. the child is considered Gillick Competent. To be



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Gillick Competent, the child must be able to fully understand and have insight into the proposed treatment, and thus capacity to consent depends upon each individual child and not upon the child reaching a certain age. Age does not necessarily confer a specified level of understanding.

There may however be occasion where the child and parent do not agree on a proposed course of treatment. If a child refuses treatment i.e. does not give consent, the person with parental responsibility can override this decision and give parental consent to allow treatment. However, a person with parental responsibility cannot override a child's valid consent to treatment.

There are some very complex issues concerning consent and children and members requiring more help in this area should seek specialist advice from either their employer (if they are employed), a special interest group such as The Association of Chartered Physiotherapists in Paediatrics, the CSP or a solicitor.

### **Members practising in Northern Ireland:**

Members are bound by the same primary legislation affecting England & Wales. However, members should also follow the guidance of the DHSSPSNI in that 'there should be a consistency of approach in consent practice across health and social services. The forms used in both health and social services should be recognisably the same.'

### **Members practising in Scotland:**

Competent adults and children can give consent under the same principles as outlined in England, Wales and Northern Ireland. For adults lacking capacity the Adults with Incapacity (Scotland) Act (2002) applies. For the purposes of this Act, an adult is a person who is 16 years of age or over.

Members must be aware that treatment may be given to incapacitated adults without consent, or when the authority of their representative is doubted, only in the cases of

- a) preservation of life or
- b) the prevention of serious deterioration.

It is therefore unlawful to act 'in the best interests' of the patient without consent.

For incapacitated adults treatment may be given without the patient's consent, beyond the cases of a) and b) above, if the patient's medical Doctor, Consultant or Hospital Registrar



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has obtained a Certificate of Incapacity. This Certificate of Incapacity MUST include every treatment such an incapacitated adult might receive for such additional intervention to be lawful. If physiotherapy is not included as a specified intervention on a Certificate of Incapacity, then physiotherapy may not be given. A Certificate of Incapacity is valid for one year but is revocable or replaceable at any time the patient's medical practitioner feels the presenting condition has changed.

An incapacitated patient can also have a legal Guardian or Representative appointed under an Intervention Order. In such cases, another person is legally able to consent on behalf of the incapacitated adult. The provisions of the Adults with Incapacity (Scotland) Act (2002) do not override the provisions of the Mental Health Act (1984) and therefore do not apply to patients covered by the Mental Health Act (1984).

Members practising in Scotland are advised that this legislation has not yet been tested in Court. The information given above is an interpretation of how the Act may affect members. Members should seek specific legal advice if they are unsure of their legal position to treat a particular patient.

The criteria and guidance overleaf apply to ALL practising members:



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## Standard 2

### Criteria

- 2.1 The patient's valid consent is obtained before starting any examination/treatment/procedure.
- 2.2 Treatment options, including significant benefits, risks and side effects, are discussed with the patient.
- 2.3 The patient is given the opportunity to ask questions.
- 2.4 The patient is informed of their right to decline physiotherapy at any stage without it prejudicing their future care.
- 2.5 If the patient declines physiotherapy, this is documented in the patient's record, together with the reasons if these are known.

### Guidance

Physiotherapists should only obtain consent for processes that they themselves are able to perform. Practitioners being asked to gain consent for procedures they cannot perform e.g. ESP's listing patients for surgery should seek the advice of their employers in this context.

Written information may need to be provided in an appropriate language and format. For example, a physiotherapist considering the use of a high velocity thrust technique would discuss the evidence for the effectiveness of the treatment and the small risk of harm from the technique.

Patients may need time to assimilate information given. They should have the option of deferring treatment until their next appointment if they are in any doubt as to the risks and benefits of treatment. The patient should be given opportunities to ask questions on a number of occasions.

In multidisciplinary settings e.g. pain clinics or extended scope triage services, the patient should be given the opportunity to see another member of the team if they decline to see the physiotherapist. The patient must be aware that they may not decline treatment by the allocated member of the physiotherapy team based on the culture, race, sexual orientation, religion, disability or age of the physiotherapist. There may be occasions however when the patient may decline treatment from a physiotherapist based on gender.

In settings where activities are usually performed by an assistant/technical instructor, the patient still retains the right to decline this treatment and request treatment from a registered physiotherapist. In such cases a careful explanation will be required particularly if the task is not normally performed by a registered physiotherapist.



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|------|---|---|
| 2.6  | The patient is informed that they may be treated by a student, assistant or technical instructor, and given the right to decline this option, and be treated by a registered physiotherapist. | This criterion only applies in student placement settings.  |
| 2.7  | The patient is informed that their treatment may be observed by a student, and given the right to decline.  | This criterion only applies in student placement settings.  |
| 2.8  | The patient's consent to the treatment plan is documented in the patient's record.  | Consent may be written or oral; both are equally valid in law. Obtaining consent is an ongoing process throughout the episode of care. Consent should be obtained and documented in the patient record prior to assessment and after formulation of the treatment plan. Thereafter, consent needs to be reaffirmed and documented if there are changes to the treatment plan, or if the patient's condition affects the balance of significant risks, benefits or likely outcomes of treatment. Consent does not need to be routinely documented at every treatment session if there are no changes to the treatment plan or to the patient's status. The important fact with the documentation of consent is that the PROCESS by which consent was obtained is explicit and deemed valid. The use of tick boxes to record consent is NOT acceptable under any circumstances. |
| 2.9  | Written consent forms should be used for any invasive or high-risk physiotherapy interventions.   | The Department of Health Reference Guidelines for Consent to Examination or Treatment do not explicitly require written consent for manipulation. However, the CSP suggests that written consent should be gained for manipulation of the cervical spine; rectal and vaginal examinations; nasopharyngeal and tracheal suction with competent patients, and exercise tolerance testing of   |
| 2.10 | Where written consent forms are used, a copy is retained in   |   |

## Standard 2

the patient's notes AND a copy is given to the patient.

patients with cardiac conditions and acupuncture. Members practising acupuncture must follow the consent requirements of their employing body if they are employed, or the requirements of any Clinical Interest or Occupational Group (CIOG) of which they are a member in determining the appropriate form of consent to be gained prior to using acupuncture.

2.11 Patient information leaflets/sheets, or other written information, should be given where possible, to assist in the consent process, and a copy of the information sheet should be retained in the patients notes.

Where possible, patients should have access to information in the language and format of their choice. Superseded versions of any patient information leaflet/sheets or other written information is retained in accordance with retention of Health Records.

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### Supporting Legislation:

Human Rights Act (1998)  
Family Law Reform Act (1969)  
Children Act (1989)  
Adoption and Children Act (2002)  
Bolam v Friern Hospital Management Committee [1957] All ER 118  
Bolitho v City & Hackney Health Authority [1993]  
Gillick v West Norfolk and Wisbech AHA [1986] AC 112  
Adults with Incapacity Act (Scotland) (2002)  
Mental Health Act (1984)  
Health and Social Care Act (2001)  
Race Relations Act (1976)  
Race Relations (Northern Ireland) Act (1998)  
Race Relations (Amendment) Act (2000)  
Access to Health Records (1998)(deceased patients only)

### Cross-references:

Rule 2 - Rules of Professional Conduct  
Health Professions Council (2003)  
Department of Health 2001a  
Department of Health 2001b  
Department of Health 2001c  
Department of Health 2001d  
Department of Health 2001e  
Department of Health 2001f  
Department of Health & Social Services and Public Safety in Northern Ireland (2003)  
PA 29 Working as an Extended Scope Practitioner  
PA 60 Consent  
JB3 Living Wills  
RCN & UNISON (undated)  
Association of Paediatric Chartered Physiotherapists (2002)

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## Standard 3

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

### Criteria

- 3.1 There is privacy when discussing personal details.
- 3.2 The written consent of patients is obtained before using identifiable clinical information (photographs, videos etc) for teaching purposes.
- 3.3 In discussion with the patient, physiotherapists may allow other healthcare workers access to the patient's physiotherapy records when it is of benefit to the patient.
- 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 process.

### Guidance

This applies during face-to-face contact with patients, carers or other health professionals and discussing patient details when using, for example, the telephone.

In accordance with Department of Health Reference Guidelines for Consent to Examination or Treatment.

Patient's confidential information remains confidential even after a person's death. In these cases, permission for disclosure must be obtained from the executor or next-of-kin.

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 prior to releasing any information. Patients should be made fully aware of the extent of the information requested and subsequently released. Patients should be made aware of their right to allow selective disclosure of information e.g. of events only after a certain date OR only pertaining to a particular episode of care, unless third parties give specific reasons for wishing a full disclosure of a patient's physiotherapy records. The patient may not have been advised of this right by their legal representative. If physiotherapists are unsure of the necessity for full disclosure of complete physiotherapy records, which may cover many years, they have a duty to contact the patient to ensure that the patient understands the extent of the

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## Standard 3

- information required and gives their consent for such information to be disclosed. This remains the case even if the patient was discharged months, or even years, prior to the disclosure request. At all times, the physiotherapist retains responsibility for the physiotherapy record and has a duty to protect the content of such records.
- 3.5 Patient identifiable information is transmitted securely.
- When information is transmitted by fax, the sender should take steps to satisfy themselves that the fax will be immediately received by the intended recipient, or authorised deputy e.g. a secretary. If this is not possible, the fax should be received in a secure environment where it will not be intercepted by unauthorised persons e.g. patient access areas. When posting documents, information should be marked 'personal for addressee' or 'confidential' and correctly and fully addressed to the recipient to avoid misdirection in postal systems.
- 3.6 Steps are taken to ensure the confidentiality of patient identifiable data held, or transmitted, in electronic formats.
- When information is held, or transmitted, electronically, steps should be taken to ensure the security, protection and audit trail of computers, networks and users to ensure that only authorised persons have access to patient identifiable data.
- 3.7 Where confidentiality cannot be guaranteed, the patient should be informed of this fact and given the option to decline giving information.
- In disclosing information, the physiotherapist needs to consider their duty of care to the patient and their obligation to work within the scope of physiotherapy practice. Disclosure of information without consent and which breaches confidentiality must only occur within specific legal situations e.g. child protection or public interest.
- 3.8 Steps are taken to ensure the confidentiality of patient identifiable data seen by physiotherapists but intended for other professional staff.
- For example, in triage services, protocols should be in place for the reading of referrals and the selection of patients for different professionals.

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## Standard 3

### Supporting Legislation:

Data Protection Act (1998)  
Human Rights Act (1998)  
Access to Health Records Act (1988)  
Health and Social Care Act (2001)  
The Children Act (1989)  
Adoption and Children Act (2002)

### Cross-references:

Rule 3 - Rules Of Professional Conduct  
Rule 5 - Rules Of Professional Conduct  
Department of Health (2001 a-f)  
Department of Health (2003)  
PA 47 General Principles of Record Keeping  
PA 1 Reports for Legal Purposes



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## Standard 4

Information relating to treatment options is identified, based on the best available evidence, in order to deliver effective care.

### General 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. Research forms an essential part of practice. Whilst every practitioner will not necessarily be engaged in generating new evidence through research, all practitioners will use research evidence in some form to inform their own clinical practice.

### Criteria

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

### Guidance

Sources may include:

- Research
- Clinical guidelines, effectiveness bulletins and other summaries of evidence of effectiveness
- Clinical interest and occupational groups.
- National guidance e.g. National Service Frameworks, National Institute of Clinical excellence guidelines.
- Local standards and protocols
- Information derived from the use of outcome measures
- Patient organisations/groups e.g. The Stroke Association
- Expert opinion
- Reflections on practice

### Supporting Legislation:

Health and Social Care Act (2001)

## Standard 5

Information relating to the patient and his/her presenting problem is collected.

### General guidance

Where appropriate, information collected should reflect the values and needs of the service user and their main carers. Background information collected regarding the patient's presenting problem may come from published research findings or published evidence collections.

	Criteria	Guidance
5.1	There is written evidence of a compilation of data consisting of	This is dependent on the health status of the patient, for example, it would not be relevant for unconscious patients.
5.1.1	the patient's perceptions of their needs	Perception of need relates to what the patient feels is their main problem.
5.1.2	the patient's expectations	The patient's expectations may be expressed as anticipated gain from physiotherapy.
5.1.3	patient's demographic details	
5.1.4	presenting condition/problems	This will include the effects of impaired activity and participation and the patient's psychological well-being.
5.1.5	past medical history	
5.1.6	current medication/treatment	
5.1.7	contra-indications/ precautions/allergies	



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## Standard 5

- 5.1.8 social and family history/lifestyle
- 5.1.9 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. This includes:
- 5.2.1 observation
- 5.2.2 use of specific assessment tools/techniques
- 5.2.3 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.
- The extent of the physical examination may be determined by the clinical specialty or by the patient's presenting condition at the time of the examination.
- Reasons for discontinuing assessment e.g. patient distress, withdrawal of consent, risks to the safety of patient or therapist, or cultural inappropriateness are documented. It must be clear if missing clinical information is either not available or has not been done. Unnecessary duplication of investigations must be avoided.

## 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.

### General guidance

The CSP database of outcome measures can be used as a resource. Published outcome measures should be used where such measures exist. Health status should be considered in its broadest context to cover health, disability and impairment, and the outcome measure selected should be appropriate to the dimension being monitored.

	Criteria	Guidance
6.1	The physiotherapist selects an outcome measure that is most relevant to the patient's problems.	The physiotherapist should consider the aim of treatment i.e. management of deterioration or promotion of recovery. The outcome measure selected should capture information related to the aims of treatment.
6.2	The physiotherapist ensures the outcome measure is acceptable to the patient.	The outcome measure should be explained to the patient.
6.3	The physiotherapist selects an outcome measure that he/she has the necessary skill and experience to use, administer and interpret.	To maximise reliability the outcome measure must be administered by someone with the skills and experience to undertake the task.
6.4	The physiotherapist takes account of the patient's welfare during the administration of the measure.	How the score is interpreted and what the score means should be known and understood.

## Standard 6

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| 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 if applicable. | This will ensure that outcome measures are available to demonstrate changes in status. Any change in score is reviewed against the aims of treatment. |
| 6.6 | The result of the measurement is recorded.   |   |
| 6.7 | The same measure is used at the end of the episode of care and at periods during the episode of care if applicable to the clinical setting.                                      |   |

## Standard 7

Analysis is undertaken in order to formulate a treatment plan, following information gathering assessment.

	<b>Criteria</b>	<b>Guidance</b>
7.1	There is evidence of a clinical reasoning process.	The peer review process (see audit tools document) provides the opportunity to evaluate the clinical reasoning process. The use of relevant research findings will support the clinical reasoning process, as would reflection on practice
7.2	There is written evidence of identified needs/problems, formulated from the information gathered.	
7.3	Subjective markers or goal lists are identified.	Subjective markers may be patient descriptions that the physiotherapist chooses to review at appropriate times.
7.4	Objective markers or goal lists are identified.	Objective markers may be examination findings that the physiotherapist chooses to review at appropriate times.
7.5	A diagnosis with relevant signs and symptoms is recorded.	The diagnosis made depends on the type of referral, if any, from a medical practitioner. A referral of 'shoulder pain' is not a diagnosis and the member will make a medical diagnosis e.g. supraspinatus tendonitis, following appropriate examination and assessment. However, if patient is referred with 'cystic fibrosis', the diagnosis is already made and the member will subsequently be recording a known diagnosis with additional records of signs and symptoms relevant to physiotherapy. If patients self-refer, the member will be making a full diagnosis. Members are entitled to disagree with a diagnosis from a medical practitioner if they are able to perform and evaluate sufficient investigations to fully justify their decisions.
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.	If no treatment is given, a record must still be made of the salient points of the assessment. The physiotherapist should record the clinical reasoning process by which it was determined physiotherapy was not appropriate. If no treatment is given because the physiotherapist feels

## Standard 7

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

that the patient has a pathology beyond the scope of physiotherapy practice, the physiotherapist must be careful not to speculate on unsubstantiated diagnoses that may distress the patient should the patient request access to their physiotherapy records. If the patient decides not to accept appropriately offered physiotherapy then this must be recorded.

These may be requested by the physiotherapist, or by other health professionals. The results of the tests inform the management of the patient e.g. X-Rays.

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## 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 the decision-making process during treatment planning.
- 8.2 The physiotherapist demonstrates that they have considered the patient and/or carer's needs within the social context.
- 8.3 The plan takes account of the skill mix of the service and makes best use of existing resources.
- 8.4 The plan clearly documents planned interventions including:

#### Guidance

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

This 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.

In some situations, the patient may need to be referred to a second physiotherapist with more relevant skills in order to implement the plan effectively. Patients themselves, carers or other health care workers may also implement parts of the plan.



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## Standard 8

- 8.4.1 Time scales for implementation and/or review.
- 8.4.2 goals
- 8.4.3 outcome measures
- 8.4.4 the identification of those who will deliver the plan including collaborative and multi-professional team working
- 8.4.5 relevant risk assessment
- 8.4.6 delegation of activities to assistants/technical instructors or carers.
- 8.5 If clinical guidelines or local protocols are used, the date, version and source of the document are recorded in the patient's notes.

This is to ensure that in the case of retrospective examination, the case notes are judged against the accepted practice of the time. The physiotherapist may wish to keep a copy of the relevant document with the patient's notes, particularly if the documents have not been dated and do not have a review date. Superseded guidance or protocols are stored in the same manner as health records.

### Supporting Legislation:

Data Protection Act (1998)

### Cross-references:

Rule 3 - Rules of Professional Conduct  
Core Standard 2  
PA 6 - Delegation of Tasks to Assistants: A guide for qualified members and students.



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## 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.
- 9.2 All advice/information given to the patient is recorded, signed and dated.
- 9.3 A record is made of equipment loaned and issued to the patient.
- 9.4 Any deviations from the intended treatment plan is recorded in the patient's notes with the reasons given.

### Guidance

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

This includes written and oral information. Copies of patient information sheets are retained in the patient's records or an accurate reference to the document, date and version is recorded. The physiotherapist must satisfy himself or herself that any information given has been understood. Any areas of lack of understanding are noted.

This is particularly important where there may be more than one person involved in the patient's care, and these persons may come from different professional backgrounds. It must be clear why any changes to the intended plan have occurred either through a written explanation or through the clinical reasoning process.

#### Cross-references:

PA 6 - Delegation of Tasks to Assistants: A guide for qualified members and students.  
Code of Conduct for Assistants



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## 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:
  - 10.1.1 the treatment plan
  - 10.1.2 subjective markers or goal list
  - 10.1.3 objective markers or goal list
  - 10.1.4 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 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 the relevant mechanisms.

### Guidance

This may be investigations that are generally available, or investigations that the physiotherapist has specifically requested e.g. X-ray, in order to assist the clinical decision making process.

This may be through employer risk management or incident reporting systems or other learning systems.

#### Cross-references:

Core Standard 4 - information gathering  
Core Standard 7 - analysis



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## Standard 11

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

### General guidance

'Transfer of care' relates to transfer of care between professionals, between secondary or tertiary centres, and the transfer of care to carers or primary care teams. Discharge relates to the cessation of care.

#### 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.
- 11.3 When the care of a patient is transferred, information is relayed to those involved in their on-going care in the most appropriate manner and format.

#### Guidance

This should include the results of any outcome measures used, with a clear explanation of the scoring used and interpretation. Information should be relayed within locally agreed time-scales. The language used should be understood by the recipient e.g. doctors may not fully understand physiotherapy jargon or terminology.

A discharge or transfer letter should always be sent if the referral was received from another health professional. Referrers should also receive summaries for those who self discharge or fail to attend. Discharge reports may be uni-professional or multi-professional to reflect the setting in which the patient was treated.



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## Standard 11

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 supplied to the patient's GP for those patients who self-refer to physiotherapy.

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

If the patient has self-referred, the physiotherapist should discuss with the patient in advance, which other health professionals e.g. GP, will receive information. The patient has the right to refuse to allow such sharing of information, but the implications of such refusal should be discussed and clearly documented. Further detailed guidance is contained within the Department of Health document 'Confidentiality'.

In disclosing information to other health professionals, the physiotherapist needs to consider their duty of care to the patient and their obligation to work within the scope of physiotherapy practice. Disclosure of information without consent and which breaches confidentiality must only occur within specifically defined situations e.g. child protection or public interest.

### Supporting Legislation:

Data Protection Act (1998)  
Human Rights Act (1998)

### Cross-references:

Rule 3 - Rules of Professional Conduct  
Core standards 2 (consent)  
Core Standard 3 (confidentiality)  
Core Standard 13 (communication)  
Department of Health (2003)



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## Standard 12

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

### General guidance

In accordance with the Health Professions Council requirements, physiotherapists should have at least an IELTS level of 7.0 with no element below 6.5 in English language proficiency. Physiotherapists should access interpreting services where necessary and practical.

	Criteria	Guidance
12.1	The physiotherapist uses active listening skills, providing opportunities for the patient to communicate effectively.	Particular care should be taken with non-verbal communication that can affect the interaction.
12.2	Physiotherapists communicate openly and honestly with patients.	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 oral, is clear, unambiguous and easily understood by the recipient and available in a variety of formats.	Abbreviations and jargon should not be used in patient information leaflets. 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, and that therefore in many cases the use of a family member is totally unsuitable. Where there is no alternative to the use of a family member, the patient should consent to this. Child interpreters should not be used. For members employed by NHS Trusts, the Trust has a statutory responsibility to make interpreting services available. Members employed by Trusts should follow the Trust's policy on the use of interpreters.

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## Standard 12

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| 12.4 | Methods of communication are modified to meet the needs of the patient.                                      | 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 in keeping with organisational responsibility. Foreign language interpreters should be used where necessary. |
| 12.5 | The physiotherapist assesses the recipient's understanding of the information given.                         | The physiotherapist should know how the information can be obtained if it is not readily available.   |
| 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.                                  | Physiotherapists should seek further support from line management, or other appropriate authority e.g. CSP or relevant Clinical Interest or Occupational Group (CIOG) , in the case of patients unable to consent for themselves.   |
| 12.8 | Consent is sought from the patient before discussing confidential details with carers, friends or relatives. |   |

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## Standard 12

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

The following guidance is extracted from the full Department of Health guidance. "A 'letter' is a communication between health professionals and includes referral and discharge communications and correspondence from health professionals to other agencies such as social services, employers or insurance companies. Where a patient is not legally responsible for his or her own care, the letter should be copied to the person with legal responsibility for the patient."

Letters should NOT be copied:

- Where the patient does not want a copy
- Where the clinician feels it may cause harm to the patient
- Where the letter includes information about a third party who has not given consent
- Where special confidentiality safeguards may be needed e.g. child protection.

### Supporting Legislation:

Data Protection Act (1998)  
Human Rights Act (1998)

### Cross-references:

Rule 2 - Rules Of Professional Conduct  
Core Standard 2 - Consent  
Core Standard 3 - Confidentiality  
Health Professions Council (2003)  
Department of Health (2001 a-f)  
Department of Health (2003)  
Department of Health (2004)  
Commission for Racial Equality (2002)  
PA 60 - Consent



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## Standard 13

Physiotherapists communicate effectively with other health professionals and relevant outside agencies 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.

	Criteria	Guidance
13.1	Physiotherapists follow locally agreed systems for referral.	These systems define procedures used for accepting referrals and referring to other professionals. For clinicians working in extended roles these should also include access to medical second opinion in clinically urgent cases. Referrals between health professionals may be by paper or electronic means. Electronic referrals must be treated in the same way as any other referral for prioritisation. Electronic referrals must conform to prevailing service standards regarding, access, security, confidentiality and audit trail.
13.2	Physiotherapists provide information for multidisciplinary assessments, planned transfers and discharges.	This is particularly important with the development of new roles e.g. advanced and extended clinical practice roles.
13.3	Physiotherapists agree common goals with the patient, multi-disciplinary team and wider carers and family.	There should be a written record of communication with other professionals/agencies involved in care; evidence could include letters, records of telephone calls, multidisciplinary meetings and onward referral. Relevant information is required for continuity of the patient's care.

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## Standard 13

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| 13.4 | Physiotherapists are aware of the roles of the other members of the multidisciplinary team.           | If the patient has self-referred or has had direct access to physiotherapy, the physiotherapist should discuss with the patient which other health professionals e.g. GP, should be notified of the treatment/outcome.  |
| 13.5 | Physiotherapists contribute to multi-professional record keeping and patient-held records where used. | The patient should be offered a copy of any transfer/discharge letter sent between health professionals. This is in addition to the patient's right to see their health records.  |
| 13.6 | Physiotherapists inform others of their own specific role.  | This may be oral, written or electronic. It should also take account of physical and sensory communication requirements.  |
| 13.7 | Information supplied to other professionals is directly relevant to their role with the patient.      | Jargon and abbreviations should not be used. Written information should be in plain English and in an appropriate accessible format e.g. corporate format/house style, and appropriate style that may be understood by the recipient. Physiotherapists may need to put 'technical' language or language that has meaning only to other registered physiotherapists into more appropriate language suitable for the recipient. However, if individuals e.g. solicitors, explicitly request a copy of the records - and decline a report - then the records should be released with the patient's consent in the format requested. If the record is being requested for release in respect of an allegation of negligence, CSP advice MUST be sought before proceeding. |

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## Standard 13

- 13.8 Physiotherapists communicate with other health professionals and agencies 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 recipient.
- 13.12 Where electronic communication is used e.g. for sending/receiving referrals, measures must be in place to ensure appropriate information is conveyed and that such communications are secure and confidential.

### Supporting Legislation:

Data Protection Act (1998)  
Disability Discrimination Act (2003)

### Cross-references:

Core Standard 3 (confidentiality)  
Core Standard 11 (transfer of care/discharge)  
Core Standard 11 - 14 (documentation)  
Department of Health (2004)  
Department of Health (2003)



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## Standard 14

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

### General guidance

While records are generally hand written, patient records also include computer records, audio tape, emails, faxes, video tape, photographs and other electronic media. 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/instance of intervention. Records may be uni-professional, multi-professional, single-assessment, electronic or paper based.

There is no distinction between 'records to satisfy legal requirements' and 'records to meet the CSP Standards'. They are the same. Members have a legal responsibility to keep an adequate record of their patient interventions to demonstrate to a third party what they did, why they did it and when they did it. The CSP standards describe the components of the written record that will satisfy this legal requirement. These standards apply equally to uni-professional, multi-professional and care-pathway records and it is the individual therapist's responsibility to ensure their records, into whatever repository, conform to the standards required. Certain types of documentation may require more written words than others, and the clinical setting will determine which is the most appropriate style of record keeping.

### Criteria

- 14.1 Patient records are started at 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.

### Guidance

Local mechanisms will need to be in place to enable community records to be completed within this period. Local mechanisms may need to be in place to meet the needs of managers and staff in achieving this requirement.

If clinical records cannot be written on the day of treatment, the entry must refer to the date and time of treatment and record the date and time at which the record was made. Clinical records are not added to after the time of writing. Any genuine omissions should be recorded at the time the omission is identified, signed, and dated accurately. Clinical records must only be made and amended by the person responsible for delivering that episode of care.

## Standard 14

- 14.3 Patient records are written at the time recorded in the records. 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.
- 14.4 Patient records conform to the following requirements:
- 14.4.1 concise
  - 14.4.2 legible
  - 14.4.3 logical sequence
  - 14.4.4 dated
  - 14.4.5 accurate
  - 14.4.6 provide adequate detail of the intervention given
  - 14.4.7 signed after each entry/attendance  
Where students are carrying out assessment and/or treatment, both the student and supervisor should sign the record at every entry.
  - 14.4.8 name is printed after each entry/attendance  
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. Job titles should also be recorded when the physiotherapist is part of a wider multi-disciplinary team or where multi-disciplinary records are kept. Cross matching names AND job titles is more accurate than matching names alone. Where patients are treated by the same physiotherapist throughout, it is sufficient for a printed name and job title 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.

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## Standard 14

- 14.4.9 no correction fluid is used
- 14.4.10 written in permanent ink that will remain legible with photocopying
- 14.4.11 any errors are crossed with a single line and initialled
- 14.4.12 each side of each page of the record is numbered
- 14.4.13 patient's name and either date of birth, hospital number, or NHS number are recorded on each page of the record
- 14.4.14 acronyms are used only within the context of a locally agreed abbreviations glossary
- 14.5 Records are appropriately countersigned.
- 14.6 If dictaphones are used to store information, the transcriptions of such records
- Abbreviations are not to be used as they may lead to misinterpretation during retrospective inspection of records.
- The qualified physiotherapist remains responsible for the patient's management at all times, although some tasks may be delegated to assistant or technical staff. If the physiotherapist is SUPERVISING tasks then each entry must be countersigned by the therapist. Students always work under supervision therefore, each entry must be countersigned. If the therapist is DELEGATING tasks to staff appropriately trained to perform such delegated tasks e.g. to assistants or technical instructors, then each entry does not need to be countersigned. In these cases the therapist should countersign where an event occurs which changes the overall patient management plan.
- The physiotherapist is responsible for the accuracy and clarity of dictated notes and thus should avoid the use of abbreviations, acronyms and jargon that may not be

## Standard 14

must include a date/time reference and a clinician/typist reference. Dictated notes must cover the same details as would a written record or manuscript.

### Supporting Legislation:

Data Protection Act (1998)  
Human Rights Act (1998)

correctly understood by the transcriber. Dictaphones must be treated in the same way as any other patient identifiable document. If they retain any patient identifiable information they should be securely stored and be accessed only by authorised persons.

### Cross-references:

Rule 4 - Rules of Professional Conduct  
Core Standard 3 (confidentiality)  
Core Standard 11-14 (assessment)  
Department of Health (2003)  
PA47



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## 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/instance of intervention. Records may be uni-professional, multi-professional, single-assessment and the format may be electronic or paper-based, audio tape, emails, faxes, video tape, photographs and other electronic media.

### Criteria

- 15.1 Patient records are kept securely in lockable cupboards/rooms.
- 15.2 Physiotherapists comply with local health informatics security policies.

### 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 any part of an unoccupied vehicle including the boot. Where whole caseloads need to be taken into patient's homes during the day's rounds, they should be stored in a locked container or suitable lockable document wallet.

If patient records need to be kept by the physiotherapist in their home overnight the records should be stored in a locked container or suitable lockable document wallet. The member needs to demonstrate that they have taken all reasonable steps to protect the content of the records from unauthorised persons, which includes friends and family within the member's own home. Employed members should clarify if they need formal permission from their employer to store patient records in their home.

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## Standard 15

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| 15.3 | Physiotherapists adhere to the local policy when asked by the patient to view his/her patient record.       | Any changes made to a computer record should be identifiable by suitably skilled persons if required. Physiotherapists should ensure that systems for ensuring access, security, confidentiality and audit trail protection of any computer held records are in place before compiling computer-based records.   |
| 15.4 | There is a clear statement available identifying who has storage and access rights over the patient record. | This will be the employer if the therapist is employed, or the organisation (including private practices) to whom a self-employed/locum physiotherapist provides services. Procedures for accessing records should be in place. Student physiotherapists should be able to access relevant information to assist them in the supervised management of the patient. |
| 15.5 | Patient records are destroyed in a secure manner after the lapse of the required time-scale.                | The law determines the length of storage required according to the nature of the record i.e. adult, child, obstetric or mental health.   |
| 15.6 | Clinical records held on audiotape must have hard copy back up.   |  |

### Supporting Legislation:

Data Protection Act (1998)  
Public Records Act (1958)  
Health & Social Care Act (2001)  
Access to Medical Records (1998) (for deceased patients only)  
Human Rights Act (1998)

### Cross-references:

Rule 3 - Rules Of Professional Conduct  
PA 42 - Access to Health Records  
PA47

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## Standard 16

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

### General guidance

This standard highlights areas of practice in which members have a duty of care towards their patients, colleagues and wider stakeholders in respect of their health and safety. It does not provide an exhaustive list of Health & Safety legislation and guidance which can be found elsewhere.

### Criteria

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

### Guidance

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

For low risk patients/areas e.g. ambulatory musculoskeletal outpatients it is acceptable to write 'no specific risks identified' or 'specific risk of...please see full risk assessment' according to the circumstances.

Knowledge of harm and risk is informed by research or evidence where this information exists.

## Standard 16

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| 16.4 | The physiotherapist is able to summon urgent assistance when required.   | This will range from systems for summoning colleagues, carers or hospital crash teams, to dialling 999 in community or private practice settings. |
| 16.5 | Infection control procedures are followed.   | For example, hand washing, correct disposal of sharps, clinical waste, and sterilisation.   |
| 16.6 | Adverse and unexpected effects, or events which could have (or did) affect patient safety are reported using appropriate local, national and professional systems. | This may be through employer risk management or incident reporting systems or other learning systems  |

### Supporting Legislation:

Health and Safety at Work Act (1974)  
Disability Discrimination Act (1995)

### Cross-references:

Chartered Society of Physiotherapy (2002b)  
Chartered Society of Physiotherapy (1994)  
ERUS 24 - Guidance to Members on Chaperoning & Related Issues  
ERUS H&S 03 - Risk Assessment  
ERUS H&S 09 - Workplace Infection Risks

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## Standard 17

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

### General guidance

This standard highlights areas of practice in which members have a duty of care towards their patients, colleagues and wider stakeholders in respect of their health and safety. It does not provide an exhaustive list of Health & Safety legislation and guidance which can be found.

	<b>Criteria</b>	<b>Guidance</b>
17.1	Policies and procedures for physiotherapists working alone are followed at all times.	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.	This could be by mobile phones, a buddy system or a dual diary system and should include names, addresses and telephone numbers of the patients being visited. All practitioners need to ensure someone is aware of their movements on a daily basis. This is particularly important in respect of sole practitioners undertaking domiciliary visits; in this case, it may be appropriate for a family member to be aware of the therapist's planned whereabouts for the day.
17.3	A personal alarm is carried by physiotherapists when the risk assessment requires it.	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.

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## Standard 17

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

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.

### Supporting Legislation:

Health and Safety at Work Act (1974)

### Cross-references:

Chartered Society of Physiotherapy (2002b)  
Chartered Society of Physiotherapy (1994)  
Chartered Society of Physiotherapy (1998)  
ERUS 24 -Guidance to Members on Chaperoning and Related Issues

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## 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 use or issuing to patients.
- 18.2 Equipment is used according to manufacturer's instructions.
- 18.3 Equipment is cleaned according to manufacturer's instructions and infection control policies.
- 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.
- 18.7 The risks associated with using electrical equipment in a patient's home are minimised.

### Guidance

- This includes for example routine checks such as wear and tear on electrodes and ferrules, correct suction pressure, wheelchair tyre pressures. Individual therapists have a responsibility to highlight attention to equipment that is outside its service schedule and to withdraw such equipment from use if necessary.
- For example, weight-bearing equipment such as a wheelchair is used within loading limits.
- This applies to situations where cleaning is required prior to each patient use. Items that are designed as single use are not reused and should not be modified from the manufacturer's original specification. If members become aware that single use items are being reused they should seek written clarification of the situation and all parties must be fully aware of their liabilities and responsibilities for taking such action.

- This will include information published in Physiotherapy Frontline and CSP Health and Safety Bulletins, for example from the Medical Devices Agency.

- Circuit breakers should be available. Battery operated equipment is used where this is available.

## Standard 18

- |       |   |   |
|-------|---|---|
| 18.8  | The patient is given instructions on the safe use of any equipment issued.  | Examples include TENS, walking aids, collars and splints. Instructions should be clear, documented and given in writing where possible.   |
| 18.9  | There is a record of all equipment which is loaned to patients.   | This log will also include details of the action required to maintain the safety of equipment between patients.   |
| 18.10 | The physiotherapist acts on 'Patient Safety Alert' notices issued on treatments/interventions that affect their practice. | These are issued by the National Patient Safety Agency regarding medicines/procedures or techniques that have a record of previously causing, or potentially causing, patient harm. |

### Supporting Legislation:

Health and Safety at Work Act (1974)  
Consumer Protection Act (1987)  
Medical Devices Regulations (2002)

### Cross-references:

Chartered Society of Physiotherapy (2002b)  
Chartered Society of Physiotherapy (1994)  
Chartered Society of Physiotherapy (1998)  
Lifting Operations and Lifting Equipment Regulations (LOLER) (1998)  
Provision and Use of Work Equipment Regulations (PUWER) (1998)

## Standard 19

The physiotherapist assesses his/her learning needs.

### General guidance

Continuing professional development (CPD) is the educational process by which physiotherapists and associate members maintain and develop their skills, knowledge and competency in order to provide safe and effective 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. It is expected that all members, in any practice setting, will maintain a portfolio of activities as evidence of their CPD. Assessment of learning needs should normally take place in conjunction with a peer or manager. The emphasis is on the individual's competency within their scope of practice, and confirmation that the responsibility lies with the individual themselves. By meeting this objective it is likely that the individual will satisfy the statutory, mandatory and organisational needs.

	Criteria	Guidance
19.1	The assessment takes account of:	
19.1.1	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 some time	
19.1.2	feedback from performance data	Performance data might include patient statistics, clinical audit and outcome audit results.
19.1.3	new innovations in practice and technological advances	In order to remain within Rule 1 of Rules of Professional Conduct, innovations should be based on best available evidence and show a link bringing research/theory into clinical practice.
19.1.4	mandatory requirements	Examples of this could include fire, cardiopulmonary resuscitation and manual handling training.

## Standard 19

19.1.5 statutory registration requirements

E.g. re-registration with the HPC

19.1.6 the fair and reasonable needs of the organisation

the term 'organisation' refers to the whole range of services, from a single-handed practice to large NHS trust.

### Cross-references:

Rule 1 - Rules of Professional Conduct

CPD Framework

PA 44 - Scope of Physiotherapy Practice

Health Professions Council (2003)

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## Standard 20

The physiotherapist plans their Continuing Professional Development (CPD).

### General guidance

This statement applies to all members, not just those involved in direct patient care. Members engaged in research, educational or management tasks all undertake activity which will ultimately affect the patient experience. CPD activities should be undertaken with the overall aim of improving the quality of patient care.

	Criteria	Guidance
20.1	There is a written plan based on the assessment of learning needs and the identification of learning outcomes.	There is a portfolio to support evidence of CPD.
20.2	The plan includes intended/ expected learning outcomes.	Learning outcomes should be specific, measurable, achievable, relevant and timed (SMART) and identify expected learning outcomes.
20.3	The plan identifies a range of activities that will lead to the achievement of the learning outcomes.	These activities may include: <ul style="list-style-type: none"><li>a reflective practice</li><li>b further formal education e.g. MSc/PhD</li><li>c reading relevant professional journals</li><li>d attending educational meetings</li><li>e secondment and shadowing</li><li>f in service education programmes</li><li>g independent study</li><li>h clinical audit</li><li>l implementing clinical guidelines</li><li>j peer review</li><li>k mentorship</li></ul>

## Standard 20

- l contact with other specialist physiotherapy groups, professions or patient organisations
- m research
- n sharing knowledge and skills with others
- o clinical supervision
- p diversity training
- q membership of a CSP recognised CI/OG

### Cross-references:

Core Standard 19

CPD 16 - Guidelines for In-Service Training for Physiotherapy Assistants

CPD 30 - The CPD Process

CPD 33 - Lifelong Learning and Physiotherapy Assistants

CPD 35 - Mentoring

CPD 37 - Clinical Supervision

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## Standard 21

The CPD plan is implemented.

### General guidance

This applies to members in all clinical settings.

#### Criteria

- 21.1 There is written evidence to show the plan has been implemented.
- 21.2 The plan is subject to appropriate review.
- 21.3 The CPD plan is linked to the individual's appraisal cycle.

#### Guidance

This will normally take place with a peer or a manager. The timescales for review will depend on the grade and role of the individual. For example, it may be appropriate for rotational staff to review their CPD at mid and end of rotation. Staff in static posts may wish to review CPD six monthly or annually. Staff undertaking long courses may review CPD on completion of the period of study. A review should always take place when a member is considering moving into new areas of clinical practice or returning to an area in which they have not practised for some time.

CPD should be linked to evidence of best practice where possible, in terms of good quality clinical care and include assessment methods, and methods of treatment evaluation and management.

The CSP recommends a minimum of one half day per month is allocated as protected learning time for informal activities. This is in addition to mandatory training and study leave for formal training activities.

## Standard 21

- 21.4 CPD activity undertaken is evaluated once completed in terms of:
  - 21.4.1 effect on the individual's practice
  - 21.4.2 impact on the service in which the member works
  - 21.4.3 impact on the practice of physiotherapy as a whole
- 21.5 there is agreed and protected working time for personal learning activity

### Cross-references:

CPD Framework  
CPD 06 - Keeping a Portfolio - Getting Started

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## Standard 22

The physiotherapist evaluates the benefit of their CPD.

### Criteria

- 22.1 There is evidence that the learning outcomes have been achieved and reflective practice has occurred.
- 22.2 New intended and expected learning outcomes are identified, to continue the cyclical process of CDP.
- 22.3 There is evidence that learning outcomes are recorded in a portfolio.
- 22.4 The individual can demonstrate that their learning has enhanced and developed their practice.

### Guidance

If learning outcomes 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.

The individual may link their learning to appraisal objectives and/or achieving recognised accreditation for an activity

### Cross-references:

CPD Framework

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## **Assessment/treatment cycle**

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

## **Buddy system**

An arrangement whereby two or more colleagues keep track of each others movements.

## **Carers**

Carers are people who look 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. Carers may also be those responsible for the care of dependent children.

## **Clinical audit**

A cyclical process involving the identification of a topic, setting standards, comparing practice with standards, implementing changes and monitoring the effects 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 and Lohr 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**

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 on their patients e.g. name, address, age, occupation, date of birth.

### **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 point of an episode of care. Agreed individual goals should be established by negotiation with each patient and any carers. These should be realistic and include time scales that are subject to ongoing review, discussion and modification.

### **Investigations**

Clinical investigations refer to physiological/laboratory tests usually performed to enable diagnosis or to monitor progress. Examples are blood tests, X-rays and MRI scans.

### **National service framework**

A framework that describes clinical standards and service models, including performance indicators, to drive up standards and reduce variation.

### **Non-verbal communication**

The use of eyes, smiles, frowns and body language to communicate messages.

### **Objective marker**

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

### **Outcome measure**

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

### **Patient record**

Any record containing patient details. It includes all media for example, paper, faxes, videos, photographs and electronic records. Used generically to mean both separate physiotherapy records and physiotherapy records contained within multi-professional records or case notes.

### **Peer review**

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

### **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 health care professionals working in primary care such as general practitioners, practice nurses, district nurses and health visitors.

### **Reflective practice**

Professional activity in which the physiotherapist thinks critically about their practice and as a result may confirm or 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.



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### **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 e.g. 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 associate staff and/or the combination of multi-professional staff within the team.

### **Standard**

Statement which describes the range of acceptable care.

### **Subjective marker**

A measurement that requires judgement on behalf of the measurer.

### **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 and 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.

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

## **Access to Health Records Act (1990)**

This established an individual's right to access records relating to themselves made by clinicians for employment or insurance purposes subject to broad exceptions. Access to health records has been superseded by the Data Protection Act and the Access to Health Records Act now only relates to the records of deceased persons. See also PA47.

## **Adoption & Children Act (2002)**

This Act aligns adoption law with the relevant provisions of the Children Act (1989) to ensure that the rights and welfare of children considered for adoption are equal to those of other children. The Act makes provision for acquisition of 'parental responsibility' by stepparents, and unmarried fathers who register births jointly with the mother.

## **Adults with Incapacity (Scotland) Act (2002)**

This Act of the Scottish Parliament makes provision as to the property, financial affairs and personal welfare of adults who are incapable, by means of mental disorder or inability to communicate. The Act allows for the intervention of another person in an individual's affairs once it is determined that the individual in question is incapable of acting for themselves. See also PA 60.

## **Bolam v Friern Hospital Management Committee [1957] All ER 118**

This case established that the standard of information imparted to a patient by a practitioner must conform to a reasonable body of opinion or to the standard of a reasonably competent practitioner. The case established the use of the Bolam Standard.

## **Bolitho v City & Hackney Health Authority [1993]**

This case refined the Bolam Standard particularly in relation to establishing the cause of any breach of duty of care. This case established that it is for the patient to prove that the damage was caused by the practitioner's negligence. It was held that, where the Bolam Standard is applied, the practitioner must demonstrate that the body of professional opinion relied upon to defend the claim has a logical basis and that the professionals advocating its use had considered the relative risks and benefits to reach a defensible conclusion. In practice therefore, the majority of negligence (breach of duty of care) cases, are successfully defended by showing that distinguished experts in the relevant field consider the treatment in question to be appropriate.

### **Children Act (1989)**

This Act established a new framework for the protection and care of children and young people. This Act defines a parent's legal relationship with their children and replaced 'parent's rights' with the concept of 'parental responsibility'. The overriding principle of this Act is that the welfare of the child is the most important consideration in any decision making process. A more detailed explanation of the implications of this Act can be found in the Rules of Professional Conduct. See also PA 60.

### **Consumer Protection Act (1987)**

This Act enables the consumers of products to claim for damages if harm results from the use of a product. Negligence of the supplier does not have to be established, but the consumer does need to show that a defect was present in the product resulting in harm.

### **Data Protection Act (1998)**

This regulates an individual's right to access information held about them. Information may be requested by the patient, anyone authorised by the patient, those with parental responsibility for children under 16, or a 'Gillick Competent' child. It enshrines the rights that people should have access to data held about them, data should be processed fairly and lawfully, data held should be accurate and data should be protected by appropriate security. An individual may only be denied access to data held about them where the information released may cause serious harm to the physical or mental health or condition of the patient or any other person, or where giving access would disclose information related to a third party who had not consented to disclosure.

### **Disability Discrimination Act (1995)**

This Act makes it unlawful for service providers to discriminate against disabled persons in certain circumstances. Service providers are required to make 'reasonable adjustments' to their service provision to ensure disabled users can use the service, and 'reasonable adjustments' to the physical features of their premises to overcome physical barriers to ensure disabled users can access the services. Section 21 has implications for health service provision, policies and procedures. Further information is given in the Rules of Professional Conduct.

### **Family Law Reform Act (1969)**

This Act allows persons 16 years old or more to consent to surgical, medical and dental treatment without the requirement for additional parental consent. See also PA 60.

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### **Gillick v West Norfolk & Wisbech Area Health Authority (1986) AC 112**

This Appeal Court case established the child's right to make their own decisions when they reached a sufficient understanding and intelligence to be capable of making up their own mind on the matter requiring a decision. The first case held that a parent's interest in their child did not amount to a 'right' but a responsibility or duty, so that, for example, prescribing contraceptives to an under-16 without parental consent could not amount to unlawful interference with parental rights.

### **Health & Safety at Work Act (1974)**

This is the enabling legislation that makes it the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare of their employees, and persons not employed by them but affected by their activities. Further later legislation and regulations are enabled by the Health & Safety at Work Act and details of these regulations can be found in ERUS Safety Representatives Information Manual and the CSP document Guidance in Manual Handling for Chartered Physiotherapists.

### **Health & Social Care Act (2001) - section 60**

Section 60 makes it lawful to disclose and use confidential patient information in strictly controlled circumstances where it is not currently practicable to satisfy the common law duty of confidentiality. An example of the use of Section 60 powers is the operation of Cancer Registries. The Data Protection Act (1998) still applies even when Section 60 powers are invoked (DoH 2003).

### **Human Rights Act (1998)**

This Act enshrines certain rights that individuals can expect to receive. The rights most relevant to the Standards of Physiotherapy Practice include

- Right to life
- Right to respect for private and family life
- Right to freedom of thought, conscience and religion
- Right to freedom from unfair discrimination in the enjoyment of Act's rights

IR Briefing Paper No 18 gives comprehensive details on the Convention Rights and its implication. Further details on the Human Rights Act can be found in the Rules of Professional Conduct.

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### **Medical Devices Regulations (2002)**

These require a practitioner to ensure that medical devices are properly maintained and comply with current standards. Healthcare Trusts should have appropriate protocols in place to comply with these regulations. Private practitioners need to be aware of, and ensure compliance with, these standards themselves.

### **Mental Health Act (1984)**

This Act makes provision for the compulsory detention and treatment in hospital of those with mental disorder. Individuals may be detained under a number of different sections of the Act on the basis of the presence of mental disorder as described in the Act and which requires hospital treatment. Different procedures apply in the case of emergencies.

### **Public Records Act (1958)**

Public records include National Health Service records. This Act allows for the selection and preservation of some of these public records in public record repositories and makes provision for these records to be made available to the public after 30 years has elapsed since the record was made, though different time scales may be stipulated. Public records which are not held in a designated public record repository and are not open to public inspection (amongst others) cannot be released under the terms of this Act. The Data Protection Act and the Access to Medical Reports Act also govern the handling of patient records.

### **Race Relations Act (1976)**

This is the principle law in the United Kingdom that defines and outlaws racial discrimination. This Act allows persons to seek legal redress for acts of racial discrimination.

### **Race Relations (Amendment) Act (2000)**

This Act extends the scope of the 1976 Act to include public authorities/bodies. Many public authorities have a statutory duty to actively promote racial equality and prevent racial discrimination, and the Home Secretary has the power to impose specific duties on public bodies covered by this Act.

### **Race Relations (Northern Ireland) Act (1998)**

This makes it unlawful in Northern Ireland for employers to discriminate on the grounds of religious belief. Outside of Northern Ireland, limited protection against religious discrimination is afforded under the Human Rights Act.

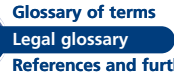
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### **Rules of Professional Conduct (2002)**

This document sets out the reasonable expected standards of ethical, moral, legal and professional behaviour and conduct of student and chartered physiotherapists.

### **Code of Conduct for Assistants (2002)**

This document sets out the reasonable expected standards of ethical, moral, legal and professional behaviour and conduct of assistant and technical instructor member of the CSP.



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PA 1	Reports for Legal Purposes (2002)
PA 5	Patients seeking treatment in the public and private sector(2004).
PA 6	Delegation of Tasks to Assistants: A guide for qualifiedmembers and students (2001)
PA 29	Chartered Physiotherapists Working As Extended Scope Practitioners (2000)
PA 42	Access to Health Records
PA 44	Scope of Physiotherapy Practice
PA 47	General Principles of Record Keeping
PA 60	Consent (2004)
CPD	CPD Framework for the creation of successful systems of CPD in physiotherapy services (2003)
CPD 06	Keeping a Portfolio - Getting Started (2001)
CPD 16	Guidelines for In-Service Training for Physiotherapy Assistants (2003)
CPD 30	The CPD Process (2001)
CPD 33	Lifelong Learning and Physiotherapy Assistants (2001)
CPD 35	Mentoring (2002)
CPD 37	Clinical Supervision (2003)
CLEF 03	Outcome Measures (2001)
JB 03	Living Wills (2002)
ERUS 24	Guidance to Members on Chaperoning and Related Issues (2003)
ERUS H&S 03	Risk Assessment (2002)
ERUS H&S 09	Workplace Infection Risks (2000)

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