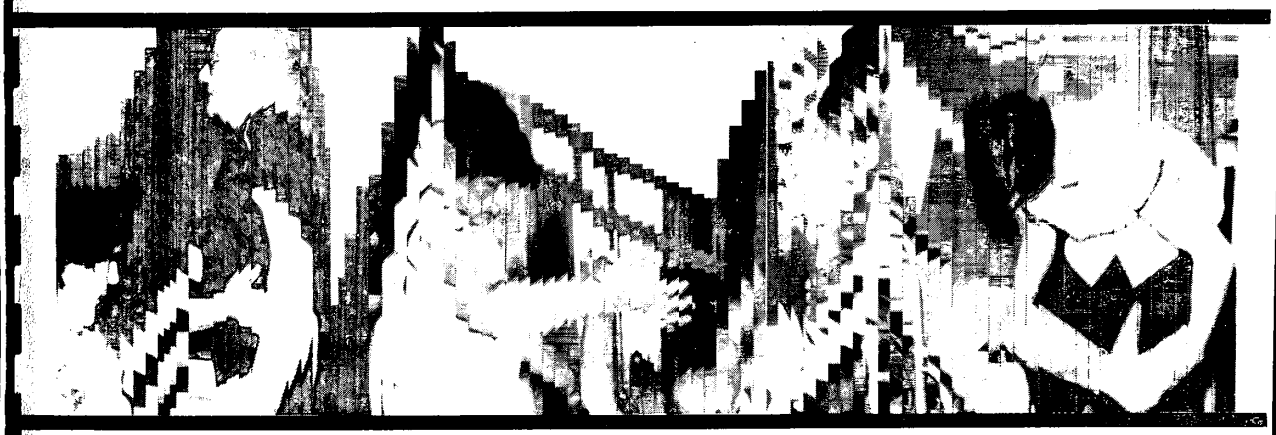


PHYSIOTHERAPY SERVICES: A BASIS FOR DEVELOPMENT OF STANDARDS

July 1987

PREFACE

In the mid 1970s accreditation and quality assurance began to emerge as important issues in the United Kingdom, stimulated by experience in other parts of the world. The increasing demand for all those working in health care to be cost effective caused concern lest quantity was measured at the expense of quality.

In 1981 the King's Fund sponsored the visit of a multidisciplinary team to the USA to explore their system for the accreditation of hospitals and examine its relevance to the National Health Service (NHS). The team included the District Nursing Officer from Tower Hamlets and the District Administrator from Hampstead Health Districts. On their return they succeeded in inspiring Doreen Hayes and Ida Bromley, the respective District Physiotherapists to pursue the definition of quality in relation to their profession.

Meanwhile, at Westminster Hospital, Barbara Sutcliffe had been working with the Brunel Institute of Social Studies on the determination of work strata and with senior physiotherapists in the District trying to define the competence of clinical specialists.

Doreen Hayes, Barbara Sutcliffe and Ida Bromley formed a working group in late 1981 to explore ways of defining 'good practice' in physiotherapy. Throughout the project Dr Cecily Partridge has been regularly consulted and has joined the working group from time to time leading the work on assessing patients' responses and physiotherapists' attitudes. The working group are indebted to Dr Partridge not only for her share of the work but also for her constant encouragement and support.

The aim has been to create a profile of agreed good practice against which physiotherapy managers can measure the strengths and weaknesses of their own service. It is envisaged that this will be a voluntary exercise amongst peers, to be implemented by choice. As standards vary widely it could have educational value by broadening individual horizons. It could also assist in identifying facilities for student education and the needs of newly qualified staff.

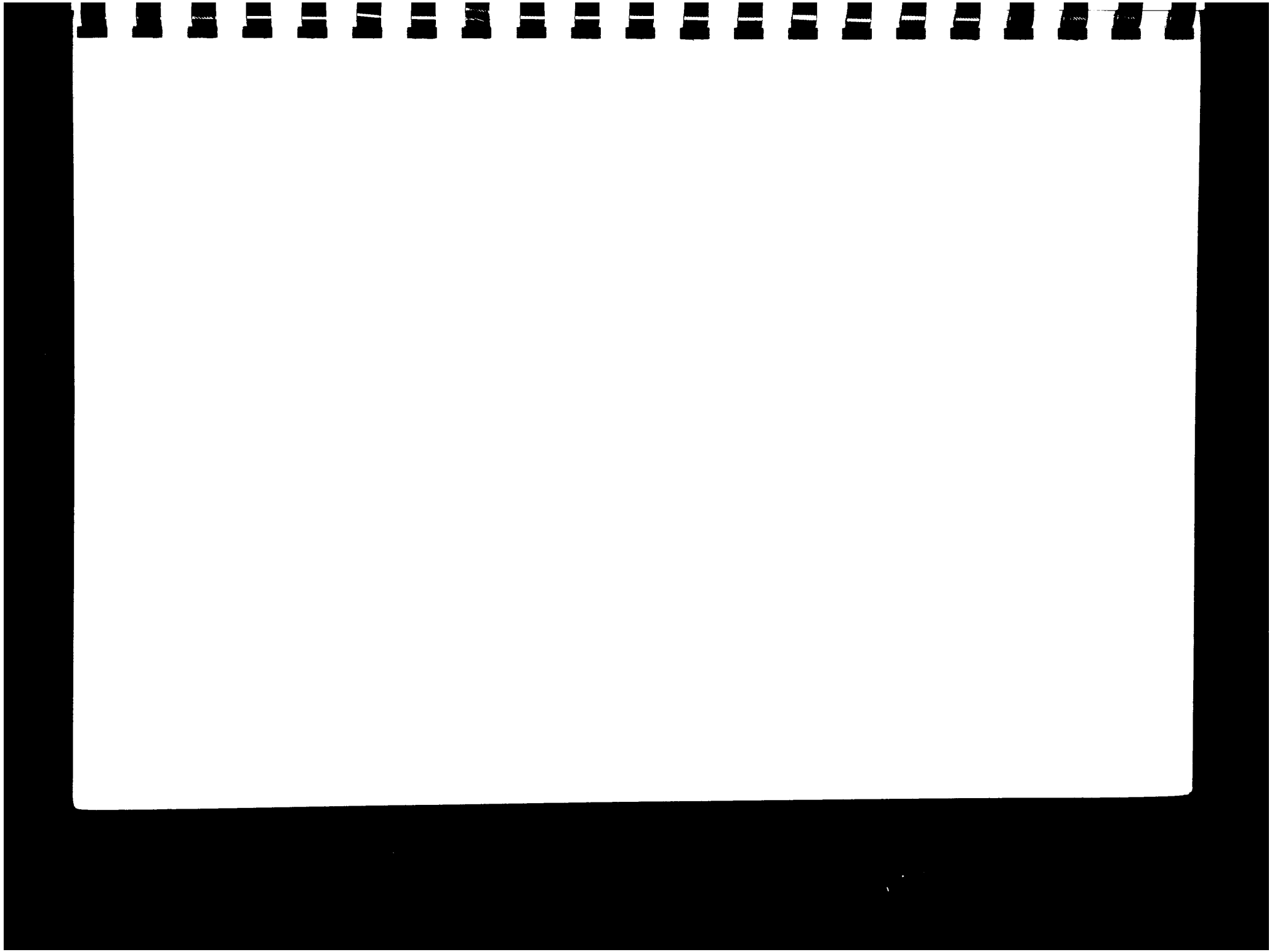
This group worked together during 1982/83 producing initial papers on a variety of aspects considered to be important indicators of quality. At a series of meetings made possible through the generosity of the King's Fund, these initial papers were presented to a wider group of peers. All members of the committees of the Association of District and Superintendent Chartered Physiotherapists and the Organisation of District Physiotherapists were invited to the initial meeting in July 1981 and those able to attend formed the peer group who have continued to work on the project. Papers have been discussed with the peer group, piloted in the Districts represented and modified accordingly. An additional two conferences were held on clinical specialties with the chairmen of the Chartered Society of Physiotherapy's Clinical Specific Interest Groups. The members of the working group would like to stress that each of them has worked on the project as an individual and has not represented any organisation.

Due to ill health, Doreen Hayes had to leave the working group and Ann Hunter, who had been one of the committee members of the Association of District and Superintendent Chartered Physiotherapists in the original peer group took her place. For her degree project Ann Hunter was working on developing standard manpower levels, closely related to what would be acceptable standards of practice to provide a 'good' physiotherapy service.

The working group are exceedingly grateful to the King's Fund, and in particular to Hazel Allen for continued support and considerable encouragement through what has been a lengthy gestation period.

The profile is intended as a 'starter kit' in good practice for assessing quality within an individual service and it is the group's hope that it will lead to an expansion of interest in defining quality and high standards in physiotherapy practice. There is still much work to be done including the development of further strategies to assess clinical competence in practice.

Ida Bromley
Barbara Sutcliffe
Anne Hunter



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INTRODUCTION

Few would disagree that -

> 'Progressive departments are attractive places to work. They buzz with activity. It is not necessarily the buildings that are attractive, although that helps, but the spirit of the working group. There is high prestige, a promise of excellence and purpose. The decisions are taken where the knowledge is. New staff want to work in the department.' **The Rising Tide (page 29 para 141)**

The aim of this project has been to devise a profile which defines some aspects of agreed good practice. District Physiotherapy Managers may, if they wish, use the standard identified in the package to measure that of their own service.

It is a tool of management devised by Physiotherapy Managers within the National Health Service for their own use. It is a yard-stick for the managers to evaluate their own performance. It is a self monitoring, self appraisal exercise. If the manager thinks it would be helpful to co-operate with peers in other Districts or Regions, this could provide additional comparative information.

Since it is defining standards it should be a self development experience - unless the defined standard has been set too low, in which case the working group will look forward to exploring an upgraded version provided by inspired users.

Users will notice that wherever possible the response to the questions is either 'Yes' or 'No'. Considerable effort has been made to avoid words which are capable of a wide range of interpretation such as 'adequate', 'sufficient', 'appropriate'. The number of positive answers enables users to assess their own performance. As with any form of assessment, it is not intended to be a one off exercise but a continuing process. Negative responses can be identified easily in order to plan the necessary remedial action.

Efforts have been made to assist therapists in their endeavours to ensure that the service meets the needs of the particular District. The highest standards of clinical expertise in a particular realm of clinical practice may not necessarily meet the identified needs of a given District population. e.g. three clinical specialists in respiratory care may not be a priority when there is no service in deprived areas such as that for elderly mentally ill people.

The profile can be used by District and/or Superintendent Physiotherapists and applied to districts, sectors or units as well as individual physiotherapy departments.

USING PERFORMANCE INDICATORS

The first step towards defining a 'good' department is to ensure that the physiotherapy service matches the health needs of the population. Performance Indicators (PIs) attempt to do this for certain services within the NHS.

Who has them?

This and other data is available in every district from a designated information officer who will advise on its interpretation. A Manual/User Guide is available to examine the PIs. The following example illustrates how the information can be analysed to monitor the input to Trauma and Orthopaedic beds. The actual length of stay divided by the expected length of stay provides a standardised ratio which is expressed as a percentage. The figure can be compared across districts to alter manpower levels. In acute elderly admission wards, the average length of stay may be 11 days. However, the turnover interval may be .5 of a day. This would indicate a heavy workload, involving frequent assessments of new patients.

What are they?

Department of Health and Social Security (DHSS) PIs - There are various categories including manpower and activity in the following services:

Acute, Elderly, Mentally Ill, Mentally Handicapped and Children

Data is available for waiting lists, available beds, length of stay, deaths and discharges and out-patient attendances.

Manpower - These PIs give the number of staff per 100,000 population. Those relating specifically to physiotherapy from the 1983 census are:

1. Cost of physiotherapy service per head of population (PI ref.No.M63)

2. Number of qualified staff per 100,000 (M64)

3. Ratio of qualified to unqualified staff (M65)

These indicators are available for England and Wales. The comparative data for England and Wales is available in each district.

Yates Data - Yates activity indicators complement the DHSS PIs, but include socio-economic data. These indicators, with a deliberate General Practitioner orientation were derived to look at areas of social deprivation. This data can also be used to compare authorities in England and Wales.

DISTRICT MANPOWER REQUIREMENTS

A broad profile of the district is required to determine future manpower needs and the following is a sample of the information available:

	INFORMATION	SOURCE
Population	% elderly	PIs
	% elderly over 75	"
	% elderly over 85	"
	% children under 5	"
	% elderly alone	District Information Officer
	% ethnic minorities	"
	% over 5 in household	"
	% without bath	"
Patient Services	Medical staff per 100,000	PIs
In Patients	Bed allocation	Hospital Administration
	Throughput	Admissions Officer
Out Patients	Attendances	PIs
	Waiting Lists	"

Further reading: YATES J M (1982) Hospital Beds Heinemann.
Health and Social Services Journal (1985) June 20, 27, July 4.

PLANNING REVIEW

The efficient Physiotherapy Service will need to review its planning system at regular intervals, within the framework of the District and Regional Strategic Plans and in relation to DHSS policy. The following questions are an aide-memoire for the District Physiotherapist and senior colleagues.

	YES	NO
Were objectives set for the physiotherapy services for the current year?	☐	☐
Have objectives been set for the physiotherapy services for next year?	☐	☐
for next 5 years?	☐	☐
Are these objectives reviewed annually?	☐	☐
Are these objectives agreed with management?	☐	☐
Are these objectives agreed with senior physiotherapy staff?	☐	☐
Do the senior physiotherapists set objectives with their staff?	☐	☐
Are physiotherapy developments included in the District Strategic Plans?	☐	☐
Are the implications for physiotherapy recognised in the Regional Strategic Plans?	☐	☐

COMMUNICATION

Physiotherapy within a District is only one part of the overall service and no document on standards is complete unless it relates the physiotherapy contribution to other aspects of the patient services. Lines of communication have not been described in any detail as the organisational structure within each District is so different.

However, three major areas of communication will be important in all Districts.

1. Communication with General Management within the Health Authority.

2. Inter-disciplinary communication.

3. Cross sector communication outside the Health Authority with, for example, Primary Care, Local Authority, Voluntary and Private Sectors.

1. Communication with General Management

Policies and procedures need to be established to ensure good communications with management at District, Unit and Sub-Unit levels. To encourage effective communication and working relationships, the District Physiotherapist should ensure that a relevant communication system is developed, particularly in relation to organisational and financial arrangements. Action plans should be agreed and monitored.

2. Inter-disciplinary Communication

The organisation and planning of physiotherapy services takes place against a background of developments in other groups, whose services interact and impinge on physiotherapy developments. In a well managed organisation, no developments should be contemplated in isolation. The most effective use has to be made of scarce resources to avoid duplication and areas of overlap. Close and effective cooperation and coordination are hallmarks of a good service.

A check-list of relevant disciplines to be consulted should be helpful in ensuring that Services are planned, organised and modified in close cooperation with colleagues of other disciplines. The check-list compiled by the local team will, of course, be different for each clinical specialty.

3. Cross Sector Communication

As physiotherapy services are provided not only within the District Health Authority, but also within primary care, local authority, voluntary and private sectors, a satisfactory communication network is essential with all these organisations. Only through such a network can a comprehensive picture of local consumer needs be constructed.

PHYSIOTHERAPISTS' ATTITUDES

Though we frequently talk about attitudes, the concept is complex. It may be helpful to consider that attitudes consist of thoughts, feelings and behaviour. It is difficult to assess or monitor thoughts or feelings and the emphasis in the following profiles will be on overt behaviour recognising that this will reflect underlying thoughts and feelings for if changes are to be brought about all components will need to be considered.

The list of behaviours provided does not claim to be comprehensive and others could be added. The concentration is on common problem areas found in practice and there would be little disagreement about the behaviours listed. These standards of behaviour can be monitored by observation in the clinical situation and in discussion with the physiotherapists. Until such exercises have been undertaken it is impossible to be certain of one's actual behaviour. It has frequently been shown that what we think we do and what we actually do varies widely. John Badenock in a symposium on Communication (reference: Journal of Royal Society of Medicine 1986, 79, 567 - **Communication in Medical Practice**) highlighted the dangers of even the most experienced clinicians assuming that they know about their own behaviour and the impressions they are giving to others.

Behaviours to be actively encouraged:

1 Making efforts to make the patient feel at ease.

2 Treating each patient as an individual of value.

3 Giving undivided attention to the patient whilst with them.

4 Maintaining body orientation and gaze towards the patient throughout the time with them.

5 Actively listening to the patient - i.e. trying to understand what they are saying so that matters <u>they</u> are concerned about can be discussed.

6 Trying to give the impression when with the patient that there is plenty of time (even if there is not).

7 Ensuring the preservation of the patient's dignity at all times.

8 Attempting to understand why a patient seems awkward or difficult.

9 Taking account of the patient's view of the 'reality' of the situation even if it conflicts with your own view of 'reality'.

10 Recognising the patient's right to make decisions about their treatment.

11 Encouraging patients to talk about their fears and worries and the goals they themselves want to achieve.

12 Showing sensitivity to the patient's needs in terms of manner and address by using the patient's full name and title - only progressing to first name terms if the patient actively encourages it.

13 Tolerance of different life styles and cultures, and flexibility towards patients of different social and cultural backgrounds.

14 Using touch as a means of establishing and maintaining good communication, reassurance and comfort.

15 Considering the needs and problems of the patient's relatives.

16 Including relatives and carers in present and future plans.

The following behaviours are to be discouraged, and mostly reflect the obverse side of the behaviours to be encouraged:

1 Talking over the patient literally or metaphorically.

2 Addressing the patient as if they are inferior, i.e. 'talking down'.

3 Assuming that the patient is stupid if they do not seem to understand instructions or explanations.

4 Setting goals that are totally physiotherapy oriented and therefore meaningless to the patient.

5 Insisting patients obey - and 'do as I say', even saying 'do it for me' should be discouraged.

6 Making patients feel they are being a nuisance (even if you feel they are).

7 Overtly or covertly labelling patients in any way, for example, as difficult, psychiatric, geriatric, or in terms of their condition strokes, fractured hips, etc.

8 Giving unnecessary attention to any one patient to the detriment of others.

9 Discussing other members of staff in front of patients.

10 Adopting the authoritarian stance of the 'therapist in charge'.

PATIENT QUESTIONNAIRE

The use of a simple questionnaire anonymously completed by patients receiving physiotherapy is one means of obtaining the consumers' opinion of the service and the behaviour of those who provide it. Departments will find that such information can be a valuable means of stimulating discussion amongst all members of the department team and should lead to greater awareness of the patients' needs and an increased understanding on the part of the staff of their own behaviour.

The following questionnaire (page 13) should be given, by someone other than the therapists, to all patients attending the Department or to those being discharged, on a particular day, or during a chosen week, twice a year.

Example of covering letter to patient:

PHYSIOTHERAPY DEPARTMENT

We are interested in ensuring high standards of care in our Department and your opinion of our services can help us to identify our strengths and weaknesses. We would be grateful if you would complete this form, by doing so you will be helping us to improve our services for all patients. Your answers will be treated in confidence, to ensure this we do not want the form to be signed.

Thank you very much for your co-operation.

ALL THE INFORMATION IN THIS QUESTIONNAIRE WILL BE REGARDED IN THE STRICTEST CONFIDENCE - PLEASE DO NOT SIGN IT

Please tick the answer to each question as appropriate. If the words you wish to use are not those given, please add your own in the space provided.

QUESTION	ANSWER	TICK APPROPRIATE BOX
1. Were you made to feel welcome on your first visit?	Yes	☐
	No	☐
2. What did the therapist tell you about your condition and treatment?	All I needed to know	☐
	Some useful information	☐
	Nothing much	☐
3. Were you given a choice of physiotherapy appointment times	Yes	☐
	No	☐
4. Have you been kept waiting past your appointment time for more than 5 minutes?	Hardly ever	☐
	Sometimes	☐
	Usually	☐
5. Did you feel at ease discussing your problems with your therapist?	Yes	☐
	No	☐

QUESTION	ANSWER	TICK APPROPRIATE BOX
6. Do you feel your personal privacy was respected during treatment?	Adequately	☐
	Not respected	☐
	Privacy doesn't worry me	☐
7. Did you feel confident in your therapist?	Yes	☐
	No	☐
8. Do you feel your physiotherapist understood your problems?	Yes	☐
	No	☐
9(a) How many physiotherapists have treated you during this course of therapy?	1	☐
	2	☐
	3	☐
	4 or more	☐
9(b) If you have been treated by more than one, did this worry you?	Quite a lot	☐
	Not too much	☐
	Not at all	☐
10. Do you feel you had sufficient attention from your physio-therapist(s)?	All the time	☐
	Most of the time	☐
	Not much of the time	☐

QUESTION	ANSWER	TICK APPROPRIATE BOX
11. Do you feel the physiotherapist who treated you was sufficiently experienced?	Yes	☐
	Not sure	☐
	No	☐
12. Do you feel you have benefitted from attending this Department?	Yes, quite a lot	☐
	Yes, some benefit	☐
	No, not much	☐

IF THERE ARE ANY OTHER COMMENTS OR SUGGESTION ABOUT OUR SERVICE YOU WISH TO MAKE, PLEASE DO SO.

THANK YOU VERY MUCH FOR YOUR HELP.

STAFFING

The September 1984 DHSS statistics for staff in post in England reveal that in the highest staffed physiotherapy services there were 92 therapists per 100,000 population whereas in the least resourced there were 5 per 100,000. The national average was 17.1 per 100,000. Within these staffing levels the proportion of staff in each grade also showed marked differences. If the basic physiotherapy grade is expressed as a % proportion of the District establishment then the range is from 4% to 49%. For the senior I the range is from 2% to 66%.

These figures illustrate the wide variation in the staffing structure of physiotherapy services across the country and reinforce the need for District Physiotherapists to look at differences in standards of performance. By identifying strengths/weaknesses and gaps in their services, District Therapists should be able to begin to remedy a number of problems, some of which may not require extra, but better use of, existing resources.

GUIDELINES FOR COMPLETION OF THE STAFF IN-PATIENT CENSUS

The form should be completed each year to provide a census of the staff:beds ratio for each specialty. Subsequent censuses may show discrepancies between staff allocation and altered bed complement which will require appropriate action.

Where a therapist works part-time in a specialty then a decimal system is recommended e.g. if a superintendent IV works ¾ time with medical patients and ¼ time in obstetrics then .75 is recorded under medical and .25 for obstetrics. The range of staff for each specialty should be clearly seen. Where someone works part-time with in-patients and part-time for example in the Geriatric Day Hospital only the in-patient time is recorded on this sheet.

Superintendents should record only direct clinical responsibility.

ANNUAL STAFF TO IN-PATIENT CENSUS

FOR: DISTRICT .....

HOSPITAL .....

UNIT .....

DATE .....

Regional Speciality																											
(tick if appropriate)		Geriatric	Psycho-Geriatric	ITU	Cardiothoracic	Coronary Care (high dependency)	Medical	Mental Handicap	Neurology	Neurosurgery	Obstetrics	Gynaecology	Oncology	Orthopaedics	Paediatrics	Psychiatry	Spinal Unit	Stroke Unit	General Surgery	Vascular Surgery	ENT	Plastic Surgery	Dental	Accident & Emergency	Neonatal Unit/SCBU	Private Patients	OTHER
Number of beds																											
Supt. I																											
II																											
III																											
IV																											
Senior I																											
II																											
Physio-therapist																											
Helper																											

ANNUAL STAFF TO IN-PATIENT CENSUS

FOR: DISTRICT Diamond

HOSPITAL Zircon

UNIT Acute

DATE 1.5.87

Regional Speciality (tick if appropriate)	Geriatric	Psycho-Geriatric	ITU	Cardiothoracic	Coronary Care (high dependency)	Medical	Mental Handicap	Neurology	Neurosurgery	Obstetrics	Gynaecology	Oncology	Orthopaedics	Paediatrics	Psychiatry	Spinal Unit	Stroke Unit	General Surgery	Vascular Surgery	ENT	Plastic Surgery	Dental	Accident & Emergency	Neonatal Unit/SCBU	Private Patients	OTHER
Number of beds	43	-	4	-	9	102	-	-	-	92	23	28	32	42	-	-	-	77	10	38	14	7	15	18	40	-
Supt. I	1																		1							
II																										
III			.5		.5																					
IV																										
Senior I	.25					.5				.5			1	.5										.35		
II	1									.25	.25	.25						.25			.75	.25	.25		.25	
Physio-therapist						.3							.66					.1	.33							
Helper	1																									

SENIOR THERAPIST PROFILE

This profile can be used by both District and Senior Physiotherapists. The District Physiotherapist can use the profile to record the basic requirements which she/he has assessed as being necessary for Clinical Senior I posts within the District.

The senior therapist can use the form in two ways:

1. to consider whether present experience and education fit the service needs already identified by the District Physiotherapist.

2. to assist in planning future career development.

The working group after prolonged consultation have set a foundation standard for the first 5 years of clinical practice in section A. and B. using a points system. This is intended to provide a simple means of quantifying experience. It will be up to each manager to decide which foundation rotations are important for a particular clinical post. It is recognised that many clinicians qualified before the present grading structure was introduced and possibly before rotational experience was common practice. For those therapists and others who qualified overseas, it should not be too difficult to equate previous experience.

Although aware of the widespread criticism that the grading structure does not recognise clinical expertise, and in the absence of any alternative, the current grading structure has been used.

GUIDELINES FOR COMPLETION OF THE FORM

The Clinician can enter individual experience in the Clinicians' column. The Managers' assessment of the service needs can be recorded in the Department column. In the majority of cases these two will coincide.

Radical adjustments in thinking are now taking place as efforts are made to assess and define the needs to be met by the service instead of only responding to demand which has usually been the traditional practice.

SECTION A

One point can equal 36 hours per week for 3 or 4 months.
or 18 hours per week for 6 months.
or 18 hours per week on each of two specialties for 3 or 4 months.
(i.e. 0.5 medical + 0.5 surgical wards).

In Section A, 3 months or more full time in the community will probably be spent in several different areas but will count as only one point.

SECTION B

As experience at Senior II level is at greater depth, one point is given for each sub-division in sections 2 and 3.

SECTION C

Following extensive consultation with representative superintendents and senior clinicians, there is general agreement that a Senior I should have a minimum of 5 years experience before appointment to ensure an adequate basis for clinical commitments.

Some clinicians may have worked in one area and moved to a second specialty. In such cases, a similar depth of experience and contribution is required, therefore, only a further 5 years experience in the specialty merits a further point. Where a wide range of in-depth experience has been gained, it may be possible, in due course, to identify an equivalent 'generalist clinician' similar to the specialty of general practice.

SENIOR PHYSIOTHERAPIST PROFILE
(Complete Appropriate Section)

Clinician's Profile — Department Profile

Name: Base Address: Title of Present Post: Date Appointed to Present Post: Qualification: Date of Qualification:	Specialty: Post : Grade :

A **Basic Clinical Experience**

1 point for each placement of 3 or 4 months duration
A maximum of 6 points during the first 24 months following qualification can be recorded

	Duration in months	Clinician Points	Dept Points
1. Adult out-patients			
2. Community Elderly)One Mental Handicap)Point Mental Health)only Paediatric)			
3. Geriatric in-patients)One Geriatric Day Hospital)Point Psycho-geriatric in-patients)only Psycho-geriatric Day Hospital)			
4. Hydrotherapy			
5. Intensive Therapy Unit/Respiratory Care in-patient			
6. Medical in-patients			
7. Mental Handicap Hospital			
8. Mental Illness Hospital/Wards in DGH			
9. Neurology/Neurosurgery			
10. Obstetrics			
11. Orthopaedic in-patients			
12. Paediatric in-patients Paediatric out-patients			
13. Surgical in-patients			
14. Other - specify:			
15. Other - specify:			
16. Other - specify:			

For continuing rotations up to 5 years from qualification
3 additional points only may be scored and recorded above.

B **Clinical Experience** SENIOR II

(Pre 1974 Qualification - see guidelines)
A minimum of 2 years experience is required prior to appointment

- 1 point for each Senior II rotation of 6 months or more up to a maximum of 6 points

Date Commenced	Date Completed		Points Clinician	Points Department
		1. Adult out-patients		
		2. Community - Elderly - GP Practice - Health Centre - Mental Handicap - Mental Health - Paediatric		
		3. Geriatric in-patients - Geriatric Day Hospital - Psycho-Geriatric in-patient - Psycho-Geriatric Day Hospital		
		4. Hydrotherapy		
		5. Intensive Therapy Unit		
		6. Medical in-patients		
		7. Mental Handicap hosp/in-patients		
		8. Mental Illness hosp/wards in DGH		
		9. Neurology		
		10. Neurosurgery		
		11. Obstetrics antenatal postnatal gynaecology		
		12. Orthopaedic		
		13. Paediatric in-patients out-patients		
		14. Respiratory in-patients cardiothoracic		
		15. Spinal Injuries Unit		
		16. Stroke Unit		
		17. Surgical in-patients		
		18. Other - specify:		

C **Clinical Experience** SENIOR I

A minimum of 5 years experience is required prior to appointment
- 5 years in a specialty gains one point
- each additional 5 years gains one point

Date Commenced	Date Completed		Points Clinician	Points Department
		e.g. Community		
		Elderly/Geriatric Medicine		
		Neurology/Neurosurgery		

SUMMARY	Points
A Basic Experience	
B Senior II Experience	
C Senior I Experience	
	Total

NAME OF MANAGER:

SIGNATURE OF MANAGER:

CLINICIANS SIGNATURE:

DATE OF COMPLETION OF FORM

CLINICAL SPECIALIST PROFILE

The Clinical Specialist Profile records the experience and education which mark the leading clinicians in the profession. Most physiotherapists could readily name the outstanding physiotherapy clinicians and the working group were encouraged to find that their early pilot studies, using the profile, immediately identified, on paper, these expert clinicians.

Many therapists will never reach these standards but the manager and aspiring clinicians will find it helpful to consider the contribution the clinician has made or plans to make and to identify areas of good practice.

The sections of the form cover post qualification education, teaching experience, professional involvement, research and publications. The profile could be used to identify areas which require future personal development in relation to service and therapists' needs.

The Senior Therapist Profile should be completed to record experience up to the Senior I level, before using this form.

GUIDELINES FOR COMPLETION OF THE FORM

SECTION A

This section is a check list which the District Physiotherapist and the clinician will be able to develop further to identify strengths and gaps in the clinicians' experience. Only major areas of work have been listed as a framework in which to record the appropriate courses. The depth and length of courses are so variable that local decisions will need to be made about their value and relevance to the service need. However, only courses equivalent to at least one academic week should be included.

SECTION C

The role of the clinician e.g. as tutor or organiser needs to be recorded, as does the level of experience of the course participants. Teaching requirements of Senior I and Senior II Physiotherapists are very different from those needed for less qualified staff or carers.

CLINICAL SPECIALIST PROFILE
(Complete Appropriate Section)

Clinician's Profile

Department Profile

Name: Base Address: Title of Present Post: Date Appointed to Present Post: Qualification: Date of Qualification:	Specialty Post Grade

Only courses of the equivalent of one academic week's duration or more to be included:

A **Post Qualification Educational Record**

Date Commenced	Date Completed	Course	Clinician	Department
		Community		
		Elderly/Geriatric Medicine		
		Industry		
		Health Education		
		Manipulation/Soft Tissue Mobilisation		
		Mental Handicap		
		Mental Illness		
		Neurology		
		Obstetrics		
		Orthopaedics		
		Paediatrics		
		Respiratory Care		
		Sports Medicine		
		Other (specify)		

B **Further Education** **Dates:**

First Degree

Higher Degrees

Other Educational Achievements

C **Teaching Experience**

Course Teaching Experience			Clinician's Function	Discipline of Course Participants
Date Commenced	Date Completed	Name of Course		

LECTURES	TOPIC	VENUE
District		
Regional		
National		
International		

D **Professional Involvement**

CSP SPECIFIC INTEREST GROUPS

1. Name: Member ☐ Committee Member ☐ Officer ☐

2. Name: Member ☐ Committee Member ☐ Officer ☐

3. Name: Member ☐ Committee Member ☐ Officer ☐

MEMBER OF OTHER SPECIFIC INTEREST GROUPS

Specify Name: Member ☐ Committee Member ☐ Officer ☐

E **Research**

Current Research

Past Research

F **Publications** (Give details eg. Title Publisher)

Book on Professional Subject

Chapter on Professional Subject

Research Papers

Articles

SUMMARY

To assist future personal development in relation to service and therapists' needs.

A	Post Qualification Education
B	Further Education
C	Course Teaching Experience
D	Professional Involvement
E	Research
F	Publication

Sections A-F (✓) if satisfactory

NAME OF MANAGER:

SIGNATURE OF MANAGER:

SIGNATURE OF CLINICIAN:

DATE FORM COMPLETED:

CHECK LIST FOR INDUCTION OF NEW STAFF

This checklist, which is not exhaustive, is intended to assist managers and their staff in the induction of members new to the service. A programme should be compiled to include these items, and any others considered necessary, to be implemented during the first few days of employment.

Does the induction programme for new staff include information on the following:

		YES	NO
1	Emergency Procedures - including:		
	Major Accident	☐	☐
	Fire Alarm	☐	☐
	Cardiac Arrest	☐	☐
	'Mayday' for department pool	☐	☐
2	Departmental Procedures	☐	☐
3	Health and Safety Procedures	☐	☐
4	Terms and Conditions of Service - including:		
	Annual Leave	☐	☐
	Study Leave	☐	☐
	Pay Arrangements	☐	☐
	Sick Leave	☐	☐
	On-Call Arrangements	☐	☐
	Uniform Requirements	☐	☐
	Telephone Rental Arrangements	☐	☐
5	Educational Facilities		
	In-Service Educational Programme	☐	☐
	Library Facilities	☐	☐
6	Records		
	Patient Record and Assessment Forms	☐	☐
	Organisation and Filing of Records	☐	☐
	Statistical Data	☐	☐

		YES	NO
7	Departmental Information		
	List of Staff Members	☐	☐
	Bleep Numbers	☐	☐
	Relevant Telephone Numbers	☐	☐
	Plan of Hospital	☐	☐
	Information about Wards	☐	☐
	Local Abbreviations	☐	☐
	Equipment Storage	☐	☐
8	Induction to the Relevant Work Areas		
	eg Hydrotherapy Pool	☐	☐
	Accident and Emergency Department	☐	☐
	Intensive Therapy Unit	☐	☐
	Other	☐	☐

STUDENTS

Complete this section if physiotherapy students gain experience in the District.

	YES	NO
Are annual meetings held with the Principal(s)?	☐	☐
Is the District Physiotherapist involved in the design of the curriculum?	☐	☐
Are meetings held between the teaching staff and the clinical specialists?	☐	☐
Do all relevant clinicians attend a course on clinical supervision?	☐	☐
Do the staff to student ratios comply with the C.S.P. guidelines?	☐	☐
Are objectives set for each student placement?	☐	☐

PATIENT RECORD AUDIT

Physiotherapists have always been interested in the outcome of their treatment but have lacked the means to examine it. Accurate records are essential if any form of assessment is to be attempted. Records can be used for surveys and peer review audit which are useful ways of reviewing the outcome of therapy.

GUIDELINES FOR UNDERTAKING A PATIENT RECORD AUDIT

All the items on the Patient Record Audit Form should be recorded on each patient record. In case some of the terms used are unfamiliar:

Subjective data - records what the patient tells the therapist.

Objective data - records any measurements obtained during examination.

Timed Goals are short term objectives set within a brief time scale.

eg for a patient with a torn lateral ligament of the ankle, such a goal might be that 'the patient will be able to run 100 yards painfree within two weeks after 10 daily treatments'.

The records should be audited every 6 months in the following way:

1 'X' records of patients treated during the previous 6 months are extracted from the files. The audit can be carried out across the entire department or in individual sections or specialities.

2 One PATIENT RECORD AUDIT FORM is completed for each patient record.

3 The number of 'NOs' are recorded. These constitute the failures of the therapists to enter the required data.

4 A plan of action to encourage staff to enter the missing information is drawn up.

5 A repeat audit should be carried out 6 months later.

('X' = 10% of the patients treated in the department, or section of the department each day for one week eg:

Total number of patients treated	on Monday	67
	on Tuesday	70
	on Wednesday	68
	on Thursday	72
	on Friday	73
	Total	350

Therefore 10% = 35 records to be audited.

PATIENT RECORD AUDIT

Please tick appropriate box

Is the following information on the record:	YES	NO	N/A
(a) Basic details about the patient:			
Record Number	☐	☐	
Name	☐	☐	
Title	☐	☐	
Address	☐	☐	
Date of Birth	☐	☐	
Telephone number - Home	☐	☐	☐
- Office	☐	☐	☐
Transport Details	☐	☐	☐
Occupation	☐	☐	☐
Hobbies	☐	☐	
Medical Diagnosis	☐	☐	
Relevant Medical History	☐	☐	
Relevant Social History	☐	☐	
Status (I/P, O/P, P/P, Overseas Visitor)	☐	☐	
b) Examination and Treatment:			
Subjective data	☐	☐	
Objective Data	☐	☐	
Problem List	☐	☐	
Short Term Goals	☐	☐	
Timed Goals	☐	☐	
Long Term Goals	☐	☐	
Progress Notes including Treatment	☐	☐	
Response to Treatment	☐	☐	

PATIENT RECORD AUDIT

	YES	NO	N/A
Discharge Summary Related to:			
- Problem List	☐	☐	
- Short Term Goals	☐	☐	
- Long Term Goals	☐	☐	
(c) Medical and Surgical Equipment:			
Dates Ordered	☐	☐	☐
Dates Delivered	☐	☐	☐
(d) Administrative Details Related to Therapy:			
Source of Referral	☐	☐	
Date of Referral	☐	☐	
Review Arrangements - Medical	☐	☐	
- Physiotherapy	☐	☐	☐
Record of Involvement with other Disciplines	☐	☐	☐
Copies of Correspondence	☐	☐	
All Entries Dated	☐	☐	
Name of Therapist on Record	☐	☐	
Signature of Therapist on Record	☐	☐	
Signature for each Treatment	☐	☐	

THERAPY

This document covers a number of areas but the manager will wish to complement this foundation package. Continuing work is required to develop strategies to measure the effectiveness of clinical practice. This will involve defining our clinical practice, our core skills common to all physiotherapists and those specific to each specialty.

The following publications may be useful in endeavours to look at the outcome of therapy.

STACEY M. (1977) Methods of social research Pergamon Press, Oxford.

PARTRIDGE C. J. (1980) The effectiveness of physiotherapy: A Classification for evaluation, Physiotherapy, 66, 153-155.

HERSON M. and BARLOW D. H. (1981) Single case experimental Designs. Strategies for studying behaviour change. Pergamon Press, Oxford.

OPPENHEIM A. N. (1976) Questionnaire design and attitude assessment. Heinemann Educational Books, London.

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POLICIES AND PROCEDURES

GUIDELINES FOR COMPLETION OF THE FORM

Every department has some information on policies and procedures but in a busy organisation it is easy to let these become out of date and even to omit some. This form should be completed annually. The annual review will also provide an opportunity to check whether the procedures still reflect current policy or whether amendments are required.

Sections 1 - 3 are self-explanatory.

Section 4 - Staff

A record should be kept for each person including non-physiotherapy staff eg helpers, porters, clerks. These records need to be filed securely. Job descriptions should have been drawn up for all staff including non-physiotherapists. It is recommended that there is a uniform format for job descriptions throughout the District. Each job description must be agreed with the post holder.

Section 5 - Educational Facilities

a) A positive response will indicate that there is a planned, regular, monitored system of post-registration education for all staff. The occasional lecture on an ad hoc basis is not sufficient.

b) Other educational sessions cover for example, teaching/lectures in the Postgraduate Medical Centre or School of Nursing.

Section 6 - Library Facilities

This section links closely with Section 5 as most of the educational ventures will require access to relevant references.

a) Staff will need access to a wide range of other publications such as the British Medical Journal, Lancet, Health Service Journal as well as International Physiotherapy journals.

Section 7 - Organisation of Work

a) Waiting lists are controversial but if they do exist there should be agreed procedures/guidelines to assess priority.

b) It is recommended that the patient and the physiotherapist arrange each outpatient appointment individually. (Ref: Williams J. Physiotherapy July 1983) Vol.69 235-237

c) Inpatients also need to be consulted about appointment times.

Section 8 - Records

The format for patient records has already been covered. There must be an effective system which enables the identification and retrieval of records of patients with similar problems.

POLICIES AND PROCEDURES FORM

For: DISTRICT _____

UNIT _____

HOSPITAL _____

(Delete as appropriate)

Completed by: _____

Reviewed by: _____

	YES	NO
1 EMERGENCIES		
Are copies of the following procedures available in the department?		
Major Accident Procedure?	☐	☐
Fire Alarm Procedure?	☐	☐
Cardiac Arrest Procedure?	☐	☐
Other Procedure? Specify	☐	☐
2 HEALTH AND SAFETY		
Has the department a written Health & Safety Policy?	☐	☐
Does the department have a Health & Safety Representative?	☐	☐
Has the representative attended a C.S.P. Course?	☐	☐
Are records kept of:		
(a) Departmental Inspections?	☐	☐
(b) Implementation of alterations requested?	☐	☐
(c) Attendance at Fire Lectures?	☐	☐
3 TERMS AND CONDITIONS OF SERVICE		
Are procedures available for staff use on:		
Annual Leave?	☐	☐
Study Leave?	☐	☐
Sick Leave?	☐	☐
Pay Arrangements?	☐	☐
Grievance and disciplinary matters?	☐	☐
Others (specify)?	☐	☐

		YES	NO
4	STAFF		
	Is a record kept of each member of staff?	☐	☐
	Are the records securely filed?	☐	☐
	Is a job description available for each post?	☐	☐
	Is an induction programme organised for new staff?	☐	☐
	Is there a record of skills taught to helpers?	☐	☐
	Is this record reviewed annually?	☐	☐
5	EDUCATIONAL FACILITIES		
	(a) Is there a planned educational programme within the department?	☐	☐
	(b) Do sessions occur weekly?	☐	☐
	(c) Do staff join other educational sessions in the hospital?	☐	☐
6	LIBRARY FACILITIES		
	(a) Do staff have access to the medical library?	☐	☐
	(b) Does the department have its own library?	☐	☐
	(c) Is there a library of research articles?	☐	☐
	(d) Is it cross referenced?	☐	☐
	(e) Does the department subscribe to Journals other than 'Physiotherapy' the C.S.P. Journal?	☐	☐
	Specify (1)		
	Specify (2)		
	Specify (3)		
7	ORGANISATION OF WORK		
	(a) If there is an O/P waiting list	☐	☐
	(b) Are agreed procedures/guidelines followed as to urgency/priority before placing patients on it?	☐	☐
	(c) Is there a day to day system for booking appointments? (transport patients excepted)	☐	☐
	(d) Are I/Ps consulted about appointment times?	☐	☐
	(e) Is there a procedure for dealing with patient's complaints?	☐	☐
8	RECORDS		
	Is there a system for the retrieval of physiotherapy records?	☐	☐
	Is the International Classification of Disease used?	☐	☐
	Other system?	☐	☐
	Specify		

ENVIRONMENT

1 A well designed and maintained environment is conducive to high standards of work but of course does not guarantee it.

2 The space requirements have to be linked with the daily through-put of patients and the number of staff available. The beginning of this questionnaire provides space for recording this data.

3 The environmental factors covered in the questionnaire range over a number of key areas but are by no means an exhaustive list. Although facilities exist they may be inadequate for the number of people using them.

4 The majority of questions apply to main DGH departments but the form can be used for other departments. It is also intended to be used as a check list to ensure that adequate facilities are provided on all sites.

5 The DHSS design guidance available from HMSO, can be used in conjunction with this section. The following are particularly recommended:

HBN (Health Building Note) 37
(Hospital Accommodation for Elderly People)

HBN 35
(Hospital Accommodation for people with mental illness)

DBS (Design Briefing System) 23
(Hospital Accommodation for Children)

HBN 40
(Common Activity Spaces) Volume 1.

The DHSS design guidance specific to physiotherapy departments is under review.

ENVIRONMENT FORM

1

For: DISTRICT _____

UNIT _____

HOSPITAL _____

(Delete as appropriate)

Completed by _____ DATE _____

Reviewed by _____ DATE _____

Comments:

	DGH Site 1				DGH Site 2				Paediatric				Geriatric				Mental Illness				Mental Handicap				Other...			
In patients - Bed numbers																												
Out patient - average daily numbers																												
STAFF Qualified w.t.e.																												
Helpers w.t.e.																												
Secretaries w.t.e.																												
Receptionist w.t.e.																												
Porters w.t.e.																												
STUDENTS - average daily numbers																												
		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a
ACCESS Is main department: a) within 5 minutes walk of main hospital																												
b) within 5 minutes walk of wards																												
c) is the department sign-posted from entrance and en-route																												
d) is parking available within 5 minutes walk:																												
i) for disabled people																												
ii) for ambulances																												

n/a = not applicable

ACCESS	DGH Site 1				DGH Site 2				Paediatric				Geriatric				Mental Illness				Mental Handicap				Other....			
		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a
Is the Department on ground level (i.e. the same level as Main Entrance)?																												
If not, then are the lifts: i) sufficient for ambulant patients?																												
ii) large enough for wheelchairs?																												
iii) large enough for patients on trolleys?																												
Is there direct street access?																												
Is there an outdoor area suitable for patient treatment?																												
HYDROTHERAPY																												
Has the DGH department a hydro-therapy section?																												
Is the pool for adults minimum 12' x 12' x 3'6"?																												
Is there a patient shower?																												
Is it suitable for disabled use?																												
Is there a staff changing area?																												
Is there a written agreed chlorination monitoring procedure?																												

n/a = not applicable

DEPARTMENTAL RELATIONSHIPS	DGH Site 1				DGH Site 2				Paediatric				Geriatric				Mental Illness				Mental Handicap				Other....			
Is the physiotherapy department adjacent to:		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a
a) Occupational therapy																												
b) Speech therapy																												
WAITING AND RECEPTION																												
1 Are there designated areas for waiting patients?																												
2 Is there a reception area?																												
3 Are waiting, treatment and reception areas adjacent to each other?																												
4 Is there an inter-com system?																												
5 Are there seats of varying heights and depths for waiting patients?																												
6 i) Is office equipment available for storage?																												
ii) Is is secure?																												
7 Is there a designated storage space for wheelchairs?																												
8 Is there a lavatory for disabled people?																												
DEPARTMENT																												
1 Are there changing rooms for patients?																												
2 Are there showers for patients?																												

n/a = not applicable

	DGH Site 1				DGH Site 2				Paediatric				Geriatric				Mental Illness				Mental Handicap				Other....			
DEPARTMENT (contd)		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a		yes	no	n/a
3 Are there individual treatment cubicles?																												
4 Is there an individual treatment room?																												
5 Is there an activity area?																												
6 Is there a designated area for record keeping?																												
7 Is there a designated storage space for equipment not in current use?																												
8 Has the DGH department a separate area for children?																												
STAFF AREAS																												
1 Are there lavatories for staff?																												
2 Are there changing rooms?																												
3 Is there a staff common room?																												
4 Is there a staff study room?																												
5 Is there storage space for cleaning equipment?																												
6 Is there a Superintendent's office?																												
7 Is there a Secretary's office?																												

n/a = not applicable

EQUIPMENT

Equipment is a valuable resource. Surprisingly the results of a survey carried out in 20 departments showed that all had most of the latest equipment.

This survey is to check that all equipment is in good repair and able to be used safely. It will also highlight any areas of under or over use. This knowledge will assist the physiotherapy manager when considering replacement or redeployment policies for equipment.

GUIDELINES FOR USING EQUIPMENT FORMS

An annual inventory has to be completed as part of the Körner requirements and this form can be used for that purpose. The patterns of usage can be determined in the following way:

1 Attach a form to each piece of equipment so that the physiotherapists can record when it is used each day for a week.

2 The superintendent collates the information at the end of the week and decides whether any further action is required.

Serial No. = Manufacturers number or identifying mark/number in department.

Frequently = Used 4 days or more per week.

Infrequently = Less than 4 days per week.

Where more than one item of any piece of equipment is available additional forms may need to be used.

USE OF EQUIPMENT FORM

For: DISTRICT _____

UNIT _____

HOSPITAL _____

(Delete as appropriate)

Completed by _____ DATE _____

Reviewed by _____ DATE _____

ANNUAL SURVEY

This survey should be done in conjunction with the department inventory.

		YES	NO
1	Is more than one piece of equipment out of service?		
2	Is the electrotherapy equipment serviced?		
3	Is the electrotherapy equipment serviced 6 monthly?		
4	Is the electrotherapy equipment tested daily by the therapist?		
5	Is the mechanical equipment serviced?		
6	Is the mechanical equipment serviced 6 monthly?		
7	Have all the staff received training in the equipment they use?		
8	Are the appropriate modalities available with 15 minutes of need?		
9	Is there a Resuscitation Trolley in the Department?		
10	Is the Resuscitation Equipment checked daily?		
11	Is there access to transit wheelchairs?		
12	Are wheelchairs available for loan to patients?		
13	Are splint making facilities available?		

ANNUAL SURVEY

USE OF EQUIPMENT - **(ELECTRICAL EQUIPMENT)**

Item	Serial No	Date of Purchase	Date of Service 1st	2nd
Infra-Red				
Wax				
Ice				
Moist Heat				
S.W. Diathermy				
Pulsed Diathermy				
Heat Pads				
Laser				
Theraktin				
U.V.L.				
Kromayer				
Ultrasound				
Interferential				
Acupuncture				
Biofeedback				
Faradism				
Electro Pressure				
TNS				
Other				

ANNUAL SURVEY

USE OF EQUIPMENT - (ELECTRICAL EQUIPMENT)
(Frequency of Use)

Item	Frequently	Infrequently	Not at All
Infra-Red			
Wax			
Ice			
Moist Heat			
S.W. Diathermy			
Pulsed Diathermy			
Heat Pads			
Laser			
Theraktin			
U.V.L.			
Kromayer			
Ultrasound			
Interferential			
Acupuncture			
Biofeedback			
Faradism			
Electro Pressure			
TNS			
Other			

ANNUAL SURVEY

USE OF EQUIPMENT - (MECHANICAL EQUIPMENT)

Item	Serial No	Date of Purchase	Date of Service 1st	2nd
Adjustable height couch				
Bobath Plinth				
Tilt Table				
Standing Frame				
Flexi Stand				
Wheeled Stool				
Westminster Pulleys				
Rowing Machine				
Bicycle				
Multigym				
Power Jogger				
Mechanical Traction				
Parallel Bars				
Stairs with variable treads				
Balance Boards				
Wall Bars				
Gymnastic Balls				
Treadmill				
Other				

ANNUAL SURVEY

USE OF EQUIPMENT - **(MECHANICAL EQUIPMENT)**
(Frequency of Use)

Item	Frequently	Infrequently	Not at All
Adjustable height couch			
Bobath Plinth			
Tilt Table			
Standing Frame			
Flexi Stand			
Wheeled Stool			
Westminster Pulleys			
Rowing Machine			
Bicycle			
Multigym			
Power Jogger			
Mechanical Traction			
Parallel Bars			
Stairs with variable treads			
Balance Boards			
Wall Bars			
Gymnastic Balls			
Treadmill			
Other			

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