Academy of PHYSICAL MEDICINE

Transcript

Lone Working - Ref223

SPEAKERS
Sarah Tribe, Steven Bruce, Sandra Harding

Steven Bruce
It was, I think exactly a year ago that we had Sarah tribe and Sandra Harding on the show to talk to us about communications and consent. They're both chartered physios, they have a business called HCP G, and they are experts in communication and consent. But today, they're going to be talking about loan working. Now, their business is all about making clinics compliant with the regulations under which we have to work in particular, in their case, the HCPC, the health, the health and care professionals Council, but that is irrelevant to you if you're an osteopath or a chiropractor, because those rules still apply if you're under the regulation of any other legislative body, really. So without me waffling on any further, let me turn to say hello to Sarah and to Sandra. Great to have you with us. How are you?

Sandra Harding
Hello. We're very well. Thank you. Yeah, it's lovely to be back again. I can't believe how quickly yours God

Steven Bruce
HCP G briefly just give us a quick overview of what ACP G does.

Sandra Harding
Basically, Sarah and I, as you mentioned, both chartered physios. And really what we say is lots of people have unconscious incompetence. They don't know what they don't know about standards and regulations. We're aiming to make you consciously incompetent, so you know what you don't know. And then we're here to help you sorted out so that if anything happens anywhere in your business, you've got a portfolio of evidence that suppose that shows that you are compliant around the standards and the regulations. And as you quite rightly says, Then, whilst we obviously look at HCPC, and CSP, chastity, physio in particular, all the standards and regs follow the same Health Care Act. So we all need to be considering these things. Anyway.

Steven Bruce
Through years ago, this was during the sort of year or two after the Gulf War, everyone took the mickey out. So I think it was Donald Rumsfeld, because he said, there are unknown unknowns. And there are unknown knowns. And there are unknown unknowns. And we don't even know what it is. We don't know. Everyone took the mickey out of him about that. But actually, it's perfectly true, isn't it, and it's great to have somebody helping us to, to find

our way around all this regulation. But you're gonna talk about loan working today in terms of regulation

Sandra Harding
we get what we're going to do is Sarah and I are going to go through some sort of five or six key points that we think are really important to consider when your loan peoples some takeaways to really think about, and then we thought at the end, we could do some questions and answers, any one that comes up in the chat. And anything that we haven't covered or any areas of queries, and so on low working yet it isn't it is under their loan working is basically what Sal and I are all about is keeping you your patients and your staff safe. And obviously long working is a key part of that.

Steven Bruce
Well, I hope you don't mind, people will send in questions as we're talking. Can I interrupt you every so often to do questions on the fly as it were?

Sandra Harding
You can it because it might be that we say we're about to talk about that one. But that's fine. Absolutely. So just come in as we go.

Steven Bruce
Right and tell us about loom working.

Sandra Harding
So basically one of the things I'm going to sort of start just saying to people, when people think about loan working, one of the really important things to consider is it's not just about your risk of being attacked, which unfortunately, nowadays is on the increase just on some violence and aggression training. And what you can find in advance aggression training, sleep, for the first time I've done it is it talks about how to defend yourself, and what legally isn't isn't acceptable, which is a sad reflection on the fact that nowadays, many people in healthcare will actually receive abuse in some way. So you just

Steven Bruce
scared us a bit there, Sandra, because you said it's on the increase, which always makes me think, is it reports of violence against lone workers, which is on the increase? Or was it statistically it is getting worse?

Sandra Harding
That's the difficulty. I think, certainly looking at statistics on the training we've done, they're higher. But is it that more people are more aware how to complain? And so it's actually been reported more often? And I'm not sure on that. But I think the thing people need to consider it is lots of people think about is it violence, but actually, it's not just about considering your safety from that perspective and from an individual, but it's also the fact that if you learn work and you collapse, or a patient collapses, what you gonna do, you need to actually be aware and have a process in place. You could be working in a building where you'll learn working within your clinic, but the clinics in a building and there's other clinics, but have you got a process, an agreed way of what you will do if something happens and how you will raise the alarm. So we want to talk around some of those little things like do you triage before you see people a lot of people have moved to triage. And actually, if you're triaging Someone, it may give you a bit of a gut feel around an individual. And one thing that said, and I always say is if your gut feel if something doesn't feel quite right, then go with it and be very careful if

you're going to consider bringing that person in, when you could potentially be loan working. Another thing that people seem to forget about loan working, is it oh, well, I've always got a receptionist. Well, what happens if the receptionist co some early on? Well, you are suddenly loan working. So Sara, and I tend to say it is very unlikely that there is not some point at some time when a clinician will not be working alone. And so you do need to really consider this even in a team in a team situation.

Steven Bruce
It's interesting what you said about gut feeling there. Because there have been a number of discussions that we've had about real cases. And so many times when somebody says, there's been a complaint or something has gone wrong, the practitioner was just trying to help the patient, but something in their headset, there's just there's something odd about this, but they were doing their best to help and they didn't want to stop. But they should have, they should perhaps have listened to those that are warning voices.

Sandra Harding
I think that's what we would say Don't you know, don't ignore those warning voices. If you know, it's think the whole thing around being a healthcare practitioner is that there is a lot does in the there's emotion around it, and you do get a feel for certain things. And you do feel those people where the report feels better than others. And if you just feel something isn't right, what we would say is just stop and think is something not right? And what are you going to do, and really look after yourself. So if we explore a little bit more, might talk a little bit about room design. So let's start with the basics. How often do people actually look at where is the exit in relation to the plinth or the couch? And are you making sure that you keep yourself between the patient and the door, so that if it was in the worst case scenario of an attack, that you could get out, you're not stuck in a room with the door behind the patient, and you're you're in that space? And also where there's the plinth. So often people just put a plinth in a room just really think about where have you positioned it? Can you get round it to get out? Or could you potentially be trapped? Because when you've put the patient on the bed, you've then got the plinth between you and the door. And so you're making it difficult in that way. And thinking about the collapse, when I was talking about a collapse, again, if someone collapsed behind the door, how are you going to open the door and get them out how you can get out and summons help? So you need to balance your way up and balance and assess, should a door open outwards? Should a door open inwards? You know, these are things to consider that people don't just think about, they just have a room put a bed in and away they go. And so

Steven Bruce
is it because of course, if I have a patient on a plinth I need to be around that plinth on all sides of it front, front, top, bottom left and right. So it's impossible to have a door on every side.

Sandra Harding
It is but it's about thinking could you know could you've got the pet, you know, could you've got someone to lay on a different way so that you can get to the other side rather than just where you've placed them. So I think it's it's kind of having a mindset of always we do risk assess everything that we do. But it's having that mindset of thinking if something was to happen here, can I get that patient to safety? Can I get myself to safety? And often we don't just we go in, we go into the space and we use it, we don't actually always think about how are we actually going to use it if things do go wrong.

Steven Bruce
From the moment ago, there is a tendency, I think, for us all to imagine that moving an unconscious body is easy, but anyone who's ever tried it will realise that it's not easy. But there isn't much you can do if a patient who's I don't know, putting on their coat or taking off their coat collapses against your door is there, you've just got to deal with

Sandra Harding
that. So seeing it's, you know, it could have a door open outwards, you know, you need to weigh that up Is there potential for a door to open outwards, so that you can still close it and you've got the privacy. But if someone did, and something happened, could the door open outwards? So it's just where you're just just making those considerations, particularly if you're designing a clinic, or you're moving into a new space, and you're going to reconfigure some of the space that you've had. So before I go into some other bits and pieces, Sarah is going to chat about some of the little points to consider before I talk around devices and various things. So it's been talking a bit about more logistics.

Sarah Tribe
Thanks. Thanks, Sandra. Yeah, I'm going to talk about management of new patients really. So we quite often have clinics that go on late. And if you have a male osteo carro physio work in the evening, think about not having any female new patients only have patients that they've actually you've actually seen before that you know, and again, you know, vice versa, if you've got females try not to have male patients. So It's about managing that risk as well. And as Saunders said, triaging, so if you are going to decide that you do want to have your patients in the evening, maybe a triage, maybe have a call with them. chaperones, you could have somebody in as a chaperone, you could have your duty to have you made sure that your section list is around. So it's just thinking about things like that. And also, if you're in the clinic, and you are the last one there, and you are leaving, at the end of the evening, does somebody know that you've actually got left the clinic? On your way? Oh, if you're a sole practitioner, but everybody knows where you are. So if you have a big team, but we were talking about with the teams about the last person, when they leave, they just get into the habit of contacting first is my manager that they want to decide it just to say that they've left the clinic. So then, if it's on a Friday evening, nobody's then wondering, I happen to live alone, don't turn up on a Monday. So it's just about thinking about things like that. And actually, the WhatsApp is a really good way just to say, Yeah, I'm out of locked up, and I'm on my way home, if something happens to them on their way home. That's very unfortunate, but it's outside your responsibility as a as a clinic owner, because that that could happen anyway. But as a clinic owner, you have a duty of care to your staff to make sure that they leave a

Steven Bruce
duty of care enhanced by simply knowing that they have left the building.

Sarah Tribe
Well, it's just making sure that they that they haven't that they that they have left the buildings that they haven't gone missing that they haven't been, I don't know whether you remember Suzy Lamplugh who showed that person to house on the Friday and didn't turn left alone and didn't turn up for work on the Monday and that's when they alerted but the alert had gone missing. So it's around just making sure that somebody doesn't go missing something some, you know, that that person has left. Okay.

Steven Bruce

On my part, what it's doing is it's reassuring you the clinic owner that the practitioner has has got to the end of their day and isn't in trouble in the clinic when they might otherwise. Yeah, thank you, Lizzie. Lizzie has asked whether there's anything you would specifically include in this triaging process, when you're deciding who to see at the end of the day?

Sarah Tribe
Well, the thing to do is obviously best the best, the best thing, the gold standard would be not to have a new patient at the end of the day when you're going to be on your own. But if you just have a conversation with that person, quite often you can pick up things on the phone and just feel I'm not quite sure about this. I think I'm going to offer this patient a appointment when there's other people around. It's just best to have that initial phone call and just get just get a sense of what that person may be like. That's what I mean by the triage. It's about so that you've just made contact and you've had, you've had some sort of weekly, it's impossible to say, Isn't it because everything would be different, but it's just it gives you that sense. It's like if you do a domiciliary visit, and you're going out, the same thing applies if somebody new phones up and says that they want to domiciliary visit, it's about doing that triage, it's about having that phone call. It's about just making sure that you do feel comfortable to go see that person. And also on that first appointment, it may be worth taking somebody with you might be worth taking a chaperone with you. And again, really important when you've gone on a domiciliary visit that somebody knows where you are or what time you're due to be back.

Steven Bruce
Absolutely. Yeah. Thank you.

Sarah Tribe
Okay, so would you like me to just talk about clinical wheels?

Sandra Harding
Yes, yeah, that was what you've just seen view Suzy Lamplugh, unfortunately. Yeah.

Sarah Tribe
So. So if you are a sole practitioner, it's worth thinking about what would happen to your patients, if you were incapacitated. If something happened to you, all of a sudden, you couldn't actually tell your patient you're incapacitated. It's it's good practice to have another peer, who will act as your, on your behalf, who would contact your patients for you and let them know what has happened and perhaps be able to refer them on to another physiotherapy. So that's worth thinking about. And that's called having a clinical will. If you die in service, then you need to make sure that your solicitor knows that on dealing with your affairs. They are going to have to deal with your business. And you're going to have to deal with those patients and make sure that they are told and that the notes are kept safely and securely. And if you retire, you need to make sure that And you'll notice that always available should be patient wish to request them in the future before those eight years that you have to keep them for. And you need to get, you need to make sure that your patients are happy, but another physiotherapist car or osteo, to have the details in that case. So just sort of other things to think about working alone.

Steven Bruce
What's the rule for you guys? And HCPC? How long do you keep patient records for?

Sarah Tribe

In ATPG? Us? So yes,

Steven Bruce
he is interesting, I look this up for osteopaths and chiropractors. And actually, the guidance was less clear than that. We will do it for eight years, or longer if the child is a child under 21. It's eight years from 20. But the rules stipulate, so we're simply following medical legislation rather than anything specific to our own professions. I could be wrong on that.

Sarah Tribe
I think it takes I think it can take up to seven years for a court case to be brought, which is where that eight years comes about,

Steven Bruce
if you all came up as a result of the data protection business, because we must keep records longer than is necessary. But of course, we maintain that there is a medical requirement to keep them. But when you try to pin down what that requirement is, it's quite difficult. And so simply following the the procedure, which is adhered to by a doctor, for example, seem to be the most obvious thing to do.

Sarah Tribe
Yeah, the ICAO actually states that you can justify not, because the patient has a right to be forgotten. And in those notes, the ICAO states that you can keep them as long as you can justify why you're keeping them. And it would be that in the event of them being requested in any future law or any future medical ID so that's the reason why it will keep them it is a bit blanket because then you keep all of them. But that you are allowed to keep them. The Ico states that

Sandra Harding
we just said face we give Steven is that people have to justify why they've kept them so that if they were caught, you know, there was a question that could explain why they kept not just, I've kept them, you know, they have to understand why they're keeping them and how they're going to keep them. And that's the bit that we reiterate, it is the eight years. But if you want to go beyond make sure you've very clearly got a process that you could use to prove why you're doing it the way you're doing it not you just haven't got round to a process, which is, unfortunately, what several people do.

Steven Bruce
It's distracting you from your own work and discretion.

Sandra Harding
So yeah, shall we so July, I talked to you I talk a little bit Stephen about some devices and things that people can use that when we're talking to and it's increasingly osteo as a joining the training that we're doing with the physios and people are saying what can we use? What can we do? Yes, we now get the idea, we need to make sure we use whatsapp or whatever. But there are devices that you can use the listening devices. And when we've spoken to the CSP about this, they're supportive with us, you can use a listening device to record a session, as long as you've risk assessed why. So it could be you're working alone in an evening and you couldn't avoid it because the receptionist has gone off sick or whatever. If you do the recording that overrides the GDPR rules, but patients must have been informed in their patient information leaflet, that you may need to record a session, but you will destroy it immediately afterwards. So the use of listening devices is acceptable as long as the the

recording is destroyed afterwards. And some of the devices have a key word, which when you purchase them, if the key word is spoken, it triggers an alert, which means the emergency services will be sent. If you go on Google. Yeah, Google, we can't promote anyone in particular, for obvious reasons. But if you go on Google, there are quite a lot of listening devices there. And they are in use in some clinics now. And some people have opted for that rather than we've got individuals who've been talking to who have chosen to have panic alarms that connect to the police. They want to press those. We've also had some individuals who have purchased very loud personal alarms and have when they're in a safe shared building. And they've made the others in the building aware that if they hear this, please Can they run to their aid, this is their alarm, and they're aware how it sounds. So there's those things but a simple thing you can use as well as putting on a video entry. So someone rings to get in and you've got a little video entry. So as long as they're not a new patient, you can recognise if the person trying to get in you Is your patient that you're expecting. So that's something to consider. But one thing we're also suggesting to all therapists is that if you're, if you're working, you're coming home alone, or you're in the community, there's an app called What three words. And that will locate you to a two metre square. And it's, it's used by the emergency services and can be accessed by the network providers. So that if you do disappear, if you have what three words on your phone and your phone is with you, then that is a quick way for them to track you. And it's supposedly far more precise than the Find My Phone apps that most phones now have. So we tend to say to individuals, you know, if you're in a scenario where you you feel you'd like to use some devices, these are some things that you can consider. So as there's a listening device, as you can look for on the, on the on the web, there's the alarms, which you can link to the, to another area or to the police. There's the video entry. And then there's a what three words app, which is a useful app to be holding on your phone, just to kind of let people find you if unfortunately, they have to do that. Well. We're

Steven Bruce
a great advocate of what three words here because we do a lot of first aid training. Because location as an obvious address, what three words is a brilliant way of getting the emergency services to your your location. It'll ask you though, about you said that if you have a recording device, or listening device you called it, which you said is recording, why do you have to destroy it straightaway, as long as the patient knows you've got it because actually, if they complain two weeks later, it would be really boring. But

Sandra Harding
it's the thing is, if you're going to keep it, you would have to state that it's going the recording is going to become part of the clinical record, we're talking about using the device purely for working alone in safety. So here, you're just using it so that it's there so that if you had a concern, you've got it. And it's there in case you feel you want to call for help. And you've got it set up to do so. So if you go to keep it, you could but you would, you would have to say you're using a listening device, you'd need to have consent, because then it would become part of the clinical record.

Steven Bruce
Yeah, and of course, with a lot of those devices, certainly with some of the software that we use, you can automatically create a transcript from it. Admittedly, one which will have lots of errors in it, but a transcript where you could recreate the transcript and just keep the paper record if for some reason recording is deemed to be less suitable.

Sandra Harding

You indeed you could and I can't tell you which was will and won't allow that because as I say, we don't go into looking into all of them. But the important thing is, people must be made aware that you've got a device and the purpose you're using it for. And as I say, if you're going to keep it, rather than just having it as a just in case for working alone, then you would need to make sure people have consented to that.

Sarah Tribe
Can I just say that Sandra as well that you were talking about the GDPR overrides. So in that circumstance, so the patient can't actually not not have to agree because it's part of the it's part of health and safety, health and safety. But if you're going to save it, save it or other reasons, then you the patient would have to be given the option.

Sandra Harding
Does that kind of make sense? Any other bits there, you want to kind of bring in there before we're going to allow some time for people to ask any more questions, Stephen, if any more of come in?

Steven Bruce
Yeah. So I just want to interrupt. I know you said you wanted to get questions at the end. But of course, we'd like to hear them as you as you run through. I've got some more questions here already.

Sandra Harding
Yeah, by all means, we've kind of covered some key themes I wanted to talk about. So you want to have a fire away with some of the questions.

Steven Bruce
Yeah, sure. Vlad has brought up reflecting on what you said about placing the treatment table in the right place. He said he'd heard that the opposite was best, which is that the treatment table should be closer to the door so that the patient doesn't feel hemmed in. And psychologically, they feel that they can get out if they have to.

Sandra Harding
I think from their point of view, blood, I don't think it matters where you're having the bed, the important thing we're saying is that you can get out from where the bed is. So it may be you've got it near the door, but still make sure you can get out if needs be and you can get the patient out if something happens. Like Like we've said the scenario of of of collapse.

Steven Bruce
Yeah, I think his point was that the patient might feel hemmed in if you're between them and the exit from the the treatment room. But as I said, there's, there's it's very difficult to find a way around that because certainly most osteopaths I know and probably most chiropractors will be working all around the table anyway. Somebody who has been named by our system Toodle pip says I don't know why I don't know why it does it. But anyway, I have been told that this is a sheet which is very happy, which is very happy which is very useful. She has an online booking system hugely popular and easy for patients. Which makes that makes it a slightly awkward since patients can book themselves in online at various time slots that suit them, some of which might be their last appointment six or seven o'clock at night as a new patient, and she and her husband worked together from home. So we wouldn't be alone. But this issue might apply to others.

Sandra Harding
That's get that's quite possible that sometimes with some of the online systems, though, you can actually, I'm assuming she can't or I don't know that she's aware, if they do this, with some of the systems, you can give visibility of spaces for new patients and spaces for follow up. And so the system would know you're a new patient, and therefore only show you the new patients spaces, which you could set them up as though they're not the ones at the end of the day. I don't know, because obviously different systems work different ways. But if you're, if you go back to your software developer, or your software provider, it might be quite possible that they could do that.

Steven Bruce
Yeah, we use Jane in my in my clinic, and I'm pretty sure that you can say that certain types of appointment aren't available at certain times. But I guess it's always difficult to predict, isn't it? Because on that day, when the receptionist is sick, and the other practitioner hasn't got any patients, you find yourself working alone, even if you were unexpected, even if it was unexpected. Yeah. Yeah. John, John has said that he had a potential new patient the other week, and he works alone. He suspected the patient of being an alcoholic and was very wary of them coming alone and without a chaperone. But thankfully, they failed to show. I'm not sure what advice he's asking on that. But you only thought Sergio, too.

Sarah Tribe
So definitely, if you if Well, the thing is that if you pick that up, when they are with you, and it's a new patient, and you think they're under the influence of alcohol, you could say that you would read rebook it? Or, you know, because they're not, you know, so there's something about that. And there's something about chaperones, you know, having those people, all you can do is risk assess as much as you can make sure that you, you know, do your risk assessments for your new patient, those things may happen. But it's, so just think about if that did happen, how would I manage it?

Sandra Harding
And also, I think so something there is, if someone is under the influence, and you're really concerned, you may be questioning how are they actually capable of giving consent? So is it better to the book? Because is this person really understanding? And do they have capacity to agree with what I'm suggesting?

Steven Bruce
I think John's point was that he suspected they were alcoholic, but wouldn't have known all that until they came into the clinic. And maybe he would have been at less risk than say, a lone female osteopath or chiropractor. But nevertheless, he wouldn't have known until they got in, they were alcoholic, and potentially a difficult patient, let's say. Somebody's come back to me, I don't know who this is about what three words, they had a patient who had to call nine, nine and was asked by the emergency services, they knew what their what three words were. And they now have it written in each of the treatment rooms, which is really useful, isn't it because the practitioners, the patients might not, but to have it written in the treatment rooms is very helpful. And if you're not aware of what what three words are, it's a simple app that you can download for nothing. It's called what the number three words, and it gives you a precise location of where you are anywhere pretty much on the on the globe to within about two or three metres. And you can test that because you bring it up on your phone and you walk across the room and you'll find you've got a different what three words. So very, very helpful. And the emergency services are all familiar with it. Now, Kevin,

Sandra Harding
it's been I think it's been encouraged as well, Steven, I think the emergency services are encouraging its wider usage, because it has been proved to be so robust.

Steven Bruce
Yes. Yeah, it takes a lot of the uncertainty out of it. And for them, of course, interestingly enough, I've been out with emergency services and even when they've got an address when they're driving down the street, they don't know which number the house is because they're not always in illogical things. But what three words will take them straight there and they don't have to watch for somebody windmilling in the middle of the street waiting for the ambulance or whatever. Kimber says that wound and it was a hero shaking. But Kim worked in a practice that locked the outside door as soon as the patient's entered because drug users thought they could get drugs in the practice. Unfortunately, a user got into a different entrance. When Kim was treating a patient. He or she heard a noise went to investigate. And the patient heard the confrontation with the intruder and got dressed to give support. Kim told the intruder to clear off in no uncertain terms threatening the police and he cleared off straightaway. But Kim did feel trapped because the door was locked.

Sandra Harding
I think that's I think that's yep, I think that's a very fair point. Yeah, and I don't think there's any particular way as you say, round that if you're going to, if you're going to lock the door for safety, then you aren't going to have the concern if someone breaks in, then potentially it is going to make you feel less safe, I can completely understand why Kim felt like that. But I don't,

Steven Bruce
there isn't in my own clinic to a certain degree because we can't use the Yale locks on the doors, because for a number of reasons, but the number, they've got a lot of duplicate keys, it's a very old building. But it's really difficult to get all the keys to work in the Yale locks from the outside. So we use the chip locks when the clinic is closed. But we have them all unlocked during the day, because of course, we need fire exits, so we can't have the chip locks, locked. And we've been puzzling over how to resolve this, and someone will say, replace the Yale locks. And we have thought about that. But it still begs the question of key control and all that sort of stuff. So again, it's all part of the risk assessment doesn't

Sandra Harding
test? Absolutely, it is it is, you know, all of these things, as you say you've, you've got a risk, assess and decide what is reasonably practical to do to show that you've done as much as you can to make things as safe as you can. But Sara and I were always saying to people, what we've got to remember is, we're humans, treating humans, it's not big being come on a production line. So occasionally things will happen. However, once you risk assess, and however much you put in place, and this is why the loan work is so important, because things will still happen. As you can see from the examples, you know, that you've you've raised already.

Sarah Tribe
And that's a really good time as that started to do an adverse events. Do you adverse events, do you, you know, documented? And then do your learning cycle and think actually, what kind of work can I put in place now, to decrease the risk of that happening again, and trying to close the loop? I mean, it's really unfortunate if those things happen, and you know, I do feel for those people. It's a horrible, but let you know, it does make you think actually, so

that happened. So what do I need to put in place now to really try and prevent that from happening again?

Steven Bruce
Yeah, I think that's that's very sound is, is making sure that you actually do take some action when something goes wrong, or even if just a possibility occurs to you during the course of the day rather than waiting for the the problem to actually occur. But I suspect that a lot of osteopath, chiropractors and physiotherapists, when they hear the words risk assessment, the shutters will come down, because I think, oh my God, that's some great bureaucratic form that I don't understand. I don't have a copy of and I don't know what I've got to cover. And genuinely a lot of people would just say it's too difficult, put it on to the maybe do next week pile. And that's where it stays forever. Is there a standard template that you can recommend for risk assessment,

Sandra Harding
we use we do do we do have a template, what we say to people is, it's a simple template that we've created. And we always say, use a risk matrix score before, put things in place score after, so that you can show that you've made a difference. And actually, if you wanting a lot more info, the Health and Safety Executive website is actually very good, and does have templates. And in some areas, they are healthcare specific. So it's well worth having a look on there. Otherwise, you know, we'll share our, our website addressing things at the end. And people can go and have an explore in our store, which we didn't have when we saw you last time. And there's lots of things in there that people can pick up.

Steven Bruce
Right. Okay. Anita sent in a question, Have you considered the process of people having to sign into the clinic with a system which can be monitored by someone else. So when patients arrive, they says they have to sign out I think is when they arrive, they sign in, when they leave, they sign out and use it's only used GP practices so they can monitor who's in or out of the rooms that

Sandra Harding
we met. So you can have a board, I mean, some clinics will have a board where there's names. And you know, you've basically slide the board when you really slide the board when you're out. That's, you know, obviously, if there's a fire incident, then you need some thing, because whoever's you're responsible individual in your fire marshal needs to know who was in the building. And they need to know if someone's nipped out for a coffee or not. Because obviously, you could be going back to look for someone who isn't actually there. So you need it on your fire point of view, you need a process. And yes, you could use the same system to see if people are in or out when they're working. But we're more concerned about when it's just that last person at the end of the day, what is the process for them to make sure they've safely got home.

Steven Bruce
You know, I'm always a little bit suspicious about those fire processes, because it's all very well saying that we sign in or sign out or you've got a tally that you put somewhere. But we all know that in reality, people go for a coffee, we'll just go for a coffee and then they're not gonna they're not gonna remember to do that. But as you say, you've got to think about the risks and then think about the processes. A final question for you then Chris has said, What about mobile phones? A colleague of Chris's got advert adverts about a topic they'd spoken about together in the clinic room. Presumably her phone would have heard anything that a

patient said as well. How does that work with GDPR? I'm not quite sure where what what the connection is there. I think he's just questioning what about phones that are listening in to what's being said in a in a treatment room. Chris, perhaps you could just elaborate a little bit on that. Are you worried that phones are listening in even when they've not been told to listen in? Or are you worried that a patient might be secretly recording what goes on in the treatment room? I'm not entirely sure about the the thrust of that. Yeah. But again, if you do you have concerns about mobile phones in treatment rooms.

Sandra Harding
We've not had concerns raised about mobile phones in treatment rooms, I think several clinics just basically have a notice to say, Please, can you switch the mobile phone off while you're in having treatment, just so that it's not an interruption? I mean, you can ask, but you still don't know if an individual has got a phone on and has left and has left a phone on?

Steven Bruce
The difference between switching a phone off and having it on silent, though, which is what people would infer from that they would assume you put it on silent?

Sandra Harding
Yeah, I think I think if I was if I was treating someone and I was to see they wanted to put the phone on the side, I'd be thinking, why do you need your phone out? Visible? Are you planning to try and record something? And that coming back to that gut feel if there's these kinds of things happening, everything can what is happening here? Why does someone feel the need to do this? So as opposed to someone who's got the phone, put it out of the way it's in the bag? And less likely, but as you say, I'm not quite sure which which tack? Chris was taken with this question.

Steven Bruce
Not sure. I'm not sure where the law stands on this. Because frankly, I wouldn't give a damn if someone was recording my treatment. Because if I'm doing anything that shouldn't be recorded, then I shouldn't be in practice. Exactly. Exactly. Again, the law might stipulate that if they if they want to record me, then they have to ask my permission, just as I would to record them.

Sandra Harding
Yes, yes. Because yeah, they need your consent. Yeah.

Steven Bruce
Yeah. Any final thoughts? I mean, what what can you add HCP G offer, the people are watching today in terms of support, Sandra?

Sandra Harding
Well, what we what we can do is we can help you with your policies, that's all available. If you go on www dot h cpg.co.uk. You can see our store. And we have policies in there, where we will sit with you, talk you through the policy, talk you through how you set on how you create it, talk you through some of the things we've talked through now, what would your process look like in your clinic, so that you can personalise that policy? What we always say to people just don't cut and paste someone else's policy. Because if you don't understand it, and you haven't gone into the depth and you haven't had the research, if something happens, that's when you'll follow because you need someone to investigate and discover that you didn't actually know what you're doing. So we're very happy to support people to go

through policies with them. And we also do some loan work in training as part of a setting up and private practice or a compliance refresher course, which is very popular that we run on a monthly basis. So we offer the policies, you know, we offer the support, or if people just need a quick call, we also have a book a call facility on the website as well. Okay.

Steven Bruce
Well, that's reassuring. What about can I just have this as a final question? And have to be fairly quick, I think, what would you advise to someone who's taking up an associate position in someone else's practice about what they should be looking for, and how far they should press their case, if they think that the procedures are not

Sandra Harding
what they should any, any individual signs up to their registered body to say that they are adhering to the standards. So any individual has a personal responsibility to adhere to the standards, whether they're the clinic manager, whether an associate, whatever, but if you're going into practice, and as part of you're working in a practice you want to do into their policies, then if their policies don't exist, you do need to raise a query, because that would mean your own professional registration, you aren't adhering to the standards, and it isn't a cop out to be able to say, Oh, well, I thought my boss had to do it. They haven't got them. Everyone is individually responsible.

Steven Bruce
Okay. Sandra, and Sarah, thank you very much for giving up your time, this lunchtime, hopefully won't be I want to get you in the studio next time. Rather than do this via the horrible team links. It would be so much more fun, and it would be a much more enjoyable experience for all of us. And I hope it won't be a year from now. We get almost exactly a year since you were in last April last time. But next time, let's make it a little bit sooner. And let's get you in the studio and whenever another great time. But thank you so much for your time. Thanks for your expertise. We'll put up your website details. I'll send those out and hopefully you helped out a lot of people with what you said today. Thank you very much. Thank you very, very welcome. It's been a pleasure.