2

STANDARDS OF PRACTICE

Declaration of Principles

MALTA ASSOCIATION OF PHYSIOTHERAPISTS

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Standards of Practice

Malta Association of Physiotherapists
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Endorsed by the members of the Malta Association of Physiotherapists

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Members of

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Foreword

The Core Standards of Physiotherapy Practice bring together the Profession's expectation of all practicing members in one document, with the focus being on taking a patient centered 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 Malta Association of Physiotherapists (MAP) has put together the standards to ensure that the criteria chosen and the guidance given is in keeping with current good practice. This has been done after a number of consultations with a group of physiotherapists with different clinical interests.

These guidelines will provide members with 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 of Practice are MAPs statement of performance and conditions that they expect physiotherapists to aspire to in order to provide high quality physiotherapy professional services to society. They provide the foundation for the assessment of physiotherapy practice. They represent the physiotherapy profession's commitment to society to promote optimal health and function in individuals by pursuing excellence in practice. These standards provide the basis for physiotherapy practice in all settings, including but not limited to, clinics, hospitals, schools, and commercial premises.

The Core Standards are applicable to all members of MAP including student physiotherapists and qualified physiotherapists and also will aim to set the guidelines at national level. Not all the standards will apply to all 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 and state-registered 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 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 parameters of Maltese Law. Secondly, registered members must work within the

framework of the regulatory body the Council of Professions Complimentary to Medicine and adhere to its Code of Ethics and Professional Conduct.

The requirements of the CPCM and the MAP are in harmony. By adhering to the Code of Ethics 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 MAP, in terms of the obligation of employee to employer, the employer's standards take precedence over the MAP 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 MAP about the standard of care given by a member, both the employer's standards and the MAP standards will be considered in addressing the patient's complaint.

Detail is provided on standards covering: administration and practice management, communication, community responsibility, cultural competence, documentation, education, ethical behaviour, informed consent, legal, patient/client management, personal/professional development, quality assurance, research and support personnel.

These standards are considered to be achievable Standards of Practice. They are presented as ideal standards to which all physiotherapists should aspire as part of their professional responsibility. At the same time, it is recognised that some interpretation will be required based on the setting, resources and support systems available.

The Standards of Practice document is a tool that may be used by physiotherapists, patients/clients, members of the public, managers, and others who have an interest in providing or receiving high quality physiotherapy services.

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President

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Standard 1 Respect for the patient

The physiotherapist should:

1. Respond to the individual's lifestyles, cultural beliefs and practices and base their response on factual information not assumptions;
2. Be courteous and considerate;
3. Address the patient by the name of their choice;
4. Inform the patient of the name of the physiotherapist responsible for their episode of care and the title by which they are addressed;
5. Make the patient aware of the role of any other member of the physiotherapy team, allied health professional, or social services staff involved in their care;
6. Preserve the patient's privacy and respect their dignity;
7. Allow/provide chaperoning when this is appropriate or needed.

Physiotherapists should respect and respond to the individual patient's needs and should consider the patient's social, occupational, recreational and economic commitments, culture, race, nationality, gender, sexual orientation, religion, politics, disability and age, beliefs, values, abilities, mental well being, and the impact any of these may have on the patient's perception of health and illness, and the impact of their own beliefs and values on their practice. One should also be aware of the cultural differences in naming systems.

Patients should be informed of the qualifications of the person treating them, and the role of that person within the service, and 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 procedures require a private setting. Where this is impossible or impractical, care should be taken to avoid discussions being overheard. Intimate examinations require greater guaranteed privacy and patient should be asked if they would like another person for support. When chaperoning is applied this will vary according to employer policy, type of examination being performed, age of the patient and when requested by the patient themselves.

Standard 2 Consent

The patient should:

1. Give a valid consent before starting any examination/ treatment/ procedure;
2. Be made aware of the treatment options including significant benefits, risks and side effects;
3. Be granted adequate time to assimilate given information, given the option of deferring treatment if in doubt as to the risks and benefits of treatment and given the opportunity to ask questions;
4. Be informed about the right to decline physiotherapy at any stage without it prejudicing their future care and in such a case, this is documented in the patient's record, together with the reasons if these are known;
5. Be informed that they may be treated by a student or assistant, and given the right to decline this option and be treated by a registered physiotherapist;
6. Be informed and written consent obtained for participation in physiotherapy research and teaching;
7. Be informed that the treatment may be observed by student and given the right to decline;
8. Give consent to the treatment plan and this should be documented in the patient's record;
9. Written consent forms should be used for any invasive or high risk physiotherapy intervention;
10. Retain a copy of any physiotherapy forms used, and another copy should be attached to the patient's notes;
11. Be given information sheets or other written information, where possible, to assist the consent process and a copy of the information sheet should be returned in the patients notes.

The physiotherapist should obtain and document in the clinical notes, when consent is received, implied, or expressed, for processes that they themselves are able to perform prior to touching the patient in any part of the patient managing process. Consent should be obtained prior to the assessment and after formulation of the treatment plan. This should be reaffirmed when changes to the treatment plan are applied or when risks/benefits are affected. Consent may be written or oral. Obtaining consent is an ongoing process throughout the episode of care.

It is advisable that written consent should be gained for certain interventions such as manipulations of cervical spine, exercise tolerance testing in cardiac patients and acupuncture.

Adequate information may need to be provided in an appropriate language and format about the evidence of effectiveness and the risk of any harm of the treatment to be performed.

In multidisciplinary settings, 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 made aware that they cannot decline treatment based on the cultural, racial, sexual orientation, religion, disability or age of the physiotherapist.

There might be occasions however when the patient may decline treatment from a physiotherapist because the gender difference places them in an awkward or uneasy situation.

Standard 3 Privacy/Data Protection

The physiotherapist should:

1. Ensure privacy when discussing personal details;
2. Obtain written consent from the patient before using identifiable clinical information for teaching purposes;
3. Discuss with the patient prior to allowing other healthcare workers access to the patient's physiotherapy records when it is of benefit to the patient;
4. Release physiotherapy information to sources other then those immediately involved in the patient's care *only* when there is a signed patient consent form to allow this process;
5. Make sure that patient identifiable information is transmitted securely;
6. Ensure the confidentiality of patient identifiable data held or transmitted in electronic formats;
7. Inform the patient where confidentiality cannot be guaranteed, and given the option to decline giving this information;
8. Ensure the confidentiality of patient identifiable data seen by physiotherapists but intended for other professional staff.

Confidentiality of information should be ensured during contact with patients, carers or other health professionals both during face-to-face AND telephone conversations. When information is transmitted through electronic media, the sender should take steps to satisfy themselves that the information will be received by the intended recipient or authorised deputy. When information is held, or transmitted, electronically steps should be taken to ensure the security, protection and audit trial of computers, networks and users to ensure that only authorized persons have access to patient identifiable data. When posting documents, information should be marked 'personal for addressee' or 'confidential' and fully addressed to the recipient.

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

It is advisable that the required timescale for the retention of documents is for 10 years.

Particular attention should be given when information is sought from an employer wishing to obtain details about an employee. Written consent from the patient must be obtained prior to releasing any information. Patient should be made aware of the extent of the information requested and what is to be selectively released. If the

physiotherapist is unsure of the necessity of full disclosure of patient's physiotherapy, they have the duty to contact the patient to ensure that the patient understands the extent of the information required and gives consent for disclosure. At all times, the physiotherapist retains responsibility for the physiotherapy records and has the duty to protect such records.

When 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.

Standards 4 - 11 Assessment and Treatment Cycle

Standard 4 The Physiotherapist bases his treatment options on the best available evidence, so as to provide the most effective delivery of care.

The Physiotherapist should take into account information about the most effective treatment options appropriate to each patient's condition. Such information could be compiled from the patient, carers/family, reflective practice, research, national clinical guidelines/ local protocols, special interest groups /specialist association, information derived from the use of outcome measures and expert opinion.

Standard 5 The Physiotherapist gathers information relevant to the patient's presenting problems.

There should be recording of data collected from the patient/carer. This would include the perception of the patient's needs, expectations of Physiotherapy, demographic details, presenting problems/condition, past medical history, current medication and treatment, allergies/precautions, social family history/lifestyle and relevant investigations.

The Physiotherapist should carry out and record a physical examination to obtain measurable data with which to analyse the patient's Physiotherapeutic needs. The extent of the examination would depend on the Physiotherapist's clinical specialty and/or the patient's condition at the time of the examination. The data would include observation, use of specific assessment tools / techniques and palpation / handling.

The findings of the clinical assessment are explained to the patient / carer.

The reason for any missing information, whether the data is not available or whether the investigation has not been carried out, should be documented.

Standard 6 The Physiotherapist should use published, standardised, validated outcome measures to assess changes in the patient's health status.

6.1 The Physiotherapist selects an outcome measure most relevant to the patient's condition/problem.

6.2 The Physiotherapist ensures that the outcome measure to be used is acceptable to the patient/carer after this is explained to her.

6.3 The Physiotherapist uses an outcome measure he is competent in using/administering and in interpreting.

6.4 The Physiotherapist bears in mind the patient's welfare during the administration of the measure.

6.5 The Physiotherapist follows manufacturer's/designer's instruction manual/s or service guidelines when administering a particular measure and evaluating its affect on the patient.

6.6 The result of the measure is recorded.

6.7 The same measure is used throughout the patient's treatment programme and at its termination, should this still be applicable to the patient's condition.

Standard 7 The Physiotherapist should analyse information compiled during the assessment so as to formulate a treatment plan.

7.1 In the treatment plan there should be evidence of a clinical reasoning process.

7.2 Needs/problems formulated from the data compiled should be recorded.

7.3 Relevant clinical investigations/results that assist the diagnosis and management plan should be documented and evaluated.

7.4 A diagnosis of relevant signs and symptoms should be recorded.

7.5 Subjective and Objective goals should be identified.

7.6 Should the Physiotherapist decide that Physiotherapy is not indicated, this must be recorded together with the reasoning process leading to this decision.

7.7 The Physiotherapist should record and convey the decision of non-intervention to the referrer should there be one.

Standard 8 The Physiotherapist forms a treatment/management plan together with the patient/carer; on the best evidence available.

8.1 The Physiotherapist ensures that the patient/carer is fully involved in deciding the treatment/management plan.

8.2 The Physiotherapist should show that he has considered the patient's and/or the carer's needs within the presenting context.

8.3 The treatment/management plan should allow for the *skill mix* that the service provides and make the best possible use of resources available.

8.4 The Physiotherapist should record the treatment/management plan's intervention details including time scales for implementing and/or reviewing the plan, goals, outcome measures, and identification of multi-professional members collaborating within the plan, relevant risk assessment and delegation of activities to carers, assistants/technical instructors.

8.5 If guidelines or local protocols of case management are used, the date, version and source should be 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.

Standard 9 The treatment plan is delivered in a way that benefits the patient

9.1 All interventions are implemented according to the treatment plan.

9.2 When there is delegation to assistants, technical instructors or students, ultimate responsibility lies with the person who has delegated the work. The person delegating the work has a duty to ensure that the task is suitable to be delegated and the person accepting the delegated task has a duty to ensure they are competent to perform the task.

9.3 All advice, instructions given to patients is recorded, signed and dated.

9.4 This includes written and verbal instructions. Any handouts should be copied and kept with the patients records or an accurate reference, date and version is recorded. The physiotherapist must satisfy him/herself that the patient has fully understood instructions/information given. Any areas of lack of understanding should be recorded.

9.5 Any equipment loaned to a patient should be duly registered including a date and signature and a copy issued to the patient.

9.6 Any deviations from the treatment plan (and reasons why) should be recorded.

9.7 This is particularly important when the patient is transferred to another health professional be it another physiotherapist or any other health professional. It must be clear why any changes have been made either through written explanation or through clinical reasoning.

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.

10.1 There should be written evidence that at each treatment session there is a review of the treatment plan, subjective markers or goal list, objective markers or goal list and relevant investigation results.

These may be investigations already taken or other investigations that the physiotherapist has recently reviewed e.g. radiology reports.

10.2 All changes both subjective and objective should be documented.

10.3 Any changes to the treatment plan are documented.

10.4 Outcome is measured at the end of each treatment session to assess impact.

10.5 Any information derived from impact of treatment is shared with patient and documented.

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

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

Standard 11 On completion of the treatment plan arrangements are made for the transfer of care/ discharge.

11.1 The physiotherapist should discharge / discontinue the patient when:

- The anticipated goals or expected outcomes for the patient have been reached;
- The patient is unable to continue to progress toward goals or when the physiotherapist determines that the patient no longer benefits from physiotherapy;
- The physiotherapist recognises that the patient has a right to discontinue treatment at any time.

11.2 A discharge summary is sent to the referrer.

11.3 A discharge summary is given to the patients who self refer to physiotherapy.

11.4 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, whether any other health professionals should receive a discharge letter.

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 would breach confidentiality must only occur within specifically defined situations e.g. child protection.

Standard 12 Communication with patients and/or their carers/relatives

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

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.

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

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

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

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 when the patient does not want a copy; when the clinician feels it may cause harm to the patient; when the letter includes information about a third party who has not given consent and whenever special confidentiality safeguards may be needed.

Supporting Legislation

- Data protection Act (2001)
- Constitution of Malta (1964)

Cross-references

- Council for Professions Complementary to Medicine -Code of Ethics

Standard 13 Physiotherapists communicate effectively with other health professionals and relevant outside agencies to provide an effective and efficient service to the patient.

13.1 Physiotherapists follow locally agreed systems for referral.

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

13.3 Physiotherapists agree common goals with the patient, multi-disciplinary team, carers and family.

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

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

13.6 Physiotherapists inform others of their own specific role.

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

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 The 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 (2001)
- Equal Opportunities Act (2000)

Standard 14 To facilitate patient management and satisfy legal requirements, every patient who receives physiotherapy must have a record.

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

Local mechanisms may need to be in place to meet the needs of managers and staff in achieving this requirement.

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

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.

14.3 Patient records are written at the time recorded in the records.

14.4 Patient records conform to the following requirements:

- Concise
- Legible
- Logical sequence
- Dated
- Accurate
- Provide adequate detail of the intervention given
- 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.
- Name is printed after each entry/attendance
- No correction fluid is used
- Written with permanent ink that will remain legible with photocopying
- Any errors are crossed with a single line and initialized
- Each side of each page of the record is numbered
- Patient's name and either date of birth or identity card number are recorded on each page of the record
- Acronyms are used only within the context of a locally agreed abbreviations glossary

14.5 Records are appropriately countersigned.

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 physiotherapist in charge. 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 physiotherapist should countersign where an event occurs which changes the overall patient management plan.

14.6 Use of dictaphones

If dictaphones are used to store information, the transcription of such records 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.

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 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.

Standard 15 Patient records are retained in accordance with existing policies and current legislation.

15.1 Patient records are kept securely in lockable cupboards/rooms.

This relates to the individual's responsibility in relation to confidentiality. 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.

15.2 Physiotherapists comply with local health informatics security policies.

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.

15.3 Physiotherapists adhere to the local policy when asked by the patient to view his/her patient record.

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 physiotherapist is employed or the organisation (including private practices) to whom a self-employed 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 Unaccessed patient records are destroyed in a secure manner after a lapse of ten years.

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

Supporting legislation

- Data Protection Act (2001)
- Constitution of Malta (1964)
- Health Care Professions Act (2003)

Cross-references

- Council for Professions Complementary to Medicine – Code of Ethics

The working environments should be safe for the patient, the carers and the service providers. Particularly, the physiotherapist should treat patients in an environment that is clean and safe; and be equipped appropriately for the interventions being provided and ensure patient, carer and self-safety.

16.1 With regard to Occupational Health and Safety

The physiotherapist conforms with the Health and Safety Act (2000), with special regard to equipment maintenance and replacement, hazard identification, adverse reactions, incident reporting and management and fire safety.

16.2 With regard to Clinical Areas

The physiotherapist should ensure that the clinic that they are working in conforms to the Standards (of clinics), and that they are working in an environment that is licensed by the authorities to carry out the work of physiotherapy.

16.3 With regard to risk assessment

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

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

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

16.4 With regard to summoning assistance

16.4.1 Physiotherapists should be familiar with all emergency telephone numbers and alarm systems. At a work place these should be clearly listed and accessible to all staff.

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

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

This will range from systems for summoning colleagues, carers or hospital emergency teams, to dialing 112 in community or private practice settings.

16.5 With regard to infection control

16.5.1 Standard infection control procedures should be followed in all circumstances and will range from hand washing, correct disposal of sharps, clinical waste, and sterilisation.

16.5.2 In the event that there is a suspicion of infectious contact, appropriate measures should be undertaken to report this event to competent authorities.

16.6 With regard to adverse events

16.6.1 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.

16.6.2 A warning sign is displayed asking those patients who are pregnant, have a pacemaker or artificial implants of any nature, have infectious diseases, are on any long-term medication, or have any ongoing illness or health problems, to advise the physiotherapist accordingly.

Standard 17 Physiotherapists take measures to ensure that the risks of working alone are minimised

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 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.

Standard 18 Equipment is safe, fit for purpose and ensures patient, carer and physiotherapist safety.

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

This includes for example routine checks such as wear and tear on electrodes and ferrules, correct suction pressure, wheelchair tyre pressures and electrical equipment. 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. All Physiotherapy Electrical equipment must be checked regularly (as stipulated by the suppliers) and there is written evidence of ongoing audit.

18.2 Equipment is used according to manufacturer's instructions.

For example, weight-bearing equipment such as a wheelchair is used within loading limits.

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

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.

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.

The physiotherapist shall ensure that instruction guidelines and manuals of usage issued by the manufacturers are read prior to use and that set-up instructions are adhered to. In the event that the physiotherapist is not competent in setting up the equipment for usage a competent person should be requested to commission the equipment for use.

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

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 involving treatments/interventions that affect their practice.

Certain procedures or techniques have a record of previously causing, or potentially causing, patient harm e.g. LASER, SWD. Adequate notices should be displayed informing the patients that the procedure is practicable in the area. Notices should also be displayed for those patients who may be in a particularly volatile circumstance, e.g. pregnancy, pacemakers or have metal implants, for them to inform the physiotherapist on the nature of their concerns.

Supporting Legislation

CSP, Core Standards of Physiotherapy Practice 2005
16th WCPT General Meeting 2007 *draft on Standards of Physiotherapy practice*
Occupational Health and Safety Authority Act 2000 Cap 424

Continuing professional development (CPD) is the educational process undertaken throughout an individual's career by which physiotherapists maintain and develop their skills, knowledge and competency in order to develop and enhance performance at work and patient care. This will normally take place in conjunction with a peer or manager.

CPD applies to all members, not just those directly involved in patient care. It 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. Members engaged in research, educational or management tasks all undertake activity which will ultimately affect the patient experience, with the overall aim of improving the quality of patient care.

Standard 19 The physiotherapist assesses his/her learning needs

The assessment takes account of:

a. Development needs related to the enhancement of an individual's scope of practice;

b. Feedback from performance data;
Data might include routinely collected statistics, results of audit or an analysis of outcome measures,

c. Mandatory requirements;
Such as fire, cardiopulmonary resuscitation and manual handling training,

d. New innovations in practice;

e. The reasonable needs of the organisation;
The term *organisation* refers to a whole range of services, from a single handed practice to a large hospital or rehabilitation centre,

f. Career aspirations.

Standard 20 The physiotherapist plans their Continuing Professional Development

20.1 There is a written plan based on the assessment of learning needs.

20.2 The plan includes learning objectives.

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

20.3 The plan includes a range of activities that will lead to the achievement of learning objectives and that may include any of these activities:

a. Reflective practice
b. Independent study
c. Reading relevant professional journals
d. Attending educational meetings
e. Secondment and shadowing
f. In-service education programmes
g. Further education
h. Clinical audit
i. Implementing clinical guidelines
j. Peer review
k. Mentorship
l. Contact with other physiotherapy groups, professions or patient organisations
m. Research
n. Sharing knowledge and skills with others
o. Clinical supervision
p. Membership of a special interest group.

Standard 21 CPD plan is implemented

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

21.2 The plan is subject to appropriate review and could be linked to the individual's appraisal cycle.

This will normally take place with a peer or a manager.

22.1 There is evidence that the learning objectives have been achieved.

If the learning objectives have not been met, the underlying reasons for this need to be discussed and understood to inform the next assessment of the individual's learning needs.

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