Academy of PHYSICAL MEDICINE

Transcript

Safety and Quality - ref247

Steven Bruce
Right. Great confusion in the studio today, and I'm sorry that you've been hanging around for so long. All because of COVID. I'm sad to report my main technician had to report sick this morning because he tested positive, Jason bravely stepped up to the plate at very short notice. But let's not hang around with all my excuses for why the stream was taking so long. What we're gonna be doing today is some very important stuff about keeping us in line with our legal obligations to follow our codes of practice, namely the osteopathic practice standards, and the code or what I tend to refer to as the chiropractic code. In particular, a theme C of the auto osteopathic practice standards and principle A of the code and to help me do that. I've got Sandra Harding and Sarah try back I think for the fourth time on the show, Sondra and Sarah I'm sorry, you've been hanging around for so long. Well, we've been sorting out our audio problems as well. But it's great to have you with us.

Sandra Harding
Thank you,

Sarah Tribe
thank you no problem at all.

Steven Bruce
No, you need it. You will use don't you to dealing with physiotherapy and of course that's governed by the health and care professions Council, but, frankly, the guidance given to us which is essentially it's about putting the health interests of patients first and it's about safety and quality and practice. There's a lot of crossover isn't there and hopefully you can give us some some good guidelines on how we can meet our own requirements.

Sandra Harding
Okay, so should you want to say a little bit about ourselves, Steven, as usual first, would that be

Steven Bruce
held? Well, I'll tell you what, since we've lost 10 minutes of the show, let's just crack straight in. We'll put up the background on you anyway, because we've we've done it several times before, but let's get straight on with how we do what we're supposed to do.

Sandra Harding
That's fine. Okay, so today, we're lucky to see you all a little bit of a change of focus from us. Today, we're going to start from a chiropractic stance, and we're going to link into osteopath

and physio, rather than us coming from our usual physio stance, and then linking it to osteo and chiropractic. And next time assuming we come back, Steven, we'll do the other way. We'll do it from the osteopathic stance and licitly link it to Ostia to the Cairo's and physios. So from a chiropractic point of view, as you've mentioned, we're going to start with principle a, but we're also going to look how this overlaps to into the quality statements, particularly those of 456 and seven, which is a reminder for the chiropractors, that's the safety and risk management quality standards, the policy development quality standard, the patient experience and involvement, quality standard and a bit around to the clinical effectiveness and communication

Steven Bruce
from the you might be confusing a few people there because I'm not aware of these quality standards, and I thought I was really up to speed on what we have to adhere to.

Sandra Harding
But there's chiropractic quality statements. So what we thought is we would look link the quote chiropractic quality statements into the code because they do overlap, but there's little more info so we thought we'd bring those in the same with the Osteopath. So you've got the GR SC standards. And as you say the focus today will be on a in an on C which a communication and patient partnership and C safety and quality in practice. But also we need to remember that the Institute of osteopaths also has a statement regarding the quality of Osteopathic practice. And I quote, because I think it sums it up beautifully for all the professions, the IO obviously the institute believes that the public deserve a consistently high quality of patient care from the Osteopath that serve them. I have membership confers a level of care to patients quality and value of service members are expected to operate in line with the values and purpose of the IO, which demonstrates to the public patients and colleagues that members have the highest standards in integrity, professional and personal conduct. And I think

Steven Bruce
I would I would say that we need to emphasise that the IO does not govern the profession. So nobody is required to be a member. Nobody is required to do what the IO says. frankly, what we're required to do is what's laid down in the osteopathic practice standards. And as you said, I thought we were talking principally about theme C today, but theme a as well. And communication and consent, I'm sure will be part of that. Yeah, it is indeed. And from the, again, I'm interrupting the GR. SKUs is such bloody confusing language, but it talks about standards in practice, and it talks about the osteopathic practice standards, and it divides those into themes. And there are lots of people who don't understand the difference between them. And it is very confusing,

Sandra Harding
isn't it. So we're gonna go under the themes of it seems a which is communication and patient partnership, and theme, see safety and quality and practice. But we're going to pick up various bits of A and C, and we'll mention them as we go along. And hopefully that'll help clarify. And from the physios in the in the room, it's going to be mainly professional standards, three from the values and behaviours, which is all around respect, communication, working safely, and putting the patient at the heart of what you do. And from a quality assurance standard focus that we're mainly going for number one, autonomy and accountability. Number two, delivering safe and effective service number four, working in partnership, and number seven communication. So without further ado, let's move on a little bit. So standard, a one for the character practice, and a one for the osteopaths. But also a

two and a seven are all around compassion care, listening to patients getting their views and their decisions, making sure you're polite and you're considerate, and that you're working in partnership with them. So what we want to talk about is I want to start by asking you a question. When you're talking to a patient, do you actually listen to speak? Or do you listen to hear, and there's a very big difference between listening to speak to them in listening to hear it. This is all about listening to hear, so that you don't miss really important factors when you're doing this assessment. And how what we would say is how can you evidence if challenged, that you've acknowledged your clients interests or given not influenced their decision making, so you really have listened to hear them, and you've involved them in the process. And what we'll be suggesting is that when you're doing that treatment plan, and you've got your time goals and your outcome measures and things, can you illustrate that those exists for both clinician and client. And very often, from a client point of view, they this could be very functional, I want to get back to walking to the shop and picking up my newspaper I want to get back in my garden. from a professional point of view, it could be about a range of movement, it could be a specific outcome measure. But it's very important that you can evidence to share decision making that's taken place around this so that the patient really is at the heart of what you do. And one thing that we just wanted to share today for people to kind of consider is that recently in the UK of tools being explored, it's being looked at, in the NHS, because shared decision making is monitored and inspected by the Care Quality Commission. And there's a tool called collaborate. And it's collaborate with capital ra te originally set up in the US in around 2017. But it's actually been looked at and validated. And there's a whole validation paper around in the BMJ and it's very simple for people to use. It has three very simple questions, which is why it's more widely used. So I'm going to share the questions with you. And if you just think about these, they're very obviously show that you have not influenced your patient. But if you'll know from the answers to all shows they've been involved in the process. And the first question it asks is how they ask it goes to the patient, how much effort was made to help you understand your health issues. It's marked on a scale of nought to nine. How much effort was made to listen to what matters most about your health issues? And the third and final question, how much effort was made to include what matters most to you in choosing what to do next. So imagine if you gather that and also picks up some patients demographics, that's a great way to actually show that you've upheld these standards where you're showing that you've cared for your patients, you've listened to them. You've acknowledged their views and decisions, you've worked in partnership with them. You've understood their needs, and you've made sure they've been able to express what is important to you. So very simple first set of standards to talk through and that one, we can show that we can use this tool to basically cover that off.

Steven Bruce
Can I ask you? Are you are you suggesting that after each appointment, we get the question or get our patients to answer those three questions.

Sandra Harding
Most places where it's tested, it's often tested after the initial beginning of the process. is because it's a good way to see if the patient does feel they're involved. And often, it's if it's an a long treatment, it may be done midway through, but it's often done at the end again. So you can you can actually compare and benchmark yourself, did you actually improve in your scores? Because you learned from the first scorer, he reflected on it, and you improved it as you moved forward during the course of treatment with that particular client.

Steven Bruce

Right, okay. Okay.

Sandra Harding
So if I move on to the next one, we basically want to talk about a two for the counter practice from the code which is respect a patient's privacy, dignity and cultural differences and their rights prescribed by law. From an osteopath point of view. It's a six, you must respect your patient's dignity and modesty. So the first thing we want to throw in which also links to the chiropractic quality statement for around risk management, have you risk assess the likelihood of invading someone's privacy in your clinic? So thinking about this, are you in Could you be seen if challenged to invade someone's privacy by having someone else in the treatment room with them without gaining therefore consent, we're not going to go in detail into concepts I'm just going to throw something out there for you to think about because consent itself is a whole session on its own. But if you're treating children, you need to remember that if you have a Gillick competent child, that you've assessed a skillet competent, you could allow their privacy to be invaded shouldn't but you could and would have allowed their pregnancy to be invaded. If you allow a parent or a carer to be in the room at the initial assessment, unless the consent process has been correctly followed. And it differs for different ages from eight to down to 13.

Steven Bruce
Can I ask about that? Because Gillick competency gives a child the right to accept treatment, but it doesn't give the child the right to refuse treatment as I understood it. Yeah, so therefore does it so therefore does that apply in terms of somebody in the room? If a parent says no, I want to be in there can the child refuse?

Sarah Tribe
The child can refuse but if the child if the child refuses on the treatment of subsidising you go to do a treatment plan with it with the child? And they say no, I don't want to have that their refusal can be overwritten. But if if they're getting it competent, then you need to ask their consent for the carer or parent to be in there with them.

Steven Bruce
And that can't be overwritten by the parent?

Sarah Tribe
Well, no, because the child is going to competence. So it's about it's about treatment and care. So it's about what you're actually doing the treatment that you're giving that child, not around who can be in there. I think it's quite a delicate subject. And it just, it's just a matter of really, really understanding the rights of a given competent child,

Steven Bruce
which is where I'm trying to get to now because generally, it's not a problem. Of course, it's very rare that Gillick competency comes into osteopathic or chiropractic care of children. But if a child if a child's decision not to have treatment can be overwritten, regardless of whether they're Gillick competent, then presumably their decision not to have their parent in the room could be overridden. So that's all I'm saying.

Sarah Tribe
Yeah, and I understand what you're saying, Yeah, I understand what you're saying. I think this has to be thought about. Why would the child not want the person for example, if you think back to that term, Gillick competency came from Victoria Gilligan, her child was given

the contraceptive pill, and the GP decided that the parent didn't need to be informed, which is where the competency came from. I think yeah, I think we could debate this for a while. But what I what I will do is I'll go find out, I'll go and investigators a bit more than that, actually, about that parent being in there.

Steven Bruce
I just imagine that most practitioners would want a parent in the room if they're treating a child unless there's very good reasons to do otherwise. And that would have them we then have to be suspecting some sort of safeguarding issue I imagine.

Sarah Tribe
Yeah, exactly. Exactly. Sorry,

Steven Bruce
I interrupted you there. But I thought it was quite important, Sandra.

Sandra Harding
That's absolutely fine. So then going on little bit from that something else that we're thinking when you risk assessing is if you have curtains and stood walls, how are you going to respect someone's privacy and dignity? Curtains is fairly obvious. But what we have found with some people that we've been working with recently, is when we've had this conversation, and they've gone back and sat in clinic rooms, they have realised that they can hear what is happening the other side of a wall to the extent that they'd have to go back and insulate the walls. So you need to look at this because obviously, they can clearly compromise confidentiality. And it's something we don't think of because we're all in treatment assessment mode and And we're almost in the zone for wanting a better description. So go and sit, excuse me go and sit in the room and go next, get some sit next door and just see what can count up.

Steven Bruce
There's another side to that as well isn't there if a patient sitting in the waiting room believes that what they're saying can be heard outside the treat the treatment room, then it will influence what they say to the person in the room. So you might might not get a proper case history, regardless of whether you whether it regardless of whether anyone actually can hear them. It's what they think is happening.

Sandra Harding
And I think I think taking that a step further as well, Steven, something else to think about is can your staff room conversation, be heard in a clinic room? If your clinic rooms next to a staff room as well? Because particularly how does it do manage patients confidence if you've nipped out to have a cup of a discussion with a colleague to kind of brainstorm a little bit and you come back in? So all of this, you know, basically go and risk assess all the rooms in your in your clinic space and check. Again, if you're if you're, as we find quite a lot of clinics are, you're in a shared space, though there's certain rooms for certain clinicians, make sure you can't hear what's going on. If another clinician has extended the walls next door to yours.

Steven Bruce
Can I put some questions from the audience to you since a questions have been coming in from our audience, Sandra Darcy says How can patients make rational decisions about their

osteopathic or other health care if they are, quote, unaware of their own musculoskeletal health issues?

Sandra Harding
Basically, what we've seen, was it Darcy Did you say see? Yes, yeah. So Darcy, what we're saying is, you can have a discussion, of course, you can have a discussion about what you've found and what your thinking is. And you've obviously talking about the risks. But what you can't do is try and coerce someone. So you've got to be very open to questions to make sure you've explained in a way that they understand so that they do feel they are involved in that process. So of course, it doesn't mean you can't, you can't give advice and propose what you want to do. But it is the manner in which we do it. And often as a clinician, we speak very much in clinical terms I've ever had, we try not to. So what we're saying is that shared decision making, there has to be that level of understanding. And you have to check that someone is understanding. So it's going back through that bit. I hope that goes up on Steven,

Steven Bruce
thank you. Someone has also asked if you whether it's okay. If you tell people that they can be heard through the curtain, is that acceptable? It doesn't overcome my issue that they won't say certain things, but potentially if they know that, but is it okay, as long as they know, they can be heard through the curtain?

Sandra Harding
I see your standards are clearly saying that they shouldn't be able to be heard that you're respecting their privacy and their dignity. And I think you would have to argue how are we respecting their privacy if you're allowing the conversation to be heard, you don't know if the person in the next cubicle knows that person? So not only the all the things that we've talked about Steven about, you know, if they if they think you brainstorming with a colleague, does that make them think does this person not know what they're doing? Also, the fact that if you hear him from the reception doesn't mean someone won't speak. It's also you don't know who that person is at the other side of that curtain. And you don't know if they know of them, or if you're starting to ask a history and they think, oh, that sounds like my mom's friend. so and so. So I think you know, it's a no, no, here's what I would say, I would not be comfortable. If someone said to me, Oh, I don't mind. I'm sorry. I personally curious

Steven Bruce
thing though, Sandra. The curious thing though sounds because we all know if you go into hospital, your consultant makes his ward rounds, he pulls the curtain rounds, then asked you the most personal questions about what you're doing in there. You have no choice, but we have no choice but to answer but if you want care, you've got to answer the question.

Sandra Harding
Completely agree. I don't agree with it at all. But I completely agree that's what happens. But personally, if it was me treating in a Minute Clinic space, and we'll be dealing to the privacy and dignity of that individual.

Steven Bruce
Okay, and just to make us all laugh, I've been told that the auto generated captions is writing gimmick competent instead of Gillick. We've all got competent gimmicks that's going to help. And someone who's who's down here as he says, this is a thorny subject. If one's got CCTV

in the session, then you're perfectly able to defend yourself if there's a complaint on any issue. Go on. What do you think about CCTV during treatment sessions?

Sandra Harding
Okay, CCTV and listening devices. We've had a long a big discussion about this. Now, I'm going to come from the CSP stance here, because we've had this this exact discussion about working alone in safety. The stance that's currently being taken is health and safety overrides everything. So if you've risk assessed that you need CCTV or a listening device, and there's a reason why and you could evidence it, it is acceptable as long as as soon as the patient has left, it is deleted, so that you've used it for the purpose it was needed for, but you can't keep it on record.

Steven Bruce
Because the purpose you're keeping it for is to defend yourself against the future complaints. You can't is it pointless if you delete it?

Sandra Harding
Yeah, that's that's where we are with the MCs. No, no, I understand. This. We know there's some little nuances of difference in some things. There's gonna pick something up later between osteo and Cairo's and physios. But that's the current one from from the physio stance. And I know it can vary depending from time to time, but literally, that is hot, hot off the presses. Earlier this year.

Steven Bruce
Some assignment has sent in an observation saying he recently had to take his mother to a&e and you could hear everything going on in the next door cubicles. And likewise, in GP practices, there's no privacy at all. If you walk into make an appointment, what do you say to them? Are they reprimanded? And of course, I suppose the difference here is that we aren't, we aren't thinking about the normal person who takes a reasonable view about this, we're we're thinking about that one person who wants to make a complaint, because possibly because something else has gone wrong. And maybe it's been picked up as part of the investigation process. And we are trying to make sure that we can't be vulnerable in some subsequent complaint process, aren't we? We are indeed, also looking for the patient's interests. Of course,

Sandra Harding
yes, I just want to say I think we're looking after the patient's interests. And also in today's more litigious society, we know that unfortunately, there are individuals out there who will make will actually go further and a complaint will go straight to seek a solicitors advice. So our advice is, we would always say err on the side of caution, so that you can't be picked up on your professional values and behaviours. And someone can't say you didn't adhere to the standard around privacy and dignity. And this is why so we would, we would always say it on the side of caution. If you choose not to, then obviously, if you're challenged, you're going to need to evidence why you chose not to.

Steven Bruce
Yeah, and you talked about risk assessment earlier on and everywhere where I've looked up the subject of risk assessment, and I've done it on a number of things. I have seen that it says your risk assessment can be written or it can just be thought through, you don't have to have it in writing. But you've got to have, as you said, if something goes wrong, you have to have be able to explain why you did what you did and how you thought you were protecting

the patient's interest. So yes, yeah, Lauren says Lauren says it's easier if we don't treat children at all.

Sandra Harding
And to be fair, and Lauren, I wouldn't disagree with that. I think if you go into treat, of course, we need to teach children because they deserve a service like everyone else. But I think if you're going to teach children, you need to be very clear and very robust around the standards and the governance that is now coming into play with children, which means there are fewer people now treating children because of this. So I think if you're making a conscious decision, that you're going to treat them, then make sure you've put everything in place that helps you treat them knowing that they're safe. You're safe, the team safe, you brand safe, and you've met the standards. Yeah. Okay, so can I can I got a little is that, okay? So sort of still talking about dignity. A few more things that we wanted to throw in and make you think about is when you send a patient leaflet out to your patients clients, before they arrive, you need to make sure that in that leaflet, you've made them aware that they're going to undress to some extent. So at least they know from a privacy and dignity point of view, from the dignity point of view, there could be some dressing. And also, you may have to adapt your literature depending on a cultural stance as to what people can and can't do, because it does differ for different cultures. But thinking about the dignity and the privacy, if you imagine this individual is probably feeling very vulnerable. They've never may never have seen you before. They could be in pain. They've had a leaflet that says they may have to come get on dressed that coming into a room that's alien, you've brought them into a room, close the door behind them and ask them to get them dressed. It's not surprising that they can be feeling more vulnerable and have a heightened level of anxiety, then think really carefully about where you're standing. Because if someone's already feeling vulnerable, and then you stand behind them, in their in a state of undress, to look at spinal flexion just think the impact that can have on someone, and could it mean they leave, and they go straight to make a phone call and say I've just had the worst experience. We can be very blase as clinicians, because we're used to being in a state of undress going on training courses where we did a state of undress. That is not the normal and I sometimes think we forget that it's not the normal. So just consider how you'd feel if you come into that space. And just think about your shorts and towels, the things you've got available. And from a cultural point of view, have you got male and female conditions? Because some cultures that only be seen by a clinician that the same sex and if you haven't, how are you going to address that and also have just really, really, really think about most complaints start from a lack of communication. And from someone in a heightened state of anxiety. If you're going to impact on the privacy and dignity, it's likely you're going to create in that state further. And on a final point that hot off the press this week, in this area around this is the women's health strategy for England has just been released. And that talks about how the healthcare inequalities and looking at in some localities, how are we addressing women's needs around pelvic conditions, the whole the whole range of Guinee and the whole menopause, and how healthcare professionals could really help to bring down some of these barriers. So it's something if you're not aware of it, have a look, the Women's Health Strategy for England just out on July the 20th. So that's hot off the press.

Steven Bruce
So you won't be aware of this Sandra, we've just done a thing had three or four programmes on the trot all about women's health. So here people are at least thinking about it.

Sandra Harding

very timely. So Lincoln. So the final little one that I'm going to talk about before I hand over to Sarah, is I'm going to talk about a three and a seven from the chiropractic code which should around taking appropriate action if you have concerns about the safety of a patient and also safeguarding the welfare of children and vulnerable adults and as a professional your obligations around this, particularly if you think someone's at risk from abuse or neglect. From the osteopathic perspective, see four is you must take action to keep your patients from harm. So the first thing that's coming to mind here is safeguarding or whistleblowing to thorny not very comfortable issues at all for us all to deal with safeguarding. Just a summary of things by all means go on our website. Our last two months blogs has been safeguarding was June's whistle of loans July's. From a safeguarding point of view, I hope we're all aware. But occasionally find people who aren't, you need to know the process of the local authority of the postcode of the patient, not your clinic, postcode, and it can vary slightly from authority to authority. We always advocate find out who you safeguard and contact leads, have a conversation with them, they'll let you know about things and concerns that are going in in your area so that you're more aware of them. They will also help you with the process. And we use flow maps, some have a policy process or send for give you the information so that if you're in that very emotive, you're getting real concerns about someone, we would always say failure professional bodies, they'll advise you or give you advice, you can also speak to the local authority. And they're useful for sense checking if you've got to concern the uncomfortable one about whistleblowing. Again, you go to your own professional body, who may tell you to escalate obviously, physiatrist HTPC, etc. The thing with whistleblowing is, and unfortunately, Sara and I could talk about this, there are still some practices that occur, that would make people's toes curl. And you'll often find out about them from someone who comes in and starts to talk about previous treatments. So just make sure you've got policies and processes, and you've got real understanding and training in these areas. But something else in this area of ham that people need to be really think about is make sure your equipment sounds obvious, but you've got a policy around equipment servicing maintenance of equipment service records, how is it signed off? How are you sharing with your team? If something's if there's a concern about a piece of equipment? What's your process for taking it out of action? It sounds obvious, but often we forget the obvious things. So it's making sure you've got this in place. And if you're loaning equipment, what's your process? How are you rechecking it, if you're going to loan it again? If you've got equipment servicing? Do you know the weight limited the equipment you've got? Do you know about the chairs in your waiting room? If someone sits on them, could they have an accident, and then obviously it comes back to you to pick up the pieces. Another thing around time again, just going to touch on it because we've mentioned it earlier, if you haven't actually made a patient aware of all the risks and done the fully informed consent process, and that's not just a policy, it's the whole process, the policy, the literature before the process, you go through the risks, the regulations, the way you record it, this whole portfolio of evidence. If the patient hasn't gone through the full informed consent process, and this is proven, then you actually can be challenged that you've actually seen as a Assault or Battery of the client. So you've got to be aware because that means actually the hand has come from yourself and that can be challenged legally. No was fully informed consent process means you can be charged for assault and battery.

Steven Bruce
And then interesting on that one, if I may interrupt there there is a very signal figure out legal difference between informed consent and valid consent. And I thought we were actually required to have valid consent.

Sandra Harding

The will some people call it valid, some call it for court call it informed with with in certain physio you can call it verbal consent obtained informed consent obtained for what you have to be able to do is evidence that the process has taken place, particularly around the risks and that the client is aware of the risks and has actually decided to proceed. But the risks have been very, very clearly explained to them. And that's the thing that often gets missed out. People choose to tell them what they think they need to know. Now under one gallery, you have to tell them everything, including in some cases that can be risk of death, but some procedures, a few people that we work with, particularly osteopaths, we've found have had sheets that they have appendices for common risks for certain procedures, and they let the patients read those clients read those and they document it. So how you do it is up to you as long as you can show that you've that you have that process. final bit in here about harm is the obvious one, health and safety. So what we tend to say to people we work with is standing outside your clinic and risk assess the patient's journey from coming in to being in reception to being in the treatment room to being on the equipment and equipment being used on them to come in back out of the treatment room and try and do it from a patient's eyes really risk assess everything so that you've checked that you've done as much as you can to keep them from harm. Patients current clients are not vaping cans on a production line is sort of CERN I always say we're human beings working with human beings and things can happen. If there is a claim, it will always start at the highest point. And what you can show you've put in place to mitigate it is what helps brings it down and helps protect your brand. So from that point of view, that is a bit of a whistle stop through loads of things around some of a C and a four osteopaths service. Now we're gonna go on with the next few things. So we've covered off that code.

Steven Bruce
Right. So the first thing is Sara and Sandra, were supposed to finish now but we started quite late. Are you happy to go on for a few minutes? That will be helpful? I'm not sure I'm not sure. Not sure all of our audience can stay because they might have two o'clock lists, but it will be kind if we could just run on for a little bit. But before we move on to Sarah as well. A couple of questions. Simon's asked whether you could give an example of Gillick competence with regards to osteopathic practice or presumably chiropractic practice.

Sarah Tribe
John, would you pick that one up. So if you let competent child is one that the professional person deemed to understand what consent is, there are no specific questions to ask is very much subjective as to the professional person, so that you are really certain that that child understands what's going to be done to them can weigh it up, and can consent to it. So some children can't, and therefore you have to get parental consent. But you have to make sure that you can't just plant it blanketly say while the 1314 15 So therefore, I'm just gonna get parental consent, you have to, to weigh it up and make your own judgement as to whether that child can can do those three things, understand, weigh it up and be able to give informed consent. That's perfect, because that's what all chiropractic and osteopathic

Steven Bruce
take right? And so I think I think the, the answer to the question that Simon is looking for is well, we wonder what circumstances is this going to arise? I mean, under what circumstances would we ever expect to have to assess the Gillick competence of a child, we always assume that their parent will be in the room with them.

Sarah Tribe

Yeah, but you can't because the laws The law states that a child who again it competent child is able to give consent for themselves, and to not have their information shared with their caregivers, all parents. So you need to you can't just blindly assume that the child is going to have the parent you need to be able to determine that that child is not going to competent and therefore the parent needs to be present for parental consent.

Steven Bruce
So we I'm trying to put this into into clinical terms, which is what Simon asked for is, how is that ever going to happen? Presumably, a child would have to present at our clinic on their own and we would have to make that assessment of Gillick competence then because otherwise, they're going to come in with a parent. Go you do from

Sandra Harding
MSK perspective, Steven for the gentleman was asked was he would bring the child in to start the assessment on their own, you could start having a conversation and then if you feel they get it competent, you can ask the question would you like your parents to join us or not? And if they say no Know that you proceed with the child without the parent? What quite a few. The osteopath that we work with has done is they have, they've documented this in their patient information leaflet, because they feel it's less emotive to make a Parent Aware that they may not be present during the treatment rather than than find out when they turn up when they're not allowed to come in.

Steven Bruce
Okay, and of course, what you've just said there, Sandra presumes that we will be able to take a child into the treatment room without their parent. But the parent will be there. And that's a very difficult conversation to have, isn't it?

Sandra Harding
That's why we say it's often easier to have in your patient information, particularly if it's going out to someone of an age where Gillick competency applies, it could say you present that on the leaflet that basically explains, we will be talking to the child alone first, to assess their competency to understand the treatment, this may mean that you're not in the room during this process. So then somebody comes with the knowledge that they may not be in, right. But then obviously, if they're there, you need to bring them in because they're not really competent, then you can bring the parent into the room.

Steven Bruce
So I'm gonna hope that's added a few layers of complexity to your thought processes in dealing with children.

Sandra Harding
Back to why somebody said you know, difficult treating children, you've got to really wait up.

Steven Bruce
And again, I'm sorry to there were so many people sending questions, and we've got 350 people watching. So it's not surprising. But people are justifiably concerned about all this. And I think sometimes we worry too much about it when we need simple procedures in place. But Dave has said this is making stuff as difficult as possible and only benefits the regulator's I can see where you're coming from Dave, but I'm not sure that it benefits the regulators, the regulators are required to respond to complaints. And actually the regulator provide by providing these guidelines is giving us the opportunity to defend ourselves. It's

not in their interest to make life complicated for us, and they don't want the profession I imagine you'd be the same. From your perspective, they don't want the professionals to come into disrepute, so Exactly. Right. And then Sarah

Sarah Tribe
Sanders covered a lot of it. So I'm just gonna pick up on a few bits that may be helpful. So I'm just going to talk about a for the chiropractic treating patients fairly without discrimination and recognising diversity and individual choice, and a one of the osteopaths about listening to patients and respecting their individual visuality concerns and preferences, and being polite and considerate. So, just some things to add to Sanders. So make sure that you've got your training up to date in equality and diversity. Use an interpreter service. In physiotherapy, we're not allowed to use relatives to interpret. I think there may be some nuances because I know there are an osteopath can use family members to chaperone. So just think about using the interpreter service. To gain informed consent, which is what we've been talking about all along, address them by the name of their choice, make sure that you call them what they want to be called, if they want to be called Mrs. Cole and Mrs. or Mr. Ahn, don't just assume that you can call them by their first name. And if they're of a different culture, take time to understand their culture. And also, you know, with culture, you need to be able to offer faithfully male and female therapists. So just bear that in mind as well. And when we say we treat them with dignity and courtesy, so I'm sure as therapists and as practitioners we all think, yes, that's absolutely what I do with my patients. If you're going to have to evidence it, which is what this is all about. You could have a patient satisfaction questionnaire, which detailed the questions around dignity and courtesy. So the sort of things that you could ask on this on this questionnaire is where you Listen, did I listen to you? Did I listen to you? So you're listening to the person's concerns? You're asking for their opinion, and let them know that that opinion is important to you. you involve them in decision making you include them in the conversation and don't speak over them, to their others to their family members to their carers, and speak to them as an adult, even if you're not sure how much they understand. So if those

Steven Bruce
Can I interject for a second? So yeah, yeah. I wonder whether actually, I'm not aware of this sort of thing being too much of a problem in osteopathic or chiropractic circles, and you may see more of the litigious side than I do. But you did say earlier on make sure your equality and diversity training is up to date. I'm not convinced we're required to do equality and diversity training. We're simply required to treat people equally. Is that the case?

Sarah Tribe
In the chat in the in one of the standards of the mandatory training and physios is that you You are one of the vendor trainees equality and diversity. So that does apply to physios listening to you, right, not

Sandra Harding
just chipping said as well. And if you're working in the NHS, it applies to all practitioner course,

Steven Bruce
yeah, the NHS has its own rules. But we need to make it clear, most Australian Cairo's are in private practice, and they're not governed by the ECPC. They're not required to do mandatory equality and diversity training, but they are required to apply equality across all races and other divisions. The other thing you said is we are required to provide male and

female practitioners, I don't believe that's true. We have to make it clear if we can't do it, but yes,

Sarah Tribe
yes, yes. So if you can't do it, if you only have female therapists or male therapists, you just need to make that clear, so that they can choose to go somewhere else to find the therapist of their choosing, you don't have to, you can just make sure that you that information is there, so that they can choose to come or not, I

Steven Bruce
suppose the bigger issue for all of us now who using online bookings and so on, is providing them with an opportunity to just select the gender of their practitioner because, you know, a a Hillary might be a man or it might be a woman they might not know from the name of the practitioner. And it may be there may be we need to make it clear that either what sex they are or given the opportunity to pick.

Sarah Tribe
Yeah. So just coming on to the patient's health and welfare, the a five of the chiropractic and the C six of the Osteopath, this is about being aware of your wider role as a health care professional to contribute to enhancing the health and well being of your patients. So just things to think about around this are shared and shared decision making, signposting them to wellness services, so cessation of smoking, health management, weight management, good mental health, maybe you know, a therapist, maybe a nutritionist, and find your sort of own hub of specialties in your area that you can signpost these people on to and think about dementia patients, if any of you have treat frail elderly, who may have dementia, or their capacity may fluctuate, just think about fitting around them rather than them sitting around you because people with short term memory loss and early stages of dementia can have capacity at times, and they're much better in the morning. So just think about often the morning appointments, those sorts of things just to sort of, sort of think about and then the last one is the A six which is treat patients in a hygienic and safe environment, and making sure that your practice is safe, clean and hygienic and compliant with health and safety. So just some of the things about well, how do I know how do I how do I? How do I know what I'm doing there? So just some of the things that you can think about in your practice. So have a daily cleaning schedule for sanitary areas for fans, air conditioners, telephones, desks, computer keyboards, think about risk assessment assessment for Legionella. Is your floor easy to clean? Have you got suitable furniture that can be wiped down? Use paper towels don't use bar soap. In physios, they need to have a sharps policy and how they dispose of that. The waste. Think about your hand hygiene. Have a hand hygiene policy. And again, PPE, which we are just coming. You know, there's lots of things around PPE at the moment. So those are just some things to think about. If you're if you're how will I evidence that I haven't I run a safe, hygienic space. So it's all about infection prevention and control, and just doing an audit, you should do an annual audit, you know, just think about doing an annual audit, I mean the physio we have to but in, you know in the other professions, just think about auditing your health and your infection prevention and control, just so that you can see that you are doing all these things. And there's your evidence if anybody was to ask you.

Steven Bruce
We're gonna have to come to the end of the show very shortly. Sara, I was just going to ask most of the people watching this show don't want to do audits, and they don't want to have the policy writing and stuff like that. So where do they get the templates? We've got

Sarah Tribe
them all on our store we thought you might have yes we do. You can do them yourself or we've got everything on the store I think so this is gonna run through a few things that that we that we've got.

Sandra Harding
Right so in a quick in a quick pull it together. We have patient info leaflets policies for informed consent for safeguarding for whistleblowing, we call it to diversity inclusion for working alone for complaints for infection control, and we have an audit tool. So if you visit our website, which is www dot h cpg.co.uk. and click the Store button. You'll see everything there. And we're going to provide Steven with a discount code that can be used by Academy members. If you follow us on social media, we have a monthly newsletter with a theme. And as I mentioned earlier, it's currently whistleblowing. And we send a weekly tip out on the theme to make you think about that theme and check your understanding. And we're here as always, HCP G. We're here to help protect you, your staff, your patients and your brand. Thank you.

Steven Bruce
And Sandra, you did send me that discount code earlier on, but I don't have it in front of me. What is it again?

Sandra Harding
It is let me hold on one second, because I've just sent two out can you bear with me one time? Because any other questions? Well, I'm just very quickly checking it.

Steven Bruce
Oh, gosh, I've got quite a few coming in. A lot of them getting quite concerned about why anyone would want to do anything in healthcare these days, given all the constraints. But you can understand that Alex, Alex has said very sensibly that I'd cuz he's his words or her words, I'd consider a child not wanting to share history or have a parent parent present during the treatment or potential red flag. And I'd certainly be thinking safeguarding issues if it happened in my clinic?

Sandra Harding
Yes, exactly. I think you have to be very aware of that. Because that could definitely be a potential,

Sarah Tribe
there may be the first time the child's actually able to talk about it as well, and not have the parent in the room. So it isn't important. It's very important to offer the child that safe space.

Sandra Harding
And I think because you said you quite rightly say that is a concern that you know, you need to probably explore this a little bit further before you bring a parent in the room. Because it could be that potentially you have got a safeguarding issue there. There, I can't get the

Steven Bruce

photo, where else I'll send I'll send it out by email this afternoon to everybody, along with links to your website and everything else. One final question for either of you. I don't mind. Carmel has asked how you would deal with a patient with poor hygiene

Sandra Harding
that he wants to do and your hygiene. But

Sarah Tribe
while yes, I think I think if if a patient comes in with poor hygiene, then I would be asking myself about is this patient vulnerable? You know, what, what's their family situation? I think it would just bring up quite a few questions for me around it. And just some delicate and gentle questioning. Because I think that can be a sign of them not looking after themselves. And you know, it's worth further investigation.

Steven Bruce
Right? Would you have a conversation about asking him to wash next time before they came in?

Sarah Tribe
I don't know sounder. What do you think?

Sandra Harding
I would say it would depend I think on the rapport I had with the patient, but I think if there was a way that I could professionally ask them to do so than I would. That's personal. I'm speaking personally on there. And Steven, I found your code, it's actually capital letters, shell back shell as in be on the beach, all one word, shell bank,

Steven Bruce
shell bag, a bag as in bag to carry things. So shell bash shell bags with the scancode. Thank you very much for that, ladies. And I'm so sorry. I kept you hanging around in the silence for so long at the beginning of the show. But technology is what technology is I guess it's been lovely to have you back on again, and lots of food for thought and prompted endless comments from the 350 odd people watching. So definitely valuable stuff. Thank you. Thank you, too, for joining us. I'm also very sorry to have kept you hanging around while you were waiting for us to sort out the technical technological problems. It seems so long since we've had them that we're perhaps a bit unprepared for them this time. Still valuable stuff. And it does make me think that we should do a couple more shows perhaps, perhaps revisiting things we've said in the past and done in the past on communication and consent. And if you look back through our library, you will find shows on communication and consent and on safeguarding. So we have covered those topics before but they're always useful to revisit, I think.