CHARTERED PHYSIOTHERAPISTS WORKING WITH OLDER PEOPLE

Quality Assurance Standards for Physiotherapy Service Delivery

AGILE supplementary paper

2013

A professional network group recognised by
THE CHARTERED SOCIETY OF PHYSIOTHERAPY

AGILE Supplementary Paper

Revised edition

2013

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Contents

Introduction

AGILE is a Professional Network of the Chartered Society of Physiotherapy (CSP) with a membership of physiotherapists and associates working with older people.

In 2012 the CSP produced Assurance Quality (QA) Standards for physiotherapy service delivery. These QA Standards build on and replace the former CSP Core Standards[1] and Service Standards[2] produced in 2000 and the Core Standards of Physiotherapy Practice updated in 2005[3] (CSP) These new QA standards have been mapped against the AGILE standards to produce this 2013 revision, to replace the *Standards of Physiotherapy Practice 2008 Supplementary paper*[4]. As such, it should be read in conjunction with the CSP QA document; it is not a stand-alone paper.

There are additional sources that AGILE members are encouraged to refer to for guidance and update; in particular those produced by the World Confederation of Physical Therapy (WCPT), the Association of International Physical Therapists working with Older People (IPTOP) – itself a WCPT subgroup, National Institute for Health and Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN) and the British Geriatrics Society (BGS).

A quality assurance audit tool (QA tool) has been developed by the CSP to facilitate the comparison of actual service delivery with the criteria in the CSP QA standards.

Content of the Supplementary paper

Additional guidance has only been added where essential. The AGILE Standards Working group recognises that implementing the Standards of Physiotherapy practice may be affected by staffing levels, skill mix, and caseload mix within teams and departments.

Using the Supplementary Paper

AGILE encourages members to use these standards as:

- A guide to appropriate professional standards for the clinician to use during their period of clinical intervention with an older person.
- An educational tool for senior staff when teaching junior staff and students about managing the older person.
- A basis for auditing departmental standards.
- A guide for managers to use with commissioners to demonstrate minimum acceptable quality and service levels for a physiotherapy service concerned with older people.
- A tool to educate members of the interdisciplinary team (IDT) about the work of the physiotherapist specialising in treating the older person.
- A resource for champions of older people to understand the levels of service older people can expect when receiving physiotherapy.
- A guide to physiotherapists when promoting the needs and interests of older people in broader contexts.

Physiotherapists working within specialist teams for older people are encouraged to share this paper with physiotherapists who may treat significant numbers of older people, but where treatment of the older person may not be focussed on as a speciality.

Philosophy

AGILE adheres to several fundamental principles on which physiotherapy practice with older people should be based. These statements of philosophy are:

- Age must not present a barrier to effective, evidenced-based physiotherapeutic treatment.
- Advancing age must not negate the older person's rights to make their own decisions about their treatment and future plans.
- Physiotherapists should be actively involved in health promotion and activities to minimise the effects of physiological ageing on function and to promote a healthy vision of older age.
- Physiotherapy must be directed at maximising function in older age at whatever level, for as long as possible, to promote quality of life for each individual.
- Physiotherapy may have a key role to play in the palliation of symptoms that go with the pathological conditions of older age
- Physiotherapists must play a key role in designing services for older people to ensure equitable access to all forms of health and social care using the current evidence base.

Quality Assurance Standards

Standard 1

Autonomy and accountability

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

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

1.3 Members fulfil their duty of care to service users

1.4 Members demonstrate professionalism at all times

No additional AGILE guidance required

Standard 2

Delivering a safe and effective service Standard

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

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

2.3 Physiotherapy services are delivered in a safe environment

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

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

2.6 The risks of lone working are minimised

2.2 *Additional AGILE guidance*

Physiotherapy with older people used to be a difficult area to recruit physiotherapists and other health professionals into. Development of services, such as dedicated Community Teams, following the publication of the Department of Health (DH) National Service

Framework for Older People (NSFOP) (2001) has altered physiotherapists' perceptions about working with this population. Recruitment has been assisted through the emphasis on promoting flexible working patterns, with attention paid to gaining an appropriate skill mix for the clinical area. Service managers should promote a structured career path for all grades of staff and provide support for suitable staff development opportunities in order to increase recruitment into the clinical area.

Service planning must continue to take account of both demographic changes and changes in service delivery:

There major demographic shift in the population continues to escalate. The number of older people is predicted to rise in proportion to the number of the working age population who are potential health care staff or carers (Figure 1). It is anticipated that there will need to be a substantial rise in physiotherapy posts to maintain services at their current levels in the future.

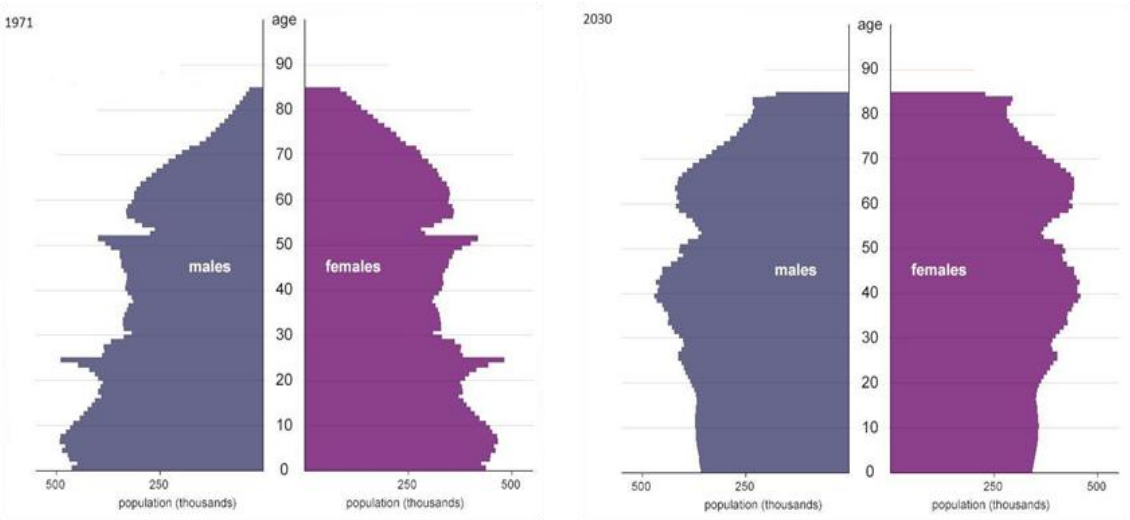

Figure 1: Change in population from 1971 - 2030.

Source: The Office for National Statistics

Expansion in the areas of service provision has continued to rise with the development of step down units, resource centres, community services such as domiciliary visits, community rehabilitation teams, rapid response services and health promotion services.

There is also an increase in the number of assistants becoming Technical Instructor grades altering the skill mix of the qualified physiotherapists to assistant staff ratio. In addition, there has been the development of generic support worker roles.

Debate continues over the impact of delivery of service over 7 days. Whilst some rehabilitation services have implemented 7-day working, there is great variation in how this is achieved and no clear picture of the improved effectiveness of a 7-day service has emerged. If moving towards a 7-day service AGILE strongly advocates that any changes should be fully funded, rather than stretching 5 day cover over 7 days.

The following section does not contain recommended staffing levels, but gives examples of the level of physiotherapy input according to staffing levels and skill mix available in differing areas of clinical practice with older people. Examples are taken from the work of Squires & Hastings (1997)[5], Williams (1991) [6]and the All Wales Physiotherapy Managers Committee (2006)[7] Illustrations are also shown highlighting how current AGILE members make decisions about service provision

The Royal College of Physicians (2000)[8] recommendation is for 1 WTE therapist for 5 rehabilitation patients; whilst an excellent model to strive for, it is recognised that in most areas this may not be achievable due to resource implications.

A survey of AGILE members by Squires & Hastings (1997) resulted in the recommendation of the following levels of staffing for a 52-week period of cover for a 25-bedded unit for older people.

	Staff Physiotherapist WTE	Senior Physiotherapist WTE	Physiotherapy Assistant WTE	Ratio of Physiotherapist : assistant
Acute Unit	0.4	0.6	0.5	1: 0.5
Rehabilitation	0.6	0.9	1.3	1: 0.8
Continuing Care	0.2	0.3	0.3	1: 0.7
Acute & rehab	0.5	0.8	0.4	1: 0.3
Mixed unit	0.4	0.6	0.5	1:0.5

All staffing calculations should allow 20% off duty time for annual, sickness and study leave. Some variations according to staff grades, specialities and responsibilities should be considered. For example, a staff physiotherapist can provide maximum clinical time under supervision, whilst more senior grade staff should undertake a part-time clinical workload, due to supervision of staff and service development responsibilities.

More recent work by the All Wales Physiotherapy Managers Committee recommends the following caseload ratios in Community and Primary Care. A caseload may contain patients not actively receiving treatment but who remain 'on the books'. They remind managers that there is a need to factor in between 10 – 20% uplift for clinical governance and other similar requirements. It is also important to note that the ratios are estimated over 42 weeks.

Area	Ratio Qualified physiotherapist: Caseload held
Day Hospital	1:15
Step – up / step down services	1:15
Re-ablement	1:15
Rapid response / Acute response	1:15
Admissions preventions schemes	1:15
Community Hospital	1:20

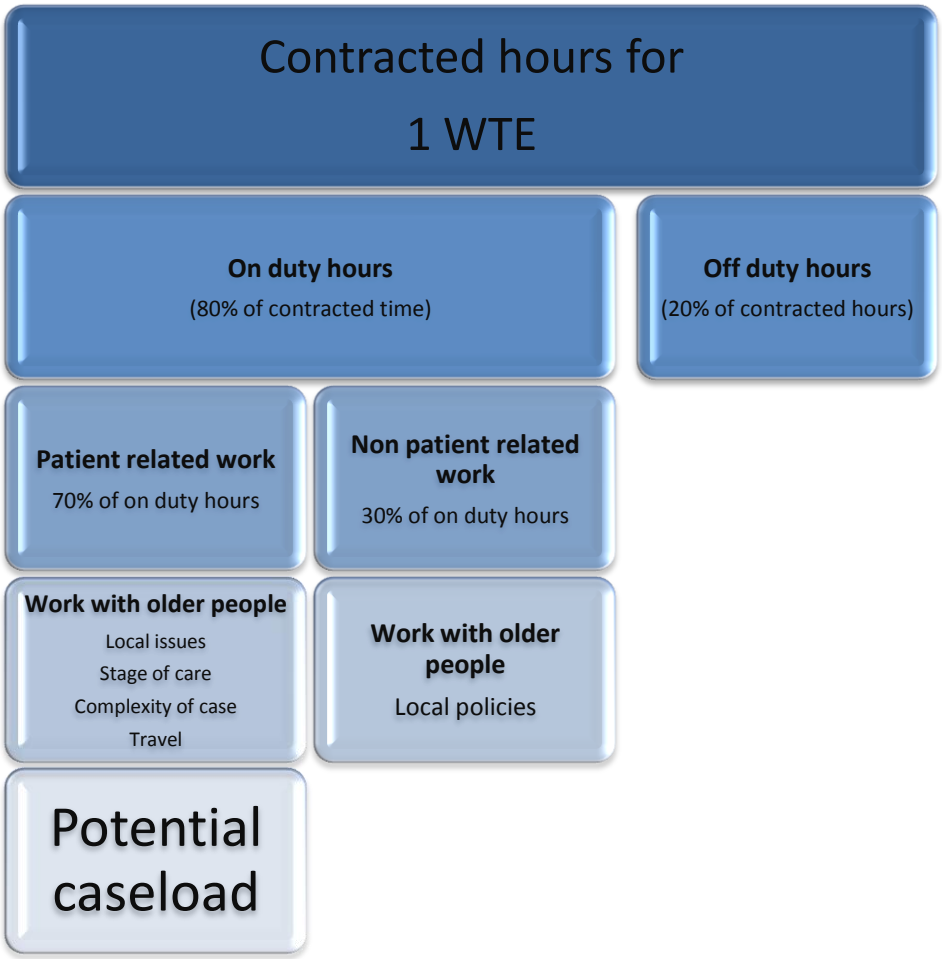

Figure 2: Generic staffing calculation from Williams (1991)

Current examples of services are not provided as many are undergoing restructuring due to the current changes within the NHS, together with many posts being downgraded. AGILE considered that illustrations of staffing would not be helpful with many services utilising new and innovative models of care that still require establishing and testing.

Standard 3

Learning and development

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

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

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

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

Additional AGILE guidance

Physiotherapist leads working with older people should have strategies in place to support the education of their staff. These may be linked to the Personal Development Plans of staff and may meet short, medium or long term learning needs. Each clinical area should have access to appropriate educational materials, which can be tailored to suit an individual's learning styles, requirements and supervision needs. Regular clinical supervision sessions should be held in accordance with local policies. Reference should be made to the AGILE Physiotherapy and Older People[9] booklet when planning the learning requirements of students on placement. The objectives for student placements can be set using the information and checklist provided in AGILE-Thames (2002)[10].

Standard 4

Working in Partnership

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

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

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

Additional AGILE guidance

It is vital when physiotherapists are working with older patients that the expectations and wishes of patients are respected, regardless of their age. The older patient's viewpoint should be considered no less valid because of their advanced age and any associated physical or cognitive impairments. The physiotherapist should communicate a positive attitude regarding the older person and their optimal potential. This positive attitude should also be conveyed to family members, caregivers and members of the Interdisciplinary team (IDT).

Example

Physiotherapists treating older people with balance deficits should aim to rehabilitate any underlying problem. They may offer a number of treatments intended to improve balance rather than automatically accept poor balance as an inevitable feature of old age. Walking aids should be issued when deemed clinically appropriate and not solely as compensation for balance deficits. Not all older people accept the need to use a walking aid, despite the physiotherapist's assessment decision. Whilst many understand the need for safety, to some, a walking aid is associated with an unwelcome sign of frailty. The physiotherapist must acknowledge this decision and try and negotiate a compromise to ensure maximal safety in the light of patient choice

It is important that physiotherapists actively promote an anti – ageist perspective at all times during their professional practice. Physiotherapists should act as advocates and champions for older people both individually and as a demographic group.

Example

A physiotherapist works in rehabilitation for falls prevention. As well as offering advice and exercise to individuals she may also be part of a multiagency group working to promote healthy ageing, safer pavements to reduce trip hazards or accessible transport provision.

Standard 5

Consent

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

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

5.3 Where a service user lacks capacity to consent for themselves the appropriate process is in place to allow a 'best interests decision' to be made under the relevant Mental Health or In/Capacity Acts[11,12,13,14]

Additional AGILE guidance

Physiotherapists are frequently treating older people with varying degrees of cognitive impairment. A diagnosis of dementia or delirium does not automatically mean that a patient is incapable of giving consent to physiotherapy intervention, especially in the early stages. Reference should be made to The Mental Capacity Act which assumes a person has capacity and a lack of capacity has to be clearly determined. All staff working with older persons should ensure that they are able to understand when and how to undertake a capacity assessment. Where a patient is unable to give consent a "Best Interests" decision would need to be made. In Scotland the Adults with Incapacity Act (2000) and the Adult Support and Protection (Scotland) Act 2007[15] provide a framework for safeguarding the welfare and managing the finances of adults who lack capacity due to a mental disorder or who are unable to communicate effectively.

Standard 6

Record Keeping & Information Governance

6.1 Every service user who receives physiotherapy has an appropriate record

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

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

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

Additional AGILE guidance

With increasing technology, and more dependent older individuals receiving physiotherapy services in their own homes, and many have "patient held records" in either electronic or paper format; these should be held in accordance to local policy.

Standard 7

Communication

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

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

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

7.4 Members treat all information in the strictest confidence

7.2 Additional AGILE guidance relating to Health Education

In 2011, the DH published an updated document agreed by the Chief Medical Officers from the four home countries, detailing recommended physical activity levels for the population, including specific guidance for the older population. Physiotherapists should use this guidance to provide information on maintaining fitness and well-being in older age, in general and in terms of local facilities and opportunities. At the end of an episode of care it is particularly important that advice is given to the patient and carers on how to maintain the gains that have been achieved and how to prevent reoccurrence of acute or reversible conditions.

Patients, family and carers should be assisted in understanding the natural course of any progressive or chronic condition and given advice on how they may optimally manage it. Physiotherapists also have a duty for patients with long term conditions to educate family or carers about how to maintain their own health and wellbeing and how to reduce the risk of injury, illness or disability resulting from the work of caring.

7.2 Additional AGILE guidance on Working with Family and carers.

Communication with family/carers should be established, with the patient's consent, as early as possible in each episode of care.

Example

The family and carers are included in goal planning, intervention and discharge planning with their needs considered alongside those of the patient.

Information should be sought on the health and wellbeing of the family or carers, their lifestyle and other responsibilities. This information should be used as part of the goal setting and treatment planning process, depending on the impact it makes on the carers

ability to care for the patient. At all times, especially when dealing with the complexities inherent in working with older people, the therapist must remember that they are the advocate for the patient, and their safety and well-being is paramount.

When teaching the family and carers any procedure involving moving and handling of the older patient, AGILE recommends that guidance given most recently by the CSP[16] plus local moving and handling policies should be followed. Use of these documents usually does not preclude the fact that some people may have developed unique strategies of moving due to existing pathology. It is important that the Physiotherapist takes care not to overload the family/carer in the interests of the caring for the patient.

Example

It may be desirable to teach the husband of a patient with Parkinson's disease appropriate exercises he can assist his wife with. However, if he is already assisting his wife with some aspects of personal care and completing domestic tasks it should be considered if this would be too much of an additional burden of care.

Family / carers should be shown how to develop coping strategies where possible. It may be useful to utilise tools such as the Carer Strain Index[17], bearing in mind that it might highlight to the family member that they may need to seek additional support for their own well being.

Example 1

Family/carers are always made aware of how to contact the physiotherapists they are working with. Once the episode of care is closed, family and carers are informed how to obtain access to physiotherapy advice in the future.

Example 2

Family /carers are given contact details of relevant statutory or voluntary support agencies that could offer additional information or services, e.g. respite care or sitting services.

Empowering the patient to remain active can reduce the call upon therapy services, and therapists should encourage patients, where able, to remain active and undertake the governments recommended physical activity guidelines (2011)[18] ; over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more.

7.3 Additional AGILE guidance

Physiotherapists should be aware that this may now involve communication between agencies outside the NHS due to the increase in new commissioning arrangements and provider-side service agreements. For people with Long Term Conditions, this might include independent providers and charitable organisations.

Standard 8

Physiotherapy management and treatment

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

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

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

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

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

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

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

8.1 Additional AGILE guidance

AGILE acknowledge that health service demands will often outstrip resources, and therefore recommend the following criteria as a guide to prioritisation of their caseload. The physiotherapist will prioritise their input the patients according to guidelines dictated to by resources of staffing levels and skill mix.

1. Life threatening e.g. acute respiratory conditions
2. Timely physiotherapy input will prevent deterioration, enhance rehabilitation, facilitate discharge or prevent re-admission.
3. Chronic conditions and protracted rehabilitation
4. Monitoring and maintenance e.g. potentially deteriorating conditions

(Squires & Hastings 1997)

Access to services should not be restricted by age but be needled. Access difficulties of the older person should be considered, e.g. alternative transport arrangements, collaboration with social care providers.

8.2 & 8.3 Additional AGILE guidance

Physiotherapists have a professional responsibility to maintain an underpinning knowledge of the biopsychosocial changes relating to old age and the impact of these changes on the older person. These changes and the impact of multi-pathology must be considered during the assessment process.

In many settings, the physiotherapist will work as part of an interdisciplinary team (IDT). It is important the physiotherapist coordinates their information gathering to that of the rest of the IDT to minimise duplication of questioning. The use of a Common Assessment Framework (such as a Single Assessment Process, Single Shared Assessment or Unified Assessment Process) where relevant is encouraged (Figure 3). If a physiotherapist takes on extended assessment roles within the IDT then it is essential that appropriate training is undertaken and local policies adhered to.

Figure 3: Assessment process

Older people should be routinely asked whether they have fallen in the past year and asked about the frequency, context and characteristics of any falls (NICE 2004)[19]

Older people may benefit from a comprehensive multidisciplinary assessment such as the British Geriatric Society 'Comprehensive Geriatric assessment'[20] (Figure 4).

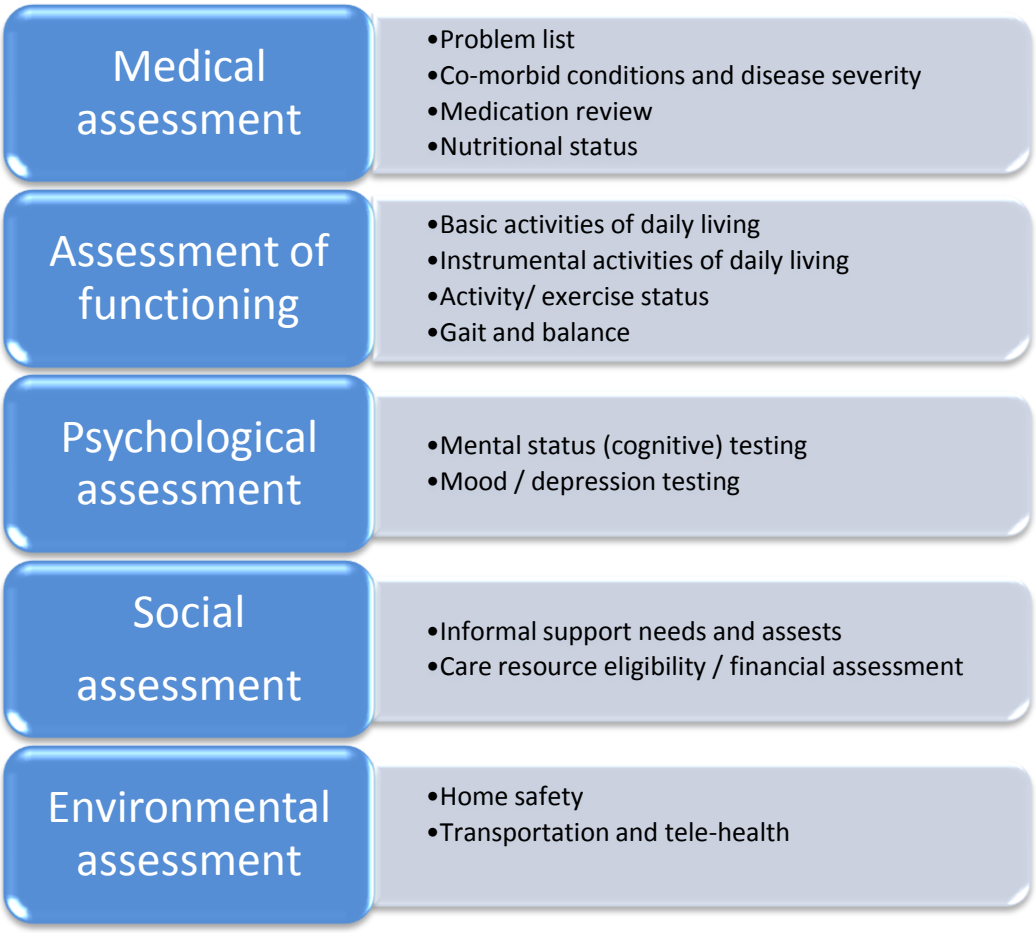

Figure 4: Components of a comprehensive geriatric assessment

8.35 Additional AGILE guidance

Whilst services may have to provide defined measures of assessment and outcome advocated by managers to enable them to share data across the health service, other outcome measures should be chosen by the physiotherapist following assessment and to reflect a particular intervention provided by the physiotherapist. These measures should be sensitive, valid and reliable for use with older people. Information on key outcome measures for use with an older population is available in the AGILE Outcome measures manual[21]. Additional information is available on the CSP website on http://www.csp.org.uk/professional-union/practice/evidence-base/outcome-measures .

Where possible and appropriate the following outcome measures should be used;

a :commended condition/disease specific patient (service user) reported outcome measures (PROM)
b one disease specific performance measure (clinical outcome measure)
c one patient (service user) reported experience measure (PREM)

In practice, measures may be chosen to reflect the whole process of intervention, i.e. they can be used to initially record assessment observations and provide an objective marker which the therapist will use to inform subsequent input. The same tool can then be used to reassess the patient at an appropriate interval and record the change in status.

Additionally, a Service may choose a specific tool to assess their patient population ability and to audit service outcomes.

Example

A physiotherapist treating an older person at risk of falls may use the 'Performance Oriented Mobility Assessment' (POMA) . The overall score can be used to assess the persons risk of falling. The information collected can also be used to highlight specific gait or balance deficits to be addressed during rehabilitation. Reassessment following intervention will identify improvement in specific deficits and a change in overall falls risk.

If physiotherapists in an appropriate setting use the POMA with **all** patients, the scores could be used to define their patient population and pre and post rehabilitation scores could be used to audit the effectiveness of interventions offered.

8.4 Additional AGILE guidance

Physiotherapists are reminded that they should make appropriate modifications to treatment plans to allow for the biopsychosocial changes relating to the ageing process and availability of support networks.

Example

A physiotherapist treating an older person with Parkinson's disease may have to modify her treatment strategy to take account of pre-existing co-pathologies. For example exercises in lying may need to be adapted due to orthopnoea from COPD.

Due to the breadth of conditions encountered when treating older people, physiotherapists should maintain links with other speciality areas to ensure their treatment plans are of optimal quality.

Example

A Physiotherapist treating an older person with lymphoedema should regularly discuss the patients management with the local lymphoedema specialist practitioner to ensure optimal treatment and advice about specialist referral requirements.

There may be a larger number of problems requiring physiotherapy intervention when working with the older patient. Therefore goals should be prioritised, in partnership with the patient, into short, medium and long term goals (Figure 5). As with any patient it is important that SMART goals are set (i.e. specific, measurable, achievable, realistic and timed). The age of the patient should in no way affect the specificity and quality of the goal setting process. Goals must be reviewed regularly with the patient, the date of review recorded and reasons for any failure to achieve goals documented.

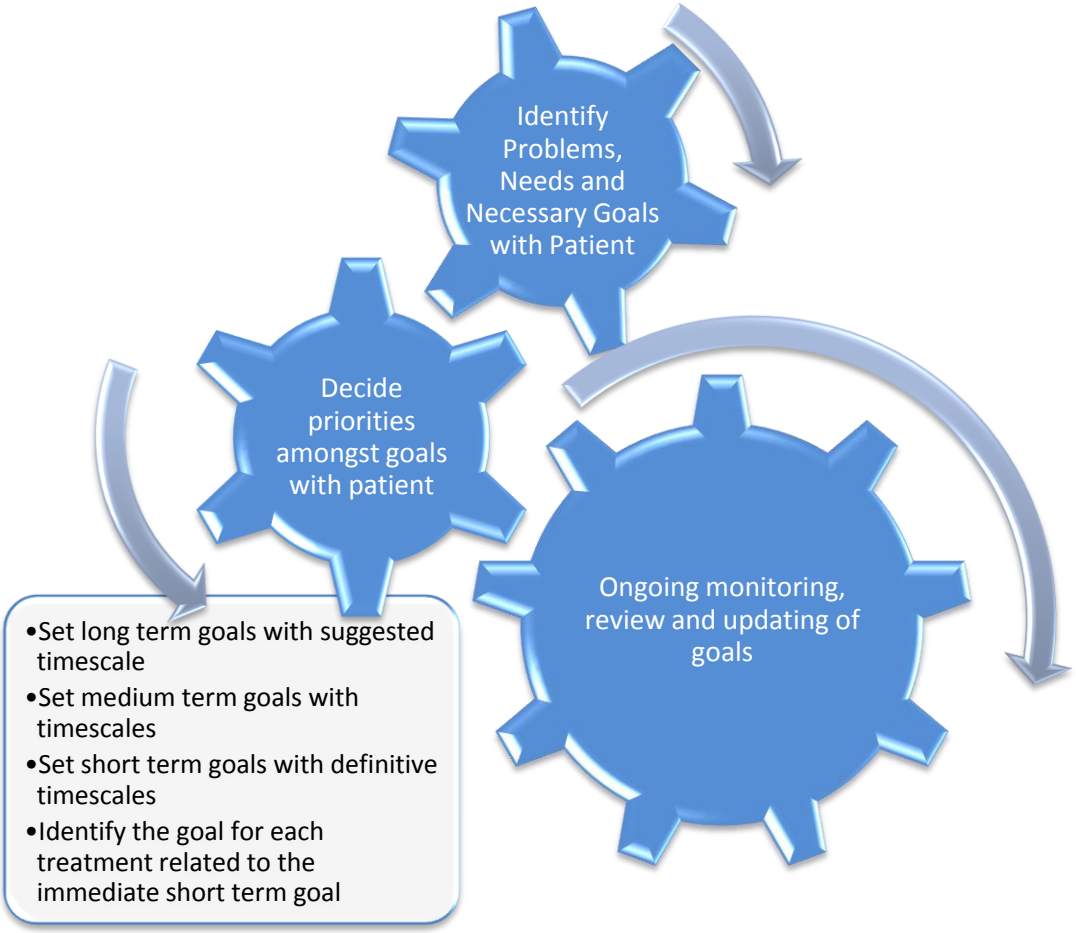

Figure 5: Goal setting

Goal setting may vary in nature when working with older people. There may need to be discussion regarding goals with the patient that explores his perception of his own situation and ability before goals can be agreed. Goals should also be discussed with members of the IDT to ensure an integrated approach to rehabilitation.

Example

A patient with poor balance and decreased standing tolerance may have goals set in physiotherapy to improve these problems. Other members of the IDT should agree these goals so that rehabilitation goals are integrated. For example an Occupational Therapist may work on standing tolerance during ADL activties rather than activities in sitting.

8.5 Additional AGILE guidance

Increasingly, patients are able to self refer for physiotherapy assessment and management. Where self referral occurs the physiotherapist must liaise with other members of the IDT to obtain accurate database information to ensure they make safe and informed decisions with the patient about their treatment options. Examples might be self referral for patients with chronic conditions known to benefit from physiotherapy (e.g. Parkinson's disease).

It is important that the physiotherapy team is led by an experienced and specialised physiotherapist with expertise in the delivery of care to older people, supported by a team with appropriate levels of knowledge and skills. Where that is not possible those physiotherapists treating older people must have access to such a team for advice.

The planning of time allocation in treatment of older people is important. The treatment of the older patient should be planned such that sufficient time is allowed for completion of each treatment session, including a rest, befitting the needs of that person. In addition each physiotherapist's caseload should allow time to treat the patients with sufficient frequency to ensure their realistic clinical objectives are achieved within any given setting.

For patients on a rehabilitation ward, expectation that they will participate in and take some responsibility in their own recovery with the support of staff needs to be encouraged. The physiotherapist may wish to provide the patient with an activity chart along with specific exercise or tasks so that they can record agreed activities daily for review by the therapist. Not only will this act as a visual prompt for set activities, but the patient, family and friends can see their improvement during admission.

8.6 Additional AGILE guidance

Attention to accurate feedback in treating older patients is important and specific feedback should be given during and at the end of treatment as to progress, where possible focusing on achievements to build confidence. As rehabilitation may be lengthy, focussing on shorter term steps towards overall progress may be beneficial.

Care must be taken where improving mobility in patients with cognitive decline as this may result in increasing their falls risk and threat of injury. Full discussion involving the IDT and family is required, especially where a decision to limit a patient's mobility may impact on the support network, equipment, patient mood and health status. Consideration must be taken with regards to patient choice and the capacity to make informed decisions.

8.7 Additional AGILE guidance

The information provided on transfer of care and/or discharge is often more complex than for other patient groups due to the biopsychosocial needs of the older person and the frailty of that group. Information should be provided around how to:

- Maintain or improve existing levels of function.
- Prevent the onset of complications of pre-existing clinical conditions.
- Support current care.
- Maintain specific processes and aspects of care already implemented.

The physiotherapist must also ensure that at the point of transfer or discharge information is given regarding the maintenance, replacement and return of any equipment issued or loaned to the patient.

IDT discussion is required around decision making for continuing care needs, with appropriate paperwork (such as the NHS continuing care checklist) completed where necessary.

Standard 9

Evaluation of clinical care and services

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

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

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

9.4 The effect of the physiotherapeutic intervention

9.1 *Additional AGILE guidance*

Historically, older people services have been underfunded and therefore neglected. Physiotherapists and service managers should facilitate effective service development within physiotherapy for older people. Service developments should primarily take account of the needs of older people as well as effective working for staff. Provision of integrated services between physiotherapy and other health and social care services should be considered for the benefit of the older person. Where possible a joint commissioning approach is recommended[22,23].

9.4: *Additional AGILE guidance*

Outcome measures should be used to evaluate physiotherapeutic intervention and it is good practise to share this information with the service user, explaining the progression, or otherwise, demonstrated.

Standard 10

Promoting, marketing and advertising physiotherapy services and products

10.1 Information provided on services accurately reflects those offered

10.2 Information provided on products accurately reflects those offered

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

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

Additional AGILE guidance

Older patients may often require additional equipment and aids that cannot be provided within current services. Additionally Older patients may purchase or request items that may not be suitable for their presentation. Physiotherapists should only supply or endorse products based on evidence and effectiveness, and when patients are purchasing their own equipment, a choice of product and retailers should be provided.

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