Safety and Quality – Ref247

with Sarah Tribe & Sandra Harding

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TRANSCRIPT

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Steven Bruce
What we're going to 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 osteopathic practice standards and principle A of the code and to help me do that I've got Sandra Harding and Sarah Tribe back I think for the fourth time on the show, Sandra and Sarah I'm sorry, you've been hanging around for so long, while 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
You are used, aren'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 essentially, it's about putting the health interests of patients first and it's about safety and quality in practice. There's a lot of crossover, isn't there, and hopefully, you can give us some good guidelines on how we can meet our own requirements.

Sandra Harding
Okay, so should I say a little bit about ourselves, Steven, as usual first, would that be helpful?

Steven Bruce
Well, I 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 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, lovely 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 link it to osteo, to the chiros 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 into the quality statements, particularly those of 4, 5, 6 and seven, which is a reminder for the chiropractors, that's the safety and risk management quality standard, the policy development quality standard, the patient experience and involvement quality standard and a bit around to the clinical effectiveness and communication.

Steven Bruce
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
Well, there's chiropractic quality statements. So what we thought is, we would link the 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 osteopaths, you've got the GOSc standards. And as you say, the focus today will be on A and on C, which are communication and patient partnership, and C is 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 osteopaths that serve them. IO 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 that's beautiful.

Steven Bruce
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's 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, communication and consent, I'm sure will be part of that.

Sandra Harding
Yeah, it is indeed.

Steven Bruce
Sorry, I'm interrupting you. The GOsC uses 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
It is indeed. So we're gonna go on to the themes, theme A, which is communication and patient partnership, and theme C, safety and quality in 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 will help clarify it. And from the physios 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, 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 A1 for the chiropractors and A1 for the osteopaths. But also A2 and A7 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 and listening to hear them. This is all about listening to hear, so that you don't miss really important factors when you're doing this assessment. And what we would say is, how can you evidence if challenged, that you've acknowledged your client's interests, and you've 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 exist for both clinician and client? And very often, from a client point of view, 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 gown. 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 the shared 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, a tool is 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 r, a, t, e, 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 very obviously show that you have not influenced your patient. But you'll know from the answers, it all should show that you have been involved in the process. And the first question it asks is, and they ask you to go to the patient, how much effort was made to help you understand your health issues? It's marked on a scale of naught 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 patient 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 use this tool to basically cover that off.

Steven Bruce
Can I ask, are you suggesting that after each appointment, we 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, because it's a good way to see if the patient does feel they're involved. And often, if it's a long treatment, it may be done midway through, but it's often done at the end again. So you can actually compare and benchmark yourself, did you actually improve in your scores? Because you learned from the first score, you reflected on it and you improved it as you moved forward during the course of treatment with that particular client?

Steven Bruce
Right. Okay.

Sandra Harding
So if I move on to the next one, we basically want to talk about A2 for the chiropractors from the code which is, respect a patient's privacy, dignity and cultural differences and their rights prescribed by law. From an osteopathic point of view, it's A6, 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 four around risk

management, have you risk assessed the likelihood of invading someone's privacy in your clinic? So thinking about this, are you and could you be seen, if challenged, to have invaded someone's privacy by having someone else in the treatment room with them without gaining their full consent? And we're not going to go in detail into consent, 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 as Gillick competent, you could allow their privacy to be invaded, shouldn't, but you could and would have allowed their privacy 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 18 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. 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 refuses on the treatment, supposing you're going to do a treatment plan with the child, and they say, no, I don't want to have that their refusal can be overwritten. But if they're Gillick 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 overridden by the parent?

Sarah Tribe
Well, no, because the child is Gillick competent. So 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 a matter of really understanding the rights of a Gillick 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's decision not to have treatment can be overridden, regardless of whether they're Gillick competent, then presumably the decision not to have their parent in the room could be overridden. 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 parents there, for example, if you think back to that Gillick competency came from Victoria Gillick, her child who was giving the contraceptive pill, and the GP decided that the parent didn't need to be informed, which is where Gillick competency came from. I think yeah, I think we could debate this for a while. But what I will do is I'll go and find out; I'll go and investigate a little bit more about their parent being in there with them.

Steven Bruce
Thank you. 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 we then have to be suspecting some sort of safeguarding issue I imagine.

Sarah Tribe
Yeah, exactly. Exactly.

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

Sandra Harding
That's absolutely fine. So then, going on a little bit from that, something else that we're thinking when you're risk assessing is, if you have curtains and stood walls, how are we 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 at the other side of a wall, to the extent that they've had 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 we're almost in the zone for want of a better description. So go and sit in the room and get someone to sit next door and just see what can and can't you hear.

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 treatment room, then it will influence what they say to the person in the room. So you might not get a proper case history, regardless of whether anyone actually can hear them. It's what they think is happening.

Sandra Harding
And 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 manage your patient's confidence if you've nipped out to have 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 clinic space and check. Again, if you're, as we find quite a lot of clinics are, you're in a shared space, so there's certain rooms for certain clinicians, make sure you can't hear what's going on if another clinician has a clinic that's the walls next door to yours.

Steven Bruce
Can I put some questions from the audience to you, since 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, was it Darcy did you say, Steven?

Steven Bruce
Yes.

Sandra Harding
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're 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 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 however hard we try not to. So what we're saying is, about 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 answers that one, Steven.

Steven Bruce
Thank you. Someone has also asked 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, potentially if they know that, but is it okay, as long as they know, they can be heard through the curtain?

Sandra Harding
The 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 you are 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 all the things that we've talked about, Steven about, you know, if they think you're 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, does it 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 their 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, is what I would say, I would not be comfortable even if someone said to me, oh, I don't mind. I'm sorry.

Steven Bruce
A curious thing though, Sandra, because we all know if you go into hospital, your consultant makes his ward rounds, he pulls the curtain round, then asks you the most personal questions about what you're doing in there. And you have no choice but, we have a 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 mini clinic space, I would be adhering 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 gonna help. And someone who's

down here as HG 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 big discussion about this. Now, I'm going to come from the CSP stance here, because we've had 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
But of course, the purpose you're keeping it for is to defend yourself against the future complaints. It's pointless if you delete it.

Sandra Harding
That's where we are with the CSP.

Steven Bruce
Oh, no, I understand.

Sandra Harding
We know there's some little nuances of difference in some things. Perhaps I'm gonna pick something up later, between osteo and chiros, and physios. But that's the current one from the physio stance. And I know it can vary depending from time to time, but literally, that is hot off the press earlier this year.

Steven Bruce
Yeah, Simon 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 thinking about the normal person who takes a reasonable view about this. 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?

Sandra Harding
We are indeed.

Steven Bruce
And also looking after 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 actually go further in a complaint, they'll go straight to seek a solicitor's 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 standards around privacy and dignity. And this is why. So we would always say, err 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, 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, as you said, if something goes wrong, you have to 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 it's easier if we don't treat children at all.

Sandra Harding
To be fair, and Lauren, I wouldn't disagree with that. I think if you go into treatment, of course, we need to treat children because they deserve a service like everyone else. But I think if you're going to treat 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's safe, your brand's safe, and you've met the standards. Okay, so can I go a little is that, okay?

Steven Bruce
Yeah, you can go on now.

Sandra Harding
So, still talking about dignity, a few more things that we want you 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 undressing, 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 may never have seen you before, they could be in pain, they've had a leaflet that says they may have to get undressed, they've come into a room that's alien, you've brought them into a room, closed the door behind them and asked 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, they're 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 blasé as

clinicians, because we're used to being in a state of undress, going on training courses where we're in 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 giving out 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 will only be seen by a clinician of the same sex. And if you haven't, how are you going to address that? And also, 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 heighten that state further. And on a final point, 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 range of gynae and the whole menopause and how healthcare professionals could really help to bring down some of these barriers. So 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
You won't be aware of this Sandra, we've just 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 the final little one that I'm going to talk about before I hand over to Sarah, is I'm going to talk about A3 and A7 from the chiropractic code which are 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, C4 is you must take action to keep your patients from harm. So the first thing that's coming to mind here is safeguarding and whistleblowing, two 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 whistleblowers July's. From a safeguarding point of view, I hope we're all aware, but occasionally we 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 your safeguarding contact leads are, have a conversation with them, they'll let you know about themes and concerns that are going in your area so that you're more aware of them. They will also help you with the process and will use flow maps, some have a policy process they'll send, they'll give you the information so that if you're in that very emotive, you're getting real concerns about someone, we would always say, phone your professional bodies, they'll give you advice, you can also speak to the local authority. And they're useful for sense checking if you've got a concern. The uncomfortable one about whistleblowing, again, you go to your own professional body, who may tell you to escalate, obviously, for physios HCPC, etc. The thing with whistleblowing is, and unfortunately, Sarah and I can't 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 harm 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 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 the equipment, what's your process? How are you rechecking it if you're loaning it again? If you've got an equipment servicing, do you know the weight limit of 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 harm, 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 full 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, it's 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 yourselves. And that can be challenged legally, no fully informed consent process means you can be charged for assault and battery.

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

Sandra Harding
Well, some people call it valid, some call it informed, in fact in physio, you can call it verbal consent obtained informed consent obtained, but 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 Montgomery, you have to tell them everything, including, in some cases, there can be risk of death with some procedures, a few people that we work with, particularly osteopaths, we 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 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, stand 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 the equipment being used on them, to coming back out to 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, clients are not baked bean cans on a production line is what Sarah and 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 bring 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 for osteopaths, Sarah is now going to go on with the next few things. So we've covered off that code.

Steven Bruce
Right. So the first thing is, Sarah 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 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
So a Gillick competent child is one that the professional person deems to understand what consent is, there are no specific questions to ask, it's 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 blanketly say, while they're 14, 15, so therefore, I'm just going to get parental consent, you have to weigh it up and make your own judgement as to whether that child can do those three things, understand, weigh it up, and be able to give informed consent. So that's for all chiropractic and osteopathic treatments.

Steven Bruce
So I think the answer to the question that Simon is looking for is well, I wonder in 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 law states that the child, a Gillick competent child is able to give consent for themselves, and to not have their information shared with their caregivers or parents. So you can't just blanketly assume that the child is going to have the parent, you need to be able to determine that that child is not Gillick competent, and therefore the parent needs to be present for parental consent.

Steven Bruce
Again, so I'm trying to put this 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.

Sandra Harding
From an MSK perspective, Steven, for the gentleman who has asked this, you would bring the child in to start the assessment on their own, you could start to have your conversation and then if you feel they're Gillick competent, you can ask the question, would you like your parent to join us or not? And if they say no, then you proceed with the child without the parent. What quite a few of the osteopaths that we work with have done, they documented this in their patient information leaflet, because they feel it's less emotive to make parents aware that they may not be present during the treatment rather than to find out when they turn up and are 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, you could send out a 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, but then obviously if they're there, you need to bring them in because they're not Gillick competent, then you can bring the parent into the room.

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

Sandra Harding
I think that goes back to why somebody said you know, difficult treating children, you've got to really weigh it up.

Steven Bruce
And again, I'm sorry, 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 regulators and 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, 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.

Sandra Harding
Exactly.

Steven Bruce
Go on, then Sarah.

Sarah Tribe
Sandra's covered a lot of it. So I'm just going to 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 A1 of the osteopaths about listening to patients and respecting that individuality, concerns and preferences, and being polite and considerate. So, just some things to add to Sandra's, 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 osteopaths can use family members to chaperone. So just think about using 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., call them Mrs. or Mr. or 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 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 sorts of things that you could ask on this questionnaire is, 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.

Steven Bruce
Can I interject for a second, Sarah? 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 one of the standards of the mandatory training in physios is equality and diversity. So that does apply to physios.

Sandra Harding
Can I just chip in as well. And if you're working in the NHS, it applies to all practitioners.

Steven Bruce
Of course. Yes, yeah, the NHS has its own rules. But we need to make it clear most osteos and chiros are in private practice. And they're not governed by the ACPC. 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.

Sarah Tribe
Yes, yeah. 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 that information is there so that they can choose to come or not.

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

Sarah Tribe
Yeah. So just coming on to the patient's health and welfare, the A5 of the chiropractic and the C6 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 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 to treat frail elderly, who may have dementia, or their capacity may fluctuate, just think about fitting around them rather than them fitting 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 offering them morning appointments, those sorts of things just to sort of think about and then the last one is the A6, which is treat patients in a hygienic and safe environment, and making sure that your practice is safe, clean and hygienic and compliance with health and safety. So just some of the things about well, I don't know, 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 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 waste. Think about your hand hygiene. Have a hand hygiene policy. And again, PPE which we are just coming, there's lots of things around PPE at the moment. So those are just some things to think about. How will I evidence that 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, in physio we have to but 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, Sarah, 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 to have policy writing and stuff like that. So where do they get the templates?

Sarah Tribe
We've got them all on our store.

Steven Bruce
I thought you might have.

Sarah Tribe
Yes, we do. You can do them yourself, or we've got everything on the store, I think Sandra is going to run through a few things that we that we've got.

Sandra Harding
Right. So in a quick pull it together. We have patient info leaflets, policies for informed consent, for safeguarding, for whistleblowing, for quality and 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.hcpg.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, HCPG, 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 second, any other questions while 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 has said very sensibly that, his words or her words, I'd consider a child not wanting to share history or have a parent present during the treatment, a 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 one.

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

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

Steven Bruce
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
Do you want to do your hygiene bit?

Sarah Tribe
Well, yes, 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. So 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. Sandra, 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, then I would. That's personal. I'm speaking personally on there. And Steven, I found your code, it's actually capital letters, shellbag, shell as in on the beach, all one word shellbag.

Steven Bruce
Shellbag, bag as in bag to carry things, so shellbag is your discount code. 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.