EUROPEAN
CORE
STANDARDS
OF
PHYSIOTHERAPY
PRACTICE

ADOPTED FINAL VERSION at the
General Meeting 09./11. May 2002
Budapest/Hungary
Core Standards of Physiotherapy Practice

Background

The World Confederation for Physical Therapy aims to improve the quality of global health care by: encouraging high standards of physiotherapy education and practice.

The commitment to ensuring high standards and quality of service is reflected in the Declarations of Principles and position statements (WCPT, 1995). The Declarations of Principle and Position Statements (1995) document outlines Ethical principles that member organisations agree to adhere to by virtue of their membership of WCPT.

The principles state that physiotherapist must:

- Respect the rights and dignity of all individuals;
- Comply with the laws and regulations governing the practice of physiotherapy in the country in which they work;
- Accept responsibility for the exercise of sound judgement;
- Provide an honest, competent and accountable professional service;
- Are committed to providing quality services according to quality policies and objectives defined by their national physiotherapy association;
- Are entitled to a just and fair level of remuneration for their services;
- Provide accurate information to clients, to other agencies and the community about physiotherapy and the services physiotherapists provide;
- Contribute to the planning and development of services which address the health needs of the community
The World Confederation for Physical Therapy recognises the absolute importance of the development and documentation of agreed standards for the practice of physiotherapy. These standards are the means by which the declarations of principle can be measured and evaluated.

These standards are necessary to:

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

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

**How have these standards been developed?**
In response to the guidance from WCPT the Professional Issues working group of the European region of WCPT considered developing a tool which provides an analysis of interaction between the individual physiotherapist or physiotherapy services in order to evaluate and promote high standards of practice.
Practice standards from several countries were reviewed and it was felt that the Core Practice Standards produced by the CSP (Chartered Society of Physiotherapy, UK) were very clear and easily adapted for use by the European Region. Permission was granted by the CSP for use of this tool.

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

**Who should use the Core Standards?**

The Core Standards is a tool that can be used by physiotherapists, patients, members of the public, managers and others who have an interest in providing or receiving high quality physical therapy services. The term *patient* is used in this document as a generic term to refer to individuals and groups of individuals who can benefit from physiotherapy intervention it includes those who may be called *clients* or *users*.

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

The core standards are those that apply to, and are the responsibility of the individual physiotherapist.
The tool includes a patient record audit, a continuing professional development audit, guidance on a peer review process, a patient feedback questionnaire and audit tool for service standards.

**Who do the standards apply to?**

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

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

**What is the status of these standards?**

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

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

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

Respect for the Individual

STANDARD 1

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

Criteria

1.1 The physiotherapist responds to individuals’ lifestyle, cultural beliefs and practices.

**Guidance:** This criteria reflects the need for physiotherapist to respect and respond actively to every patient as an individual. Factors affecting this include social, occupational, recreational and economic commitments and are regardless of background or beliefs. For example, to respect the Muslim holy day Friday appointments could be avoided. Single sex treatment facilities should be available and offered as appropriate.

1.2 The physiotherapist is courteous and considerate.

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

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

1.5 The patient is made aware of the role of any physiotherapist involved in their care.

**Guidance:** It is important that patients are aware if a physiotherapy student is treating them.

1.6 The patient’s privacy and dignity is respected.

**Guidance:** Examinations, assessments and treatment require a private environment. Care should be taken about discussions being overheard. Intimate examinations may need greater privacy.
Informed Consent

**STANDARD 2**

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

**Guidance:** For patients who may not be competent to give informed consent, for example unconscious patients, some children, patients with severe mental health problems, confused patients and some patients with learning disabilities, consent is obtained wherever possible from parents, guardians, carers or others designated to act on the patient’s behalf. Where difficult decisions about consent have to be made, circumstances should be discussed with colleagues and other health professionals involved in the care of the patient, before making a final decision. The WCPT Declarations of Principle (1995) should be read in conjunction with these standards.

**Criteria**

2.1 The patient’s consent is obtained before starting any examination/treatment.

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

**Guidance:** For example: a physiotherapist considering the use of electrotherapy would discuss with the patient the evidence for its effectiveness, but also highlight the very small risk of injury from burns.

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

**Guidance:** Patients may need time to absorb information and be given opportunities to ask questions on a number of occasions.
2.4 The patient is informed of their right to decline physiotherapy at any stage without it prejudicing their future care.

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

2.6 The patient is informed that they may be treated by a student and given the right to decline and to be treated by a qualified physiotherapist. **Guidance:** This criterion applies only to those practices that have student placements.

2.7 The patient is informed that they may be observed or treated by a student and given the right to decline.

2.8 The patient's consent to the treatment plan is documented in the patient's record. **Guidance:** Refer to Standard 8, criteria 8.1.
Confidentiality

STANDARD 3

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

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

Criteria

3.1 There is privacy when discussing personal details

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

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

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

Guidance: It should be remembered that confidential information still remains confidential after a person’s death. In these cases, permission must be obtained from the executor or next of kin (closest relative).

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

Guidance: This is particularly important when information is sought from an employer wishing to obtain details about an employee. For legal reports, written consent from the patient must be obtained before releasing any information.
Assessment and Treatment Cycle

Assessment

STANDARD 4

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

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

Criteria

4.1 The physiotherapist considers and critically evaluates information about effective interventions relating to the patient’s condition. Sources may include:

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

4.2 The physiotherapist is legally responsible for all aspects of the physiotherapy intervention

4.3 The physiotherapist is entitled to refuse to deliver physiotherapy treatment should it be considered that such treatment would adversely affect the patient or should it be deemed not to be in the patient’s best interest.
STANDARD 5

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

Criteria

5.1 There is written evidence of a gathering together of data consisting of:
   a. the patient’s perceptions of their needs

   Guidance: This is dependent upon the health status of the patient, for example it would not be relevant for unconscious patients.
   b. the patient’s expectations of physiotherapy intervention.
   c. the patient’s demographic details
   d. presenting condition/problems
   e. past medical history
   f. current medication/treatment
   g. contra-indications/precautions/allergies
   h. social and family history/lifestyle

   Guidance: This will include the effects of impaired activity and participation.
   i. relevant investigations

5.2 There is written evidence of a physical examination carried out to obtain measurable data with which to analyse the patient’s physiotherapeutic needs.
   This includes:
   a. observation
   b. use of specific assessment tools/techniques
   c. palpation/handling

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

5.4 If any of the required information is missing or unavailable, reasons for this are documented.
STANDARD 6

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

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

Criteria

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

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

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

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

6.3 When the physiotherapist does not have the necessary skills and experience to treat the patient, the patient is referred to another therapist. *(refer to standard 7)*

**Guidance:** When the test administration is delegated, the person this is delegated to must have the necessary skill and experience to carry it out. This will maximise reliability.

6.4 The physiotherapist takes account of the patient’s well being during the administration of the measure.
6.5 Written instructions in the manufacturer’s manual, test designer’s manual or service guidelines are followed during the administration and scoring of the measure.

6.6 The result of the measurement is recorded immediately.

6.7 The same measure is used at the end of the episode of care.
Analysis

STANDARD 7

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

Criteria

7.1 There is evidence of a clinical reasoning process

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

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

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

7.3 Subjective measures are identified.

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

7.4 Objective measures are identified.

**Guidance:** Quantifiable measures such as range of movement and limb girth are included.
A physiotherapy diagnosis is recorded.

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

The term ‘physiotherapist diagnosis’ is arrived at either independently of or in conjunction with a medical diagnosis. Physiotherapy diagnosis refers to the presenting physiotherapy problem. It is generally expressed in terms of how a condition compromises the functioning of a patient. Whereas ankle sprain may be a medical diagnosis, lateral ligament sprain and instability may be a physiotherapeutic diagnosis.

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

7.5 Physiotherapists recognise the limits of their own professional skills and refer the client to other professionals when appropriate.
Treatment Planning

STANDARD 8

A treatment plan is formulated in partnership with the patient.

Criteria

8.1 Physiotherapists ensure that the patient is fully involved in any decision-making process during treatment planning. 

**Guidance:** Refer to standard 2, criteria 2.2, 2.3 and 2.8.

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

**Guidance:** The plan will be based on the information gathered during the assessment process relating to social and family history (e.g. work, sport and lifestyle) and reflect cultural and religious beliefs.

8.3 The plan takes account of the skill mix of the service.

8.4 The plan documents:
   a. time scales for implementation and/or review
   b. goals
   c. outcome measures
   d. the identification of those who will deliver the plan

**Guidance:** In some situations physiotherapists may need to refer the patient to another physiotherapist with more relevant skills in order to implement the plan effectively. Patients themselves, carers, or other health care workers may also implement parts of the plan.
Implementation

STANDARD 9

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

Criteria

9.1 All interventions are implemented according to the treatment plan.

**Guidance:** Where there is delegation to students or others, responsibility remains with the person who delegated the task.

9.2 All advice/information given to the patient is recorded.

**Guidance:** This includes written and verbal information.

9.3 A record is made of equipment
Evaluation

STANDARD 10

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

Criteria

10.1 There is written evidence that at each treatment session there is a review of:
   a. the treatment plan
   b. subjective measures
   c. objective measures

10.2 All changes, subjective and objective, are documented.

10.3 Any changes to the treatment plan are documented.

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

10.5 Information derived from the use of the outcome measure is shared with the patient.
Transfer of Care/Discharge

STANDARD 11

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

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

Criteria

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

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

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

**Guidance:** This should include any outcome measures used, with a clear explanation of the scoring used and interpretation. Information should be relayed within locally agreed timescales.

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

**Guidance:** Referrers should also receive summaries for those who self-discharge or fail to attend.
Communication

Communication with patients and carers

STANDARD 12

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

Criteria

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

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

12.2 Physiotherapists communicate openly and honestly with patients.

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

12.3 All communication, written and verbal, is clear, unambiguous and easily understood by the recipient.

**Guidance:** Abbreviations and jargon should be avoided. Interpreters should be available for those who have a hearing impairment or who do not speak the native language. When identifying a suitable interpreter the physical therapist should be aware of cultural requirements, age and relationship to the patient.

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

**Guidance:** Communication should take account of an individual’s culture and language. The use of alternative forms of communication such as signing, video/audio cassettes and pictures should be considered.
12.5 The physiotherapist assesses the recipient’s understanding of the information given.

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

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

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

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

STANDARD 13

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

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

Criteria

13.1 Physiotherapists follow locally agreed systems for referral.  
**Guidance:** These systems define procedures used for accepting referrals and also referring to other professionals.

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

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

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.  
**Guidance:** See also core standard 3.3 and 11.4.
13.8 Physiotherapists communicate with health professionals and other relevant professionals involved in the patient’s care. **Guidance:** There should be a written record of communication with other professionals involved in care; evidence could include letters, records of telephone calls, case conferences, multidisciplinary meetings and onward referral.

13.9 Physiotherapists communicate relevant information promptly. **Guidance:** Relevant information is that which is necessary for continuity of the patient’s care.

13.10 The physiotherapist selects the most appropriate means of communication. **Guidance:** This may be verbal, written or electronic. It should also take account of physical and sensory communication deficits.

13.11 Language used should be easily understood by the person receiving it. **Guidance:** Avoid the use of jargon and abbreviations.
STANDARD 14

To facilitate patient management and satisfy legal requirements, every patient who receives physiotherapy must have a record which includes information associated with each episode of care.

**Guidance:** Whilst records are generally hand written, patient records also include computer records, audio tape, emails, faxes, video tape, photographs and other electronic media. Keeping records is an essential part of a physiotherapist’s duty of care to the patient and to the profession of physiotherapy.

**Criteria**

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

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

14.3 Patient records are contemporaneous.

**Guidance:** Records are not added to after the time of writing. Any genuine omissions should be recorded at the time the omission is identified.

14.4 Patient records conform to the following requirements:

a. concise
b. legible
c. logical sequence
d. dated

**Guidance:** In some circumstances, to be determined locally, it will also be important to record the time treatment was given. In these circumstances, the audit of the standards should include this.
e. signed after each entry/attendance

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

f. name is printed after each entry/attendance

**Guidance:** This is necessary so that the physical therapist can be traced easily when the signature is not legible. Where patients are treated by the same physio therapist throughout, it is sufficient for a printed name to appear once on each side of each page of the record. An equivalent system for the identification of the author must be in place for electronic records.

g. no correction fluid is used

h. written in permanent ink that will remain legible with photocopying.

i. any errors are crossed with a single line and initialled

j. each side of each page of the record is numbered

k. the name of the patient and either date of birth, record/archive number, or personal id number are recorded on each page of the record

l. abbreviations are used only within the context of any locally agreed abbreviations glossary.
STANDARD 15

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

Criteria

15.1 Patient records are kept securely

Guidance: This relates to the individual’s responsibility in relation to confidentiality. It applies to all patient related information; written, computer records, audiotape, emails, faxes, videotape, photographs and other electronic media. In a community setting, patient records should be taken with the physiotherapist and not left in an unoccupied vehicle. If the records need to be kept by the physiotherapist in their home overnight they should be stored in a locked container.

15.2 Physiotherapists comply with local Information technology security policies.

15.3 Physiotherapists adhere to the local/national policies when asked by the patient to view their patient record.
Promotion of a Safe Environment

Patient and physiotherapist safety.

STANDARD 16

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

**Guidance:** Read in conjunction with local policies and national legislation in these areas

Criteria

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

**Guidance:** This will include a manual handling risk assessment, contra-indications and precautions. It may also include checking for wet floors, etc which might be a hazard to the patients, and ensuring that suitable clothing and footwear is worn.

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

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

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

**Guidance:** This will range from systems for summoning colleagues, carers or hospital emergency teams, to dialling the national emergency number in community or private practice settings.
16.5 Environmental, personal hygiene procedures and infection control procedures are followed.

**Guidance:** For example; routine cleaning of treatment area and routine hand-washing. Infection control procedures include correct disposal of sharps, clinical waste, sterilisation.

16.6 Adverse events are responded to.
Physiotherapists Working Alone

STANDARD 17

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

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

Criteria

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

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

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

Guidance: This could be through the use of mobile phones, a written list left with a colleague which includes names, addresses and telephone numbers of the patients being visited.

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

Guidance: The risks involved should be assessed and a decision made as to whether an alarm is needed. Examples where an alarm may be required include community working, weekend working, on-call duty and outpatient staff working alone.
17.4 Where known risks exist, patients’ homes are not visited alone.

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

STANDARD 18

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

Criteria

18.1 Visual and physical safety checks are made of equipment prior to its use or issuing to patients. **Guidance:** This includes routine checks, such as wear and tear on electrodes and ferrules, correct suction pressure, wheelchair tyre pressures, etc.

18.2 Equipment is regularly maintained according to manufacturers’ instructions. All maintenance and repairs are documented. **Guidance:** For example, weight bearing equipment, such as wheelchairs, is used within loading limits.

18.3 Equipment is cleaned according to manufacturer’s instructions and infection control policies. **Guidance:** This applies to situations where cleaning is required prior to each patient use.

18.4 Any equipment faults identified are reported.

18.5 Faulty equipment is taken out of use immediately.

18.6 The physiotherapist acts on new guidance about equipment safety. **Guidance:** This will include information published by the Government or health departments.
18.7 The risks associated with using electrical equipment in a patient’s home are minimised.

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

18.8 The patient is given instructions on the safe use of any equipment issued.
Continuing Professional Development/Lifelong Learning (CPD/LLL)

STANDARD 19

The physiotherapist assesses his/her learning needs.

*Guidance:* This will normally take place in conjunction with a peer or manager. “Life-long learning and professional development is the hallmark of a competent physical therapist, participation in continuing education contributing to the development and maintenance of quality practice.” *(WCPT Declarations of Principle, 1995)*.

Criteria

19.1 The assessment takes account of:

a) development needs related to the enhancement of an individual's current scope of practice

b) feedback from performance data

*Guidance:* Performance data might include routinely collected statistics, results of audit or an analysis of outcome measures.

c) mandatory requirements

*Guidance:* Examples of this could include fire and cardiopulmonary resuscitation training.

d) new innovations in practice.

e) the needs of the organisation

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

f) career aspirations
STANDARD 20

The physiotherapist plans his/her CPD/LLL

Criteria

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

20.2 The plan includes learning objectives.

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

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

Guidance: These activities may include:

a) reflective practice
b) independent study
c) reading relevant professional journals
d) attending educational meetings
e) secondment and shadowing
f) in-service education programmes
g) courses
h) clinical audit
i) implementing clinical guidelines
j) peer review
k) mentorship
l) contact with other specialist physio therapy groups, professions or patient organisations
m) research
n) sharing knowledge and skills with others
o) clinical supervision
STANDARD 21
The CPD/LLL plan is implemented

Criteria

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

21.2 The plan is subject to at least six monthly review. **Guidance:** This will normally take place with a peer or manager.
STANDARD 22

The physiotherapist evaluates the benefit of their CPD/LLL.

Criteria

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

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

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


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

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

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

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

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

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

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

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

Clinical supervision

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

Clinical team

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

Criteria

The measurable component of a standard.

Demographic details

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

Discharge summary

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

Evaluation

The review and assessment of the quality of care for the purpose of identifying opportunities for improvement.
Goal setting
Desired end points of care. Agreed individual goals should be established by negotiation with each patient and any carers. These should be realistic, include time scales that are subject to on-going review, discussion and modification.

Health Care Workers
Include any medical or other allied health care professional

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

Manual Handling risk assessment
See risk assessment

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

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

Physiotherapeutic Diagnosis
Is arrived at either independently of or in conjunction with a medical diagnosis . It is generally expressed in terms of how a condition compromises the functioning of a patient .
**Objective measure**
A measurement that is not affected by the person making the measurement.

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

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

**Patient record**
The patient record refers to any record containing patient details. It includes all media, for example; paper, faxes, videos, photographs, computer records. Used generically to mean separate physiotherapy record and physiotherapy record contained within multiprofessional record or case notes.

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

**Portfolio**
A tool that helps individuals record and evaluate learning activities undertaken for professional development, and that provides a resource for planning future learning.
Primary care team
A team of healthcare professionals working in primary care, usually comprises the general practitioner, practice nurses, district nurses, health visitors etc.

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

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

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

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

Sharps
Any clinical material that contains sharp components; needles, glass, scalpels.
Skill mix
The mix of skills held by the healthcare workforce needed to deliver a service. It can refer to the grade mix within one profession, the proportion of professional and assistant staff and/or the combination of multiprofessional staff within the team.

Standard
Statement which describes the range of acceptable care.

Subjective measure
A measurement that requires judgement on behalf of the measurer.

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

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

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