CHARTERED SOCIETY OF PHYSIOTHERAPY

Quality Assurance Standards

for physiotherapy service delivery

Contents

Foreword

As the Chair of Council, I am pleased to introduce the Society's new Quality Assurance (QA) Standards for physiotherapy service delivery. These replace the original Core and Service Standards developed in 2000 and updated in 2005. The QA Standards provide an integrated and person-centred approach to practice and service delivery which reflects the complexity of service delivery and physiotherapy practice. They are intended to support members in meeting their legal, ethical and regulatory requirements.

These QA Standards have been developed in response to Member feedback that the CSP Standards continue to be relevant to member's working lives and integral to delivering and assuring the high quality of physiotherapy services. The project to develop them involved extensive consultation with CSP members throughout the UK working in a range of organisations and roles and was overseen by a steering group representing members.

The QA Standards provide statements of expected levels for service delivery which members, through consultation, agree are set at a level which is reasonable and achievable by a CSP member, or physiotherapy service in the UK. They apply regardless of an individual's role, grade or experience and apply to individual members, physiotherapy teams delivering services and those, including managers or employers whose background may not be physiotherapy, with a responsibility for overseeing service delivery. The QA standards are a tool for members to use collectively or as individuals as part of a quality assurance process. They will also be useful for service users and those purchasing services. The QA standards resource includes a QA tool which enables the comparison of actual services with these standards.

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Introduction

Purpose of the Quality Assurance Standards

These Quality Assurance (QA) Standards have been developed by the Chartered Society of Physiotherapy (CSP) for its members; qualified members, associates and students.

The QA Standards together with the Quality Assurance (QA) Audit Tool have been developed to:

- promote and assure quality in clinical practice and service delivery
- support CSP members in assuring and demonstrating the standard of physiotherapy care and services
- support CSP members in delivering safe and effective physiotherapy services
- provide a marker for CSP members and those who purchase or use physiotherapy services on which to assess the standard of a local physiotherapy service or care
- support CSP members in meeting the expectations of the Society as articulated in the *Code of Professional Values and Behaviour* [1]
- Support qualified Members in meeting the requirements of the Health and Care Professions Council as set out in the *Standards of Proficiency – Physiotherapists* [2] and *Standards of Conduct, Performance and Ethics.* [3]

Development of the Quality Assurance Standards

Physiotherapy is a healthcare profession that works with people to identify and maximise their ability to move and function. Functional movement is a key part of what it means to be healthy. This means that physiotherapy plays a key role in enabling people to improve their health, wellbeing and quality of life.[4]

The CSP has the responsibility for leading the physiotherapy profession in the UK. It provides a range of resources for its members and others interested in the practise of physiotherapy. It is anticipated that a wide range of individuals and organisations will use these resources to inform their knowledge of physiotherapy and the physiotherapy profession.

These QA Standards build on and replace the former CSP Core Standards[5] and Service Standards[6] produced in 2000 and the Core Standards of Physiotherapy Practice updated in 2005.[7] The QA Standards have been developed in consultation with CSP members working in a range of organisations and roles and in response to member feedback that the CSP Standards have remained a tool which is used and valued by them. The key changes, seen in this document, has been to develop a single resource which integrates and builds on the Core and Service Standards, applies to all CSP members and places greater emphasis on their role in promoting and assuring quality clinical practice and service delivery. In response to feedback a range of formats are available to enable members to access the QA Standards in the depth required at any given time.

Interpretation of the Quality Assurance Standards

The QA Standards are set at a level which, members through consultation agree, is reasonable and achievable by a CSP member or physiotherapy service in the UK. The QA Standards apply to individual members, physiotherapy teams delivering services and those, including managers or employers whose background may not be physiotherapy, with a responsibility for overseeing physiotherapy service delivery. The QA Standards have been developed to reflect the complexity of service delivery and physiotherapy practice. As such, although accessing a section of the resource may be relevant at times, each section should be considered as part of a whole.

The QA Standards apply regardless of an individual's role, grade or experience. Their interpretation will vary for different member groups or levels of practice and not all of the standards will be applicable in all situations or at all times of an individual's career. CSP members should critically reflect on their role and individual scope and the context of their practice and the service within which it is delivered to determine when standards do not apply.

The QA Standards are organised into 10 sections. Within each section are a number of standards. These QA standards provide clear statements on expected features of physiotherapy service delivery provided by members of the physiotherapy profession. Each of the standards has a number of measurable criteria relating to them which present the components of how a standard may be met. These are provided for quality assurance purposes. These criteria are not exhaustive and it is likely that there may be other ways in which to demonstrate that a standard has been met and these should be agreed locally.

A quality assurance audit tool (QA tool) has been developed to facilitate the comparison of actual service delivery with the criteria in the QA standards. There are links throughout the standards to this tool.

Terminology

The term 'organisation' has been used throughout the QA Standards to refer to the context within which the physiotherapy service is delivered, e.g. a single handed independent practitioner delivering a service, or a service within a large organisation.

The term service user has been used to include all those in receipt of physiotherapy including patients, clients, carers and others.

The term 'intervention' has been used to include all aspects of service delivery, clinical care and physiotherapy management.

Responsibility for implementation

CSP members are responsible for the implementation and audit of these QA Standards. There is no intention to monitor the implementation of them as they are a tool for members to use either collectively or as individuals as part of a quality assurance process. Individuals and services are advised to identify locally where responsibility for ensuring the actual implementation of a specific standard and criteria lies.

It is likely that the QA Standards will be used at a local level for reference and support in organisational governance systems and used nationally for reference, in cases heard by the Health and Care Professions Council (HCPC). Where appropriate, in a fitness to practice case the regulator looks for evidence of what is a reasonable standard of practice and what the average professional would do. The QA Standards, along with other documents produced by the CSP, in particular the Code[1], the Physiotherapy Framework[4] and the Learning & Development Principles[8], may also be used to form part of this professional framework.

Participation in audit should be part of a member's continuing professional development (CPD) and use of the QA tool supports CSP members' activity in this way. The link to the ePortfolio[9] provides the individual member with a tool for recording participation in the quality assurance process. The ePortfolio profile tool allows members to add evidence to demonstrate how they fulfil the criteria in each standard and therefore becomes a log of development of practice and service delivery.

Quality Assurance audit tool[10]

The QA audit tool has been developed to facilitate the comparison of physiotherapy service delivery with that presented in the QA standards. The QA, through the QA audit tool, enable the audit of the standards in either their entirety or in sections if required. The QA audit tool uses the criteria beneath the standard to identify whether the actual standard has been met. The majority of the criteria are measurable and information can be gathered from records or policies, or may be observed or assessed. However, there are some criteria which may require reflection by the physiotherapist or physiotherapy team member through, for example, peer review or

gathering service users' experiences to demonstrate that the criteria have been met.

The QA audit tool comprises three elements which enable the triangulation of information;

- a data collection tool to gather information from the service user or physiotherapy records and organisational policies
- a structure for gathering service user's experiences
- a tool for peer review

Use of the QA Standards as a framework for quality assurance will provide one method through which actions can be identified for service improvement and will support members in complying with the legal, moral and ethical obligations placed on them when practising physiotherapy in the UK. Use of the QA audit tool will provide evidence that physiotherapy service delivery is of a standard quality; and will provide useful information as part of a cyclical quality assurance process. This information may be shared, both within the service as part of the quality improvement cycle and with those outside the service to assure the quality of a service being delivered. Where the process identifies variations from the standard, the physiotherapist or physiotherapy team member is responsible for communicating this information to the responsible person(s).

At times the organisational policy may conflict with the QA Standards and prevent a standard being met. In analysing the results of the QA process these discrepancies should be identified action taken to explore this further. In this situation the individual member and the organisation are advised to consider legal responsibilities, organisational responsibilities HCPC requirements, and responsibilities to service users.

The annex on related resources includes a range of resources to support the understanding and implementation of these QA standards.

1 Autonomy and accountability

Quality Assurance Standards

1.1 Members work within the scope of practice of the profession and their individual scope of practice
1.2 Members demonstrate the behaviours, skills and knowledge to fulfil the responsibilities of their role
1.3 Members fulfil their duty of care to service users
1.4 Members demonstrate professionalism at all times

Introduction

Maintaining autonomy and accountability to the service user, the patient, the profession and the public requires each CSP member to be aware of the many environmental factors underpinning these: such as the need to practice within the legal obligations of the country and the organisation in which they work.

As an autonomous profession, physiotherapists can accept referrals for assessment from a range of sources: from an individual themselves (self-referral) or from other people involved with that individual. Professional autonomy means that a member makes decisions and acts independently within a professional context and is responsible and accountable for these decisions and actions. A key element of professional autonomy is understanding and working within the limits of personal competence and scope of practice.

Neither physiotherapy students nor support workers hold professional autonomy. Both groups of members undertake physiotherapy-related activity with appropriate forms of supervision. Physiotherapy students are prepared through their qualifying education to assume the responsibilities of professional autonomy on qualification. While not autonomous practitioners, physiotherapy support workers take responsibility for undertaking the tasks delegated to them in delivering a physiotherapy service.

As the professional body for physiotherapy, the CSP defines scope of practice for physiotherapy in the UK. Scope of practice relates strongly to competence and professionalism. The concept recognises the profession's scope of practice is evolving, and needs to evolve, in line with changing patient and population needs, developments in the evidence base, changes in service design and delivery and changing opportunities for professional and career development. Individual members have a responsibility to be aware of how their practice may challenge the boundaries of the scope of practice of UK physiotherapy and to take appropriate action. Individual members also have a responsibility to limit their activity to those areas in which they have established and maintained their competence.

Professionalism defines what is expected of a professional, and what it means to be a professional. Broadly, it can be summarised as; a motivation to deliver a service to others, adherence to a moral and ethical code of practice, striving for excellence, maintaining an awareness of limitations and scope of practice and a commitment to empowering others (rather than seeking to protect professional knowledge and skills).

1.1 Members work within the scope of practice of the profession and their individual scope of practice

Criteria

1.1.1 Members demonstrate an understanding of their personal scope of practice and the scope of the profession
1.1.2 Members practise within their individual scope of practice
1.1.3 Members identify their learning needs and put in place learning opportunities which consider the needs

of the service and service users

1.1.4 Members are insured for the activities that they undertake

1.2 Members demonstrate the behaviours, skills and knowledge to fulfil the responsibilities of their role

Criteria

1.2.1 Members reflect on their role and evaluate their learning needs

1.2.2 Members identify areas of learning required to develop and maintain competence in their role

1.2.3 There is a policy which includes:

a. checking physiotherapists are registered with the HCPC on initial employment and annually

b. checking physiotherapy team members have undergone relevant disclosures

c. assessing the suitability of new physiotherapy team members using the relevant person specification and job description

d. holding personnel files which include a CV where applicable, references, records of appraisal, and evidence of engagement in CPD

e. an appraisal system to evaluate learning needs

1.2.4 A signature, job title and work area is recorded in the signature book for all physiotherapy team members and retained in line with record keeping legislation

1.3 Members fulfil their duty of care to service users

Criteria

1.3.1 Members demonstrate an understanding of their duty of care responsibility, including how this relates to organisational, regulatory and professional standards

1.3.2 Members take responsibility for fulfilling their duty of care to the service users

1.3.3 Members take responsibility for identifying where factors, including implementation of organisational decisions and structures, have the effect of compromising their duty of care to individual service users

1.3.4 There is a policy in place to ensure that CSP members are supported in identifying and addressing factors that may compromise their fulfilment of their duty of care to service users

1.4 Members demonstrate professionalism at all times

Criteria

1.4.1 Members demonstrate practice that is ethical and in accordance with relevant organisational, legal and regulatory requirements

1.4.2 Members behave in such a way that their manner, attitudes and actions instil confidence in the profession

1.4.2 There is a policy in place which includes:

a. an appearance policy

b. duty to report

c. the use of social media

d. physiotherapy team members working excessive hours

e. physiotherapy team members working in roles outside of physiotherapy

2 Delivering a safe and effective service

Quality Assurance Standards

2.1 There is a planned orientation and induction programme for members working in new roles
2.2 Physiotherapy staffing and skill mix is sufficient to support the services being provided
2.3 Physiotherapy services are delivered in a safe environment
2.4 There is a systematic, proactive and responsive approach to risk management that follows the organisation's overall strategy
2.5 All medical devices are safe and fit for purpose, ensuring service user, carer and physiotherapy team safety
2.6 The risks of lone working are minimised

Introduction

Delivering a safe and effective service requires a range of activities to assure the safety of service users and those who work within it and the effectiveness of the service delivered. A comprehensive range of policies and procedures are required to underpin this service delivery. The requirements and emphasis on specific aspects of this will vary according to the organisation, service delivered, service users and the context of care. The CSP provides a broad range of resources to support members in these areas.

2.1 There is a planned orientation and induction programme for members working in new roles.

Criteria

2.1.1 There is an accessible and planned orientation and induction programme for all members working in new environments, e.g. returners, new starters and members going to new sites etc
2.1.2 Members attend the induction programme and identify where components of it are omitted
2.1.3 Members provide feedback on the induction programme to ensure its continued relevance
2.1.4 There is a policy in place for the induction programme which includes:
- *a.* content and structure of the programme
- *b.* a named person responsible for planning and for implementation
- *c.* a named person responsible for evaluation and review to ensure the programme continues to fulfil its intended purpose
- *d.* completion of the programme within locally agreed time-scales
- *e.* issue of the programme to each new member of the physiotherapy team

2.1.5 Mandatory training is completed within agreed timescales
2.1.6 Members receive training in:
- *a.* fire procedures
- *b.* life support
- *c.* moving and handling
- *d.* dealing with violence and aggression
- *e.* control and prevention of infection
- *f.* confidentiality
- *g.* information governance
- *h.* safeguarding children
- *i.* safeguarding vulnerable adults
- *j.* familiarisation with record keeping systems (eg storage of paper records or electronic access)
- *k.* an approach to record keeping within the team (style/use of acronyms and short forms etc)

2.2 Physiotherapy staffing and skill mix is sufficient to support the services being provided

Criteria

2.2.1 There is a policy which includes;

a. an appropriate recruitment and selection procedure

b. staffing commensurate with delivering a safe and effective service which makes best use of existing resources in terms of:

- grade
- skill mix
- experience
- staff numbers

c. managing:

- situations where staffing levels fall below locally agreed minimum levels
- the regular review of staffing levels
- the regular review of skill mix

d. prioritisation of workload if demand exceeds staffing levels

- flexibility in both service provision and the needs of CSP members
- a system to ensure all physiotherapy team members have skills and experience in the areas in which they are required to work
- arrangements for identifying and addressing learning needs arising from changing service requirements
- arrangements for the delegation of activities within teams
- arrangements for clinical leadership
- arrangements for the clinical leadership of services
- a procedure to recognise and correct poor performance

2.3 Physiotherapy services are delivered in a safe environment

Criteria

2.3.1 The physiotherapy service acts on health and safety guidance

2.3.2 The physiotherapy service (where part of a larger organisation) is considered, and if appropriate included, in the wider organisational plans for emergency incidents which could affect provision of normal services

2.3.3 Physiotherapy services comply with policy on;

a. safeguarding children

b. safeguarding vulnerable adults

c. national child protection guidance

2.3.4 Service users receiving physiotherapy are made aware of how to summon assistance

2.3.5 There are systems in place to identify, report and learn from service user safety incidents and other notifiable incidents, using appropriate local and/or national governance systems and to demonstrate resulting improvements in practice

2.3.6 There is a health and safety policy which includes procedures to manage;

a. fire

b. waste disposal

d. disposal of medical waste

e. resuscitation

f. first aid

g. control and prevention of infection

h. disposal of sharps

i. lone working

j. chaperoning arrangements

k. interpreters
l. working outside normal hours
m. control of substances hazardous to health
n. safe moving and handling of loads
o. reporting of industrial diseases and dangerous occurrences
p. planned maintenance
q. rehabilitation e.g. practising stairs policy
r. the summoning of urgent assistance when required

2.3.7 There are policies in place for the maintenance of:
a. temperature
b. humidity
c. lighting
d. ventilation

2.4 There is a systematic, proactive and responsive approach to risk management that follows the organisation's overall strategy

Criteria

2.4.1 Care is taken to minimise risks to physiotherapy team members and service users
2.4.2 Regular health and safety audits are undertaken in accordance with locally defined time-scales
2.4.3 Notices of hazards to service user are prominently displayed in areas of known risk
2.4.4 There are policies for risk management which include:
a. clearly defined procedures for the management of risks
b. training in undertaking risk assessments which include identification and effective management of risks
c. the indications for a documented risk assessment
d. indications for a risk assessment carried out for every service user, prior to each procedure or treatment
e. indications for a risk assessment carried out for every activity involving a physiotherapy team member
f. the analysis of findings from risk assessments to make recommendations for changed work practices.
g. action taken on the results of a risk assessment, to minimise any hazards identified

2.5 All medical devices are safe and fit for purpose, ensuring service user, carer and physiotherapy team safety

Criteria

2.5.1 There is a process in place for;
a. registration to receive by email patient safety and MRHA (Medicines and Healthcare products Regulatory Agency) alerts
b. cascading information on 'Patient Safety Alert' notices
c. for acting upon Patient Safety Alerts and other communications that relate to the safe provision of physiotherapy
d. ensuring that action is taken on new guidance about medical devices safety and on 'Patient Safety Alert' notices issued on treatments/ interventions that affect practice

2.5.2 There are policies in place which include;
a. the use of medical devices according to manufacturer's instructions
b. regular servicing of medical devices, whereby servicing is undertaken and action taken

when indicated

c. visual and physical safety checks of medical devices prior to use or issue to service users
d. the identification, reporting and recording of action taken regarding faults of medical devices
e. cleaning of medical devices according to manufacturer's instructions and policies for control and prevention of infection
f. removal of faulty medical devices
g. evaluation of new medical devices in the context of a clinical trial to meet the requirements of research governance
h. safe equipment for the care of bariatric service users (to include visible maximum weight of furniture e.g., treatment couches, waiting room chairs, department toilets and upstairs flooring)
i. weighing and recording of the weight of service users where indicated

2.5.3 There are polices in place which ensure;

a. training is provided in issuing and maintaining medical devices
b. a training record is kept
c. a record is kept of medical devices and/ or products loaned to service users
d. a record is kept of medical devices and/ or products purchased by the service user
e. where medical devices and/ or products are loaned or sold to service users instructions on the safe use are provided

Standard 2.6 The risks of lone working are minimised

Criteria

2.6.1 There are policies in place for lone working which include:

a. members working alone
b. communication links between members working alone and their base
c. the use of personal alarms
d. home visiting
e. home visiting where a known risk exists
f. the indications for and use of chaperones.

3 Learning and Development

Quality Assurance Standards

3.1 Members actively engage with and reflect on the continuing professional development (CPD) process to maintain and develop their competence to practise
3.2 Members offer quality CPD opportunities that help others learn and develop
3.3 Members actively engage with supporting students' practice education and the development of their professional socialisation
3.4 There are recognised structures, processes and resources in place that support learning and development in the workplace and enable members to meet the requirements of their role and meet professional and regulatory CPD requirements

Introduction

Learning and development is integral to physiotherapy practice. The CSP expects its members to actively engage with the two faces of learning and development; as learners through the process of continuing professional development (CPD), and as facilitators of others' learning and development.

Active engagement with CPD ensures that CSP members can maintain and develop their competence to practice and continue to work within an evolving scope of practice. CPD is therefore a professional and regulatory requirement. By enabling members to actively engage with CPD opportunities appropriate to their individual learning needs, organisations can ensure that the physiotherapy workforce is able to provide person-centred, ethical and effective services that reflect (and shape) developments in research and practice. It also means that the behaviours, knowledge and skills of the physiotherapy workforce are deployed safely and effectively by ensuring that physiotherapy team members can take responsibility for delegation of tasks. Support for CSP members' CPD therefore enables employers to address governance issues by assuring that the physiotherapy workforce fulfilling professional and regulatory requirements for practice.

The CSP's outcomes-based approach to CPD means that members are expected to demonstrate how their learning through CPD supports the development of practice. This outcomes-based approach also recognises that learning can occur through a wide range of activities (both formal and informal) and in a variety of spaces (e.g. workplace, classroom or online), and encourages the integration of learning and practice.

The behaviours, knowledge and skills required to engage in CPD are the same as those required to help others learn and develop. Both processes are about learning: CPD is about being a learner, while helping others learn and develop is about being a teacher, or facilitator of learning (e.g. by offering mentorship/ preceptorship, practice learning or supervised practice opportunities). The process of helping others learn and develop can offer a valuable CPD opportunity that supports the development of individuals, the service and physiotherapy practice.

3.1 Members actively engage with and reflect on the continuing professional development (CPD) process to maintain and develop their competence to practise

Criteria

3.1.1 Members assess their learning and development needs and preferences
3.1.2 Members develop and engage in a personalised plan to meet their learning and development needs
3.1.3 Members critically evaluate their learning in terms of how it relates to their current/future practice
3.1.4 Members record and evidence the outcomes of the learning process

3.2 Members offer quality CPD opportunities that help others learn and develop

Criteria

3.2.1 Members work with learner(s) to establish learning outcomes for any CPD opportunity provided

3.2.2 Members design and deliver materials/experiences that facilitate an individual's learning and development

3.2.3 Members evaluate the effectiveness of the CPD opportunity provided

3.2.4 Members critically reflect on the learning and development process

3.3 Members actively engage with supporting students' practice education and the development of their professional socialisation

Criteria

3.3.1 Members work collaboratively with colleagues, other health professions and Higher Education Institutions (HEIs) to plan and provide mechanisms, resources and activities to facilitate students' learning as an integral part of service development and delivery

3.3.2 Members actively engage with, and reflect on the CPD opportunities available to them that exist to develop their ability to support students' learning and development

3.3.3 Members strive to provide opportunities for students to learn and develop including by:

a. ensuring that multidisciplinary working promotes understanding of the roles and the value of other professions involved in delivering high quality healthcare

b. working collaboratively with other colleagues to ensure appropriate models of supervision

c. critically evaluating their own learning and development needs and preferences as well as their students, in order to adapt their teaching styles appropriately

d. sharing their own learning appropriately with other colleagues involved in supporting students, and with the students themselves

3.3.4 Members ensure consistency and transparency in the assessment of student learning

3.4 There are recognised structures, processes and resources in place that support learning and development in the workplace and enable individuals to meet the requirements of their role and meet professional and regulatory CPD requirements

Criteria

3.4.1 The development needs of the service are evaluated on an annual basis and used to inform the learning and development needs of physiotherapy team members

3.4.2 There are policies in place to ensure;

a. that CPD policies and processes are inclusive and equitable, and implemented in ways that accommodate all members' learning and development needs

b. Members have protected personal learning time of at least ½ day/month for informal CPD activities in addition to study leave arrangements for formal CPD and mandatory training

c. Members have access to advice, guidance, and a variety of learning and development resources that enable the individual to implement their CPD plan.

4 Working in partnership

Quality Assurance Standards

4.1 Services are designed, planned and delivered with the aim of promoting and improving the health of individuals and the local population and decreasing health inequalities
4.2 Service users are respected as individuals and placed at the centre of service planning and physiotherapy management
4.3 Information is provided to enable service users to participate fully in their care

Introduction

To ensure effective and efficient services, at an individual or service level, physiotherapy care must be delivered in partnership with the service user(s).

Person-centred practice is an approach to health care within which the goals, expectations, preferences, capacity and needs of service users form the focus of all activity. In delivering the service consideration needs to be given to respecting and promoting diversity, that is the process of recognising, respecting and valuing people's differences (e.g. age, disability, gender, race, religion and belief, sexuality) and including this in the decision making process.

Person-centred practice includes acknowledging and understanding that, at times, the view of an individual may conflict with the view of a member, the profession or the organisation within which a service is being delivered. Consideration should also be given to the service user as an individual and the degree of involvement they would like to have in planning their care and services as this will vary according to individuals.

4.1 Services are designed, planned and delivered with the aim of promoting and improving the health of individuals and the local population and decreasing health inequalities

Criteria

4.1.1 Service users and carers are involved in the planning, development and delivery of services
4.1.2 Service development and delivery is informed by local demographic/epidemiological data
4.1.3 Processes are in place to explore the effect of rationing and other measures on the sufficiency and quality of care received by service users
4.1.4 There is a system in place for obtaining feedback from service users about existing services
4.1.5 There is evidence of action taken as a result of service users' feedback and experiences

4.2 Service users are respected as individuals and placed at the centre of service planning and physiotherapy management

Criteria

4.2.1 Service users are involved in service planning and service evaluation through service user experience surveys, focus groups and ongoing service user feedback
4.2.2 Service users are informed of the contact name of the physiotherapist responsible for their episode of care where appropriate
4.2.3 The service user's privacy and dignity is respected
4.2.4 The service user is offered a chaperone where appropriate
4.2.5 Members;
a. demonstrate care and compassion in their interaction with service users.
b. are courteous and considerate
c. address the service user by the name of their choice

d. consider the service user's lifestyle, cultural beliefs and practices
e. respect and respond appropriately to an individual's lifestyle, personal and cultural beliefs and practices

4.3 Information is provided to enable service users to participate fully in their care

Criteria

4.3.1 Appropriate information is available to service users on:

a. the range of services and options of intervention available
b. arrangements for the first contact with the physiotherapist
c. access to services
d. costs of care where appropriate
e. transport and access
f. did not attend / cancellation policies
g. access to medical records
h. access to physiotherapy records
i. hazards related to clinical care
j. discharge planning
k. how to provide feedback on the physiotherapy service
l. how to make a complaint

Consent

Quality Assurance Standards

5.1 Members obtain and document the service user's informed consent before any advice, assessment, examination, intervention, treatment or procedure

5.2 Where written consent is obtained a copy of the consent record is included in the service user's records

5.3 Where a service user lacks capacity to consent for themselves the appropriate process is in place to allow a 'best interests decision' to be made under the relevant Mental Health or In/Capacity Acts[11-15]

Introduction

Consent is the voluntary agreement given by a person to allow something to happen to them and /or to allow their participation in something. It is a fundamental right that every adult with capacity has the absolute right to determine what happens to their own body and this right is protected in law. Physiotherapists should ensure that service users have the capacity to consent, give consent voluntarily without coercion, and have sufficient information on which to make this decision. Consent should be reaffirmed throughout therapeutic interaction where there are significant changes to the service user's treatment plan or condition or the service user reports new information.

Consent may be written or oral and the law does not require written consent for physiotherapy treatment. However, it is recommended that written consent is obtained for any intervention that is invasive e.g. acupuncture or injection therapy.

5.1 Members obtain and document the service user's informed consent before any advice, assessment, examination, intervention, treatment or procedure

Criteria

5.1.1 The service user's consent is obtained and documented before giving advice or beginning an assessment, examination, intervention, treatment or procedure

5.1.2 The consent process includes:

- *a.* consideration of the service user's age, capacity to consent, emotional state and cognitive ability,
- *b.* discussion of treatment options, including significant benefits, risks side effects and alternatives to proposed intervention
- *c.* opportunity for the service user to ask questions
- *d.* establishing the service user's consent or otherwise to sharing information to others directly involved in their care
- *e.* informing the service user of their right to decline physiotherapy at any stage
- *f.* specific recording in the notes when a service user declines physiotherapy, including a note as to the service user's rationale for the decision if known
- *g.* informing the service user that their physiotherapy may be observed or delivered by another healthcare professional/ student
- *h.* giving the service user the opportunity to decline observation of their physiotherapy treatment by another healthcare professional confidentially
- *i.* provision of written information, where possible, to assist in the consent process

5.1.3 Where written information/ leaflets are used this is documented in the notes

5.1.4 Versions of written information/ leaflets are stored in line with legislation for the retention of medical records

5.1.5 There are policies for the consent process which include;

a. induction and training in gaining consent
b. indications of appropriate situations for the delegation of the gaining of consent
c. members undertake the delegated task of gaining service user's consent only when it is appropriate to do so
d. those interventions requiring written consent forms
e. situations where the service user declines treatment by a student or support worker
f. safeguarding children
g. safeguarding vulnerable adults
h. situations where a formal assessment of capacity may need to be made by an appropriate practitioner

5.2 Where written consent is obtained, a copy of the consent record is included in the service user's records

Criteria

5.2.1 A policy is in place detailing those physiotherapy procedures where written consent is to be obtained
5.2.2 Where written consent is gained, a copy is retained in the service user's records and a copy is given to the service user

5.3 Where a service user lacks capacity to consent for themselves the appropriate process is in place to allow a 'best interests decision' to be made under the relevant Mental Health In/Capacity Acts[11-15]

Criteria

5.3.1 There are polices in place for identifying when a service user may lack the capacity to give consent for treatment themselves
5.3.2 Qualified members are aware of the process for invoking the relevant Mental Health or In/Capacity Act[11-15] where a service user lacks the capacity to give consent for themselves
5.3.3 Where consent is gained by the service user's advocate under the relevant Mental Health or In/Capacity legislation, a record is retained in the service user's records
5.3.4 Where a valid Lasting Power of Attorney (LPOA) is in place its directions are followed
5.3.5 Where there is a valid advanced directive its directions are followed

6 Record keeping and information governance

Quality Assurance Standards

6.1 Every service user who receives physiotherapy has an appropriate record
6.2 Records are stored while current and disposed of according to legal requirements
6.3 Data capture systems are designed and maintained to provide effective and secure transfer of patient identifiable information
6.4 There is evidence that regular audits of record keeping are planned, undertaken and action taken asla result

Introduction

CSP members have a professional and legal obligation to keep an accurate record of their interaction with service users in whatever system or format (paper or electronic) the organisation specifies.

A 'health record' is any record which:

- consists of information relating to the physical or mental health condition of an individual, and
- has been made by or on behalf of a health professional in connection with the care of that individual.

A record can be in paper or electronic format, or a mixture of both, and includes all the information relating to the health status and management of the individual service user. There are various types of records in practice: for example, summary/full record; shared record; uni-professional record; and service user record.

The record may contain information about the current episode of care only, or may be a compilation of every episode of care for that individual in a given time-frame. Depending on the needs of the service user, and the care setting(s) involved, the record may be maintained by an individual health care professional or a group of different professionals across the care pathway.

Members involved in recording, accessing, and storing health records must be aware of the legal context within which they work, and comply with regulatory, national, professional body and local employer guidance on record keeping.

CSP members must be aware of, and adhere to the relevant information[1] or governance framework when dealing with service user identifiable information. Audit serves as a learning process rather than merely a compliance tool, and organisations should plan and deliver audit as part of a planned audit cycle through which individuals and teams are helped to learn from mistakes, etc.

6.1 Every service user who receives physiotherapy has an appropriate record

Criteria

6.1.1 Records;

a. are started at the time of the initial contact
b. written immediately after the contact with the service user or before the end of that working day
c. include a reference in each entry to the date and time of treatment or advice
d. include a reference to the date and time that the entry into the record was made
e. are legible, factual, consistent and accurate such that service users and other health professionals can understand the content
f. are attributable to the individual completing them
g. provide evidence of the care planned, the decisions made, the care delivered and the information shared
h. identify problems that have arisen and the action taken to rectify them
i. provide evidence of actions agreed with the service user (including consent to treatment and/or consent to

disclose information)
j. are written, wherever appropriate, with the involvement of the service user
k. use standard coding techniques and protocols for electronic records where appropriate

6.1.2 Records comply with policies which include:
a. a locally agreed short forms glossary
b. disclosure of information
c. service user access to records, including charges for viewing or receiving a copy of a health record

6.2 Records are stored while current and disposed of according to legal requirements

Criteria

6.2.1 There are policies for:
a. the retention of records
b. the secure storage of records while current so that they can be easily retrieved
c. the secure storage of records once they are no longer current
d. the disposal of records in accordance with statutory requirements
e. identification of who has storage and access rights over the record
f. access to records by service users and others .

6.2.2 Records are kept in accordance with relevant legal and regulatory requirements

6.2.3 The local policy is followed when the service user asks for the record.

6.2.4 There is:
a. a signature book to ensure physiotherapy team members can be recognised and traced by their signature, job title and work area or other identifiable information
b. information available to ensure that the service user is aware of their right to access their records
c. a glossary of short forms describing the allowable abbreviations and their meaning
d. a process for destroying service user records in a secure manner after the (lapse of the) required time

6.3 Data capture systems are designed and maintained to provide effective and secure transfer of patient identifiable information

Criteria

6.3.1 There is a policy for IT (Information Technology) and data security which is updated annually.

6.3.2 Systems are configured to meet information governance standards around maintaining the security and confidentiality of service user identifiable data, including encryption of emails and use of mobile/portable device.

6.3.3 Members are made aware of their responsibilities under the Data Protection Act (1998).[16]

6.3.4 Members comply with local health informatics/ IT security policies

6.4 There is evidence that regular audits of record keeping are planned, undertaken and action taken as a result

Criteria

6.4.1 Members are clear of the standards in place for governing their record keeping practice

6.4.2 Audit of record keeping is planned and undertaken annually to monitor compliance with relevant legislation and ensure best practice guidance is being upheld

6.4.3 There is evidence that the results of audit are disseminated and recommendations made for action

6.4.4 There is evidence that action is taken as a result of the outcomes of audit

7 Communication

Quality Assurance Standards

7.1 Mechanisms exist to ensure effective communication within and outside the physiotherapy service
7.2 Members communicate effectively with service users to ensure effective and efficient services
7.3 Members communicate effectively with other health professionals and relevant outside agencies to ensure effective and efficient services
7.4 Members treat all information in the strictest confidence

Introduction

Communication is the interactive process of constructing and sharing information, ideas and meaning through the use of a common system of symbols, signs and behaviours. It includes the sharing of information, advice and ideas with a range of people, using a variety of media (including spoken, non-verbal, written and e-based) and modifying this to meet service user's preferences and needs

Effective communication requires consideration of the context and nature of the information to be communicated and engagement with technology, particularly the effective and efficient use of Information and Communication Technology

Where the service user does not have capacity reference should be made to Section 5 Consent.

7.1 Mechanisms exist to ensure effective communication within and outside the physiotherapy service

Criteria

7.1.1 The organisation has
- *a.* an organisational chart available
- *b.* locally agreed systems for referral
- *c.* locally agreed processes for the provision of information for multidisciplinary assessments, planned transfers and discharges
- *d.* policies which govern the use of electronic communication to ensure it is appropriate, secure and confidential
- *e.* policies for the use of social media professionally, socially and responsibly

7.2 Members communicate effectively with service users to ensure effective and efficient services

Criteria

7.2.1 Members communicate openly and honestly with service users and consider the wishes of those who do not want themselves or other's e.g. a relative to know the diagnosis
7.2.2 Members assess the recipient's understanding of the information given
7.2.3 Members use active listening skills, providing opportunities for the service user to communicate effectively
7.2.4 The service user is aware of the role of any other member of the physiotherapy team, allied health professional, or social services staff involved in their care
7.2.5 All communication, written and oral, is clear, unambiguous and modified, where appropriate, to meet the needs of the service user
7.2.6 Methods of communication are modified to meet the needs of the service user e.g. where there is a language barrier an interpreter is used
7.2.7 Information is available on condition-specific support groups and networks
7.2.8 Where written information is provided to service users;

a. a copy or reference is kept in the service user's record
b. all information provided identifies the author, production date and review date
c. superseded versions of information documents for service users are retained for the same length of time as health records

7.3 Members communicate effectively with other health professionals and relevant outside agencies to ensure effective and efficient services

Criteria

7.3.1 There are organisational policies in place for the;
a. referral and transfer of care
b. use of electronic communication to ensure appropriate information is conveyed and that such communications are secure and confidential
c. delegation of treatment to outside agencies
d. use of multi-professional record keeping and service user-held records

7.3.2 Members;
a. are aware of lines of communication within and outside the organisation
b. inform others of their own specific role
c. are involved in regular team meetings/ briefings
d. are represented at organisation-wide meetings where these exist
e. are involved in senior management policymaking and the business planning process
f. are aware of the roles of members of the multidisciplinary team
g. provide information for multidisciplinary assessments, planned transfers and discharges
h. ensure that the information supplied to other professionals is directly relevant to their role with the service user
i. communicate with other health professionals and agencies involved in the service user's care
j. communicate relevant information clearly and promptly
k. agree common goals with the service user, multidisciplinary team and wider carers and family
l. when delegating a task, ensure that the line of responsibility is understood and clear
m. ensure that where a task has been delegated, the outcome is clearly communicated

7.4 Members treat all information in the strictest confidence

Criteria

7.4.1 Members ensure that;
a. there is privacy when discussing personal details e.g. communication of a sensitive nature
b. service user identifiable information is transmitted securely
c. service user's information is only released to sources, other than those immediately involved in the plan for intervention, with permission or when there is a signed consent form to allow this process
d. the written consent of service users is obtained before using identifiable clinical information (photographs, videos etc) for purposes other than the treatment of the patient
e. where confidentiality cannot be guaranteed, the service user is informed of this fact and given the option to decline giving information
f. when it is of benefit to the service user and in discussion with the service user, other healthcare workers may be given access to the physiotherapy record
g. consent is sought from the service user before discussing confidential details with carers, friends or relatives

7.4.2 There are policies in place, which are followed to;
a. ensure the confidentiality of service user identifiable data held, or transmitted, in electronic formats
b. ensure the confidentiality of service user identifiable data seen by members but intended for other professional team members

8 Physiotherapy management and treatment

Quality Assurance Standards

8.1 There is fair and equitable access to physiotherapy services according to need
8.2 There is a system to ensure that physiotherapy care is based on the best available evidence of effectiveness
8.3 Appropriate information relating to the service user and the presenting problem is collected
8.4 Analysis is undertaken following information gathering and assessment in order to formulate a treatment plan, based on the best available evidence
8.5 Appropriate treatment options are identified based on the best available evidence, in order to deliver effective care
8.6 The plan for intervention is constantly evaluated to ensure that it is effective and relevant to the service user's changing circumstances and health status
8.7 On completion of the treatment plan, arrangements are made for discharge or transfer of care

Introduction

Delivering effective clinical care is a process undertaken in partnership with the service user to ensure the treatment plan is individualised to meet the individual's goals. This includes the systematic collection of information from a wide variety of sources relevant to the decision making situation; the processing and analysis of the information collected; an analysis of the intervention and reflection of the effectiveness of it; discussion with the service user to identify the most acceptable management plan and critical evaluation of the plan and its outcomes during implementation.

Where treatment or assessment highlights that a service user may lack capacity, the relevant policies should be followed.

8.1 There is fair and equitable access to physiotherapy services according to need

Criteria

8.1.1 There is evidence within the organisation of

a. stakeholder engagement specifically to support the planning and design of services
b. access routes to physiotherapy services being promoted to all referrers and appropriate service user groups or within appropriate service user environments
c. transparent and ethical protocols governing waiting list management and the prioritisation of service users
d. service features which support service user's choice; these may include for example appointment times or place of treatment
e. a clearly communicated procedure for managing referrals which have not been seen within a locally agreed time-scale
f. protocols that ensure effective and appropriate discharge arrangements

8.2 There is a system to ensure that physiotherapy care is based on the best available evidence of effectiveness

Criteria

8.2.1 Members;

a. actively engage with the evidence base through critical appraisal of available evidence
b. have access to;
- library and library search facilities
- internet facilities

8.2.2 There are systems in place;
- *a.* for disseminating information about effective practice
- *b.* for providing links with external agencies to identify good practice
- *c.* to demonstrate implementation of evidence-based clinical guidelines and the use of research evidence
- *d.* that support the integration of research activity within day-to-day practice
- *e.* that enable and encourage members to develop evidence and to share their research findings through appropriate channels

8.3 Appropriate information relating to the service user and the presenting problem is collected

Criteria

8.3.1 Where appropriate, standardised datasets are in use that facilitate benchmarking of data and respond to national good practice initiatives and requirements

8.3.2 There is evidence that information is collected to inform the physiotherapeutic process which, where appropriate, includes:
- *a.* the service user's demographic details
- *b.* presenting condition/problems
- *c.* history of the presenting condition including management of the problem to date
- *d.* the service user's perception of their needs
- *e.* the service user's expectations of intervention
- *f.* past medical history
- *g.* current medication/treatment
- *h.* contra-indications/precautions/allergies/red flags
- *i.* social and family history/lifestyle
- *j.* documentation and evaluation of relevant clinical investigations/results to assist the diagnosis and management process

8.3.3 There is written evidence of a physical examination carried out including measurable data which includes:
- *a.* observation
- *b.* use of specific assessment tools/techniques
- *c.* handling/palpation

8.3.4 Where the required information is missing or unavailable, the reasons are documented

8.3.5 Appropriate outcome measures are identified and implemented at assessment including, where possible and appropriate;
- *a.* one recommended condition/disease specific patient (service user) reported outcome measures (PROM)
- *b.* *one disease specific performance measure (clinical outcome measure)*
- *c.* one patient (service user) reported experience measure (PREM)

8.4 Analysis is undertaken following information gathering and assessment in order to formulate a treatment plan, based on the best available evidence

Criteria

8.4.1 There is consideration and critical evaluation of information about effective interventions relating to the presenting condition
8.4.2 There is evidence of a clinical reasoning process with identified needs/problems, formulated from the information gathered
8.4.3 A working hypothesis/diagnosis is formed, with relevant signs and symptoms recorded
8.4.4 The clinical impression is documented and discussed with the service user
8.4.5 Subjective markers are agreed with the service user
8.4.6 Objective markers are agreed with the service user
8.4.7 Analysis is undertaken following information gathering and assessment in order to formulate a plan for intervention, based on the best available evidence
8.4.8 Where there is no intervention indicated, this information is relayed to the referrer, where there is one
8.4.9 Information relating to options for intervention is identified, based on the best available evidence, in order to deliver effective care
8.4.10 The findings of the clinical assessment are explained to the service user.

8.5 Appropriate treatment options are identified, based on the best available evidence, in order to deliver effective care.

Criteria

8.5.1 Clinical reasoning is recorded that explains why a specific approach has been implemented.
8.5.2 The service user is enabled to make an informed choice about their care, based on the best available evidence on effective and appropriate interventions
8.5.3 Goals are agreed with the service user, multidisciplinary team including outside agencies and wider carers and family
8.5.4 Where clinical guidelines or local protocols are used this is recorded in the records
8.5.5 A treatment plan is included in the physiotherapy record
8.5.6 All interventions are implemented according to the treatment plan
8.5.7 Members contribute to the development of evidence by gathering information throughout the treatment of service users
8.5.8 All advice/information given to the service user is recorded, signed and dated.
8.5.9 A record is made of medical devices loaned and issued to the service user
8.5.10 When it is in the best interest of the service user a referral is made to another professional and the reasons discussed with the service user

8.6 The plan for intervention is constantly evaluated to ensure that it is effective and relevant to the service user's changing circumstances and health status

Criteria

8.6.1 At each treatment session there is a review of:
- *a.* the treatment plan
- *b.* subjective markers
- *c.* objective markers
- *d.* results of relevant investigations.

8.6.2 All relevant changes, subjective and objective, are documented.
8.6.3 Any changes to the intended plan are recorded in the record with the reasons given
8.6.4 Any changes to the treatment plan are documented

8.6.5 Outcome is measured as appropriate to each indicator to assess the effect of intervention
8.6.6 Information derived from the use of outcome measures is shared with the service user
8.6.7 Adverse and unexpected effects occurring during treatment are reported and evaluated using the relevant mechanisms

8.7 On completion of the treatment plan, arrangements are made for discharge or transfer of care

Criteria

8.7.1 The service user is involved with the arrangements for their transfer of care/discharge and offered copies of transfer or discharge summaries
8.7.2 Arrangements for the transfer of care/discharge are recorded in the record
8.7.3 When the care of a service user is transferred, information is relayed to those involved in their on-going care in the most appropriate manner and format
8.7.4 A discharge summary is sent to the referrer upon completion of the episode of care in keeping with agreed local policies
8.7.5 Where service user's information is transferred this meets the requirements of consent, confidentiality and disclosure

9 Evaluation of clinical care and services

Quality Assurance Standards

9.1 Effective quality improvement processes are in place, which are integrated into existing organisation-wide quality programmes
9.2 There is a clinical audit programme to ensure continuous improvement of clinical quality with clear arrangements for ensuring that clinical audit monitors the implementation of clinical effectiveness
9.3 There is a clear and responsive procedure for making and dealing with complaints
9.4 The effect of the physiotherapeutic intervention and the treatment plan is evaluated to ensure that it is effective and relevant to the goals

Introduction

The process of developing and (re)designing services and improving the effectiveness, efficiency and quality of current services requires a critical evaluation of physiotherapy service delivery. This involves a cyclical process of information gathering, analysis and action.

Quality improvement processes are necessary to maintain the effectiveness, efficiency and quality of a service provided, to recognise situations where elements of the service are compromised and facilitate action to ensure improvement and learning takes place.

9.1 Effective quality improvement processes are in place, which are integrated into existing organisation-wide quality programmes.

Criteria

9.1.1 Members identify and contribute to progressing service improvements
9.1.2 There is a strategy for the implementation of clinical governance, which is linked to the organisation's overall strategy
9.1.3 There are locally agreed standards of practice for common conditions developed by multi-professional groups in order to implement national guidance
9.1.4 The physiotherapy service produces an annual clinical governance report that contributes to the organisation's overall clinical governance report
9.1.5 Members are supported to identify and contribute to service improvement processes as an integral part of the process of service improvement

9.2 There is a clinical audit programme to ensure continuous improvement of clinical quality, with clear arrangements for ensuring that clinical audit monitors \ the implementation of clinical effectiveness

Criteria

9.2.1 Members participate in a regular and systematic programme of clinical audit
9.2.2 Members participate in multi-professional clinical audit, where it is undertaken
9.2.3 The clinical audit programme takes account of service user, organisational, service and national priorities,
9.2.4 The documented results and recommendations from clinical audit are made available through the clinical governance process
9.2.5 Changes in practice are implemented as part of the clinical audit cycle, in order to rectify any deficiencies identified

9.3 There is a clear and responsive procedure for making and dealing with complaints

Criteria

9.3.1 All members understand their role within the complaints procedure.

9.3.2 There are policies in place which ensure;

a. service users have access to information about the service's complaints procedure

b. complaints are managed within a locally defined time-scale

c. complaints are monitored in order to identify trends and to inform the process of service improvement and risk management

d. complaints inform the process of service improvement

9.4 The effect of the physiotherapeutic intervention and the treatment plan is evaluated to ensure that it is effective and relevant to the goals

Criteria

9.4.1 There is a policy;

a. to support members in engaging with service improvement initiatives

b. for the use of service user experience surveys

c. for the use of measures to evaluate clinical effectiveness

9.4.2 An appropriate measure is used to evaluate the effect of physiotherapeutic intervention(s);

a. the measure chosen is published, standardised, valid, reliable and responsive

b. the measure used is the most relevant to the service user's problems to evaluate the change in the service user's health status

c. the measure is acceptable to the service user

d. the metric is used in an appropriate way for that specific measure (possibly at the start and end of treatment and at appropriate intervals including follow up)

e. members ensure they have the necessary skill and experience to use, administer and interpret the measure

f. members take account of the service user's welfare during the administration of the measure

g. the result of the measurement is recorded

h. information derived from the evaluation and the use of the outcome measure is shared with the service user and documented

i. written instructions in the manufacturer's manual, test designer's manual or service guidelines are followed during the administration and scoring of the measure if applicable

10 Promoting, marketing and advertising physiotherapy services and products

Quality Assurance Standards

10.1 Information provided on services accurately reflects those offered
10.2 Information provided on products accurately reflects those offered
10.3 Products sold or supplied to service users are necessary in delivering effective care
10.4 The endorsement of a product or service is based on sound clinical reasoning, evidence, and consideration of cost and quality

Introduction

CSP members are increasingly involved in promoting services or products to those who will use or purchase them. In doing so at all times the professionalism of the CSP member and the needs of the service user is central to this relationship. At times the CSP member may feel compromised and further guidance may be sought from the CSP as a professional body and the HCPC as a regulator.

10.1 Information provided on services accurately reflects those offered

Criteria

10.1.1 Information accurately reflects the service(s) offered and supports the decision making process
10.1.2 The promotion of services is based on evidence
10.1.3 The use of benchmarking and comparative statements is based on fact

10.2 Information provided on products accurately reflects those offered

Criteria

10.1.2 Information accurately reflects the products offered and supports the decision making process
10.1.2 The promotion of products is based on evidence
10.1.3 The use of benchmarking and comparative statements is based on fact

10.3 Products sold or supplied to service users are necessary in delivering effective care

Criteria

10.3.1 Medical devices and products sold or supplied are appropriate to the presenting condition to support the achievement of expected treatment outcomes
10.3.2. The costs, to the service user (or service), of supplying medical devices are considered
10.3.3 Where possible, service users are offered information on sourcing products and a choice in the goods recommended and the retail outlet for these goods

10.4 The endorsement of a product or service, by a member, is based on sound clinical reasoning, evidence, and consideration of cost and quality

Criteria

10.4.1 When exploring the endorsement of a product, members consider:

a. the appropriateness of the product or service in respect of presenting conditions
b. member's own experience of the effectiveness of the product or service
c. the evidence presented by the manufacturer with regard to the stated purpose and benefits of the medical device
d. a reasonable assessment of the quality and cost of the service or product

Glossary

Accountability taking responsibility for, and accepting the consequences of, a personal decision or action

Advocacy acting on behalf, and in the best interests, of an individual or group of individuals with the intention of having a positive influence on a decision or action affecting that individual or group

Associate member a support worker who has joined the CSP as a member

Autonomy the ability to make decisions and act independently

Client a person in receipt of a service; where the term uses 'individual' or 'client', this should be interpreted to include any other responsible person such as a carer, parent or guardian, as appropriate to circumstances; in the case of animal physiotherapy, the term may be interpreted to mean an animal and its owner/carer

Code of Professional Values and Behaviour or **'The Code'** The Code sets out the CSP's expectations of all members: qualified physiotherapists, associates and students

Compassion a human emotion initiated by the experiences or suffering of others and leading to a desire to alleviate their suffering

Competence the synthesis of knowledge, skills, values, behaviours and attributes that enables members to work safely, effectively and legally within their particular scope of practice at any point in time.

Consent the process by which an individual allows something to occur to themselves

Continuing professional development (CPD) a wide range of learning activities through which members' abilities are maintained and developed throughout their career to ensure the capacity to practise safely, effectively and legally within an evolving scope of practice (including, in the case of qualified, practising members, fulfilment of the CPD requirements of the Health and Care Professions Council (HCPC)) formerly Health Professions Council (HPC)

CSP Chartered Society of Physiotherapy

CSP member a person who is a member of the CSP in one of the following categories: as a qualified (chartered) physiotherapist, physiotherapy student, or associate (as a physiotherapy support worker)

CSP membership open to physiotherapists who hold registration with the Health and Care Professions Council (HCPC) and are therefore eligible to practise physiotherapy in the UK, physiotherapy students, and physiotherapy support workers; physiotherapists who have been eligible for and Care Professions registration but who have retired, are taking a career break, or who reside/work outside the UK may also be members, as may physiotherapists who practise on animals

Delegation the process through which one person allocates work to another person on the basis of deeming that individual competent to undertake that task, with the delegated individual then carrying responsibility for undertaking the delegated task

Disclosure an organisation will ask for a disclosure to ensure that necessary legal information for recruitment and placement decisions can be made especially in positions involving children & the vulnerable (i.e. Protection of Children & Protection of Vulnerable Adults). There are a number of mechanisms through which this is undertaken in the United Kingdom

- England and Wales: The criminal records bureau
- Northern Ireland: Access NI is a Criminal History Disclosure Service within the Department of Justice In Northern Ireland.
- Scotland : Scotland Protecting Vulnerable Groups (PVG) scheme www.disclosurescotland.co.uk/pvg/pvg_index.html

Dignity an individual being respected and esteemed

Duty of care the responsibility held by members to ensure that their decisions and actions are in the interests of the individuals receiving or affected by physiotherapy services that they deliver

Empowerment the process of giving someone power or authority over a decision or action

Ethics issues of correct conduct informed by moral principles

Evidence different forms of valid and relevant information that are used to underpin decision-making; and action that are often, but not exclusively, the outcome of research activity

Fairness reasonable behaviour that is motivated by a consideration of the needs of others and the delivery of services equitably

Health and Care Professions Council (HCPC) formerly the Health Professions Council (HPC) the statutory regulatory body for the allied health professions (AHPs), formed in 2002 (as the successor to the Council for Professions Supplementary to Medicine (CPSM))

A 'health record' any record which: consists of information relating to the physical or mental health condition of an individual, and has been made by or on behalf of a health professional in connection with the care of that individual

Individual a person receiving a service from a CSP member (as a patient or client, or as the carer of a patient or client), or a person who is affected by a CSP member's delivery of a service; e.g. deriving from research, education or management activity

Informed consent in the UK this is taken as meaning that the patient/ service user has been told of the 'nature and purpose of the proposed treatment, together with all significant and material risks, benefits and outcomes of the proposed treatment AND has been told of all the alternative and comparative treatments that are available for the condition being treated.'

Intervention a term used to include all aspects of service delivery, clinical care and physiotherapy management.

Leadership an act or instance of providing guidance or direction

Lone working individuals who work alone – whether on a regular or permanent basis or for a short period of time each day

Member a member of the CSP

Medical devices an instrument, apparatus or other which is intended for use in the diagnosis of disease or treatment or management of conditions.

Organisation the structure(s) within which a member undertakes his or her physiotherapy activity, within the public, private, independent and third sectors

Person-centred practice putting the person at the centre of practice describes the behaviour, knowledge and skills required to: demonstrate respect for the individual; provide information and support that enables an individual to make informed choices; involve individuals in shaping the design and delivery of their service

Physiotherapy service the physiotherapy service delivered to the service user including advice, assessment, examination, intervention, treatment or procedure at an individual, group or organisational level.

Physiotherapy practice the practical (psycho-motor) skills used by the physiotherapy workforce. These include manual therapy, electro-physical modalities and other physical approaches. As with physiotherapy knowledge, an individual's skill-base will evolve according to their experiences and context of practice, but individual's must demonstrate how their skills relate to physiotherapy and their personal scope of practice

PREM Patient reported experience measure

Professional autonomy the application of the principle of autonomy whereby a Member makes decisions and acts independently within a professional context and is responsible and accountable for these decisions and actions

Professionalism defines what is expected of a professional, and what it means to be professional. Broadly, it can be summarised as; A motivation to deliver a service to others, Adherence to a moral and ethical code of practice, Striving for excellence, maintaining an awareness of limitations and scope of practice and A commitment to empowering others (rather than seeking to protect professional knowledge and skills)

PROMS Patient reported outcome measures

Quality Assurance the process by which services or care are monitored to ensure that mandatory standards are being met

Record a physiotherapy record is a health record. That is any record which: (a) consists of information relating to the physical or mental health or condition of an individual, and (b) has been made by or on behalf of a

health professional in connection with the care of that individual. A record can be in paper or electronic format, or a mixture of both, and includes all the information relating to the health status and management of the individual service user. The record may contain information about the current episode of care only, or may be a compilation of every episode of care for that individual in a given timeframe. There are various types of records in practice; for example, summary/full record; shared record; uni-professional record; and patient-held record. Depending on the needs of the patient, and the care setting(s) involved, the record may be maintained by the CSP member or a group of different professionals across the care pathway.

Referral when one health professional asks another health professional to take over the care of the service user

Risk Assessment a logical process of identifying hazards and putting in place sensible measures to prevent or control them

Reasoning the ability to make logical inferences from available information

Service user an individual or individuals in receipt of a service from a member to include patients, clients, carers and others.

Scope of practice the scope of practice of physiotherapy is defined as any activity undertaken by an individual physiotherapist that may be situated within the four pillars of physiotherapy practice where the individual is educated, trained and competent to perform that activity

Support worker anyone in a direct or indirect clinical support role. They are not subject to professional registration

Valid consent an individual being in receipt of sufficient knowledge of all relevant facts and factors to agree to, or refuse, a particular course of action

Value the importance or worth of something (an outcome, intervention or service) for an individual

Values ideals that individuals or a profession find morally compelling

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Annex 1

Steering group

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Focus Groups

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Cardiff University – Liz Wright
Sheffield Hallam University
Western Isles Hospital – Sheila Nicholson
Keele University – Jackie Waterfield
Royal Wolverhampton Hospitals NHS Trust – Sheila Stringer

Annex 2

Additional Reading

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