Information for the professions allied to medicine

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Physiotherapists are part of the Professions Allied to Medicine (PAMS) who are working closely together in developing clinical terms and user requirements for Clinical Work Stations with the objective of enhancing clinical effectiveness. These professions comprise: chiropody and podiatry, dietetics, occupational therapy, physiotherapy, psychology, and speech and language therapy. This list includes primarily the therapy professions rather than the diagnostic orientated professions, such as radiography and medical laboratory technicians. This is deliberate as the information needs of these professions and the focus of record keeping are different from the diagnostic orientated professions.

It is self-evident that information is required to fulfil a wide range of needs: clinical, research and management information, to name but a few. The Professions Allied to Medicine, because of their small numbers, appear to have had a small impact on the NHS information requirements. However when you add together the number of these professionals, the NHS alone employs at least 60 000 to 70 000. It is therefore only when the professions work together, and that is happening increasingly, that the need for information technology, given the number of patient contacts, becomes evident.

Physiotherapy itself has been looking at its information requirements for a considerable length of time. In 1977 a health circular was published which identified the profession as free-standing, with the ability to take referrals, set its own treatment programmes - using appropriately skilled staff, and all this with minimal reference to the medical practitioner. This obviously raised the profile of adequate record keeping. Only a short while later the requirement for management information across the whole of the NHS was looked at more closely and we were increasingly involved in the Korner initiative. This involved a requirement on physiotherapists to generate management information and a minimum data set was agreed and piloted as long ago as 1982.

Even though the Korner initiative has in effect disappeared, and I do not think there have been too many tears about that, one or two very important principles were established at that time. The most important being that clinicians will only willingly be involved in fulfilling management data requirements if these fall out naturally from clinical data which also allows clinicians research, evaluation and audit facilities. This principle is still true today. It is upon this that the profession has developed its current systems.
Because of the lack of investment in physiotherapy data systems, the profession has developed these themselves, piecemeal, across the country, using a variety of funding and some very sophisticated and highly-tuned systems which are now up and running. Many have been developed locally by physiotherapists themselves and are therefore owned by them. These enable local physiotherapists to undertake limited amounts of audit, evaluation and research, as well as giving physiotherapists specific management and manpower data. These systems often stand alone, and although they may be linked in with hospital PAS system with a master patient index, there are often insufficient terminals to serve all the localities where care is given.

This type of development has also occurred amongst other PAM professions. This historic piecemeal approach to PAM IT is recognised by the IMG and I quote from a document recently published by the NHS Executive Information Management Group on the Integrated Clinical Work Station which states:

- "The PAMs have never had significant political power, from a management point of view they are heterogeneous and the NHS has not been sure how they should be managed. Partly because their role is not primarily to cure medically defined diseases, management have tended not to recognise their importance for the health and self-reliance of the patient. Partly because these activities are spread across all organisational boundaries their vital role for reducing the future resource needs of patients has not been highly rated by any one set of managers. Managers in both the IMG and NHS have appeared to underestimate both the need for a continuous drive towards good clinical information systems and also the exacting requirements imposed by clinical work at the point of care. There is so little understanding of what is wrong, that failures are often explained by the diagnosis that clinicians suffer from IT block. Reality is the other way round, clinicians are keen to have any help they can get for clinical care, they regret the imbalance of current information strategies and the inadequacy of much of the current NHS information technology. Some have struggled to remedy the deficiencies by their own labours."

Please note the emphasis on the clinical needs of the patient in those two paragraphs.

So what are the needs of physiotherapy and the other professions allied to medicine in respect of person-based records? It must be remembered that the PAMs do not work in large numbers in many settings. They are seen in the acute sector, the community sector, working in prevention and health promotion, in GP practices, in clinics, in homes and that is only in the NHS. They usually work in small numbers, and often as part of multi-professional teams. They are not primarily guided by diagnosis as such, but by signs and symptom shown by the patient and the problems these create. The need to assess and identify the goals required of the patient and the problems in the way of achieving such goals. Also the routes by which patients are referred to practitioners vary widely and include self-referral, even in the NHS. The PAMs work on their patients needs, they move from hospital to community and into the patient's homes, that is, they follow the patient.

Current IMG projects in hospitals and in the community, and the interest in sharing information across the NHS, could be greatly assisted by a full understanding of the problems facing the PAMs. To these professions, seamless care is a top priority. The recent introduction of patient access to their own records and the moves particularly
in the community of patient held records is welcomed by the PAMs, as the patient-held record can also be used to give information to the patient about their overall management.

**Partnership**

The different professions use a variety of treatment approaches. All therapists enter into a contract with the patient. Very few of the therapies actually 'do things' to patients. There has to be a willingness for the two parties to work together. Not only must the patient and the therapist be involved in this contract setting process, but also carers and other professionals, to assist the patient to achieve their full physical and psychological potential. It must also be remembered that therapists are increasingly seeing patients over a considerable length of time. This is quite clear when talking about a child with cerebral palsy, but as care moves more into the community and to those with chronic problems, particularly physically disabled people or long-term degenerating neurological conditions, the role of the therapists in the long term care of the patient becomes more important. Therefore information requirements, based on short inpatient episodes for the professions allied to medicine are not helpful and are increasingly inaccurate.

So what do we mean by adequate records? I am sure I do not need to emphasise legible and contemporaneous records. Not only are these required to ensure that the ongoing care of the patient is smooth, but also to fulfil the requirement for audit in respect of standard setting and the need to establish outcome measures from a given intervention. It also has an important legal requirement.

**Record design**

The structure of the physiotherapy clinical record and our legal requirements have an impact on the issues around the multi-disciplinary record. To a very large extent physiotherapists plan their record in a style not dissimilar to that of the medical record. That is a history is taken, signs and symptoms identified, a full assessment is made of the patient and in some instances this can be in considerable detail Ñ the musculo-skeletal system for example. Then a programme of care, or treatment, or management is identified. This is usually goal orientated and set within a problem-solving framework. Time limits may be set and the physiotherapist may also identify programmes for the patient to undertake themselves.

If treatment is given, the specific details of that treatment will need to be recorded. For example, if an electrotherapy treatment is given, then the machine that is used is identified, the dosage, the time and any reaction following it. Also for many electrotherapy activities, a skin test of some kind will need to be undertaken beforehand, and the result noted. This means that, for some patients, lengthy records are required. It is also necessary over a short, sharp treatment time or a long term approach that regular assessments and on-going assessments are carried out. Often patients develop quite bulky physiotherapy treatment files and the storage of these can present quite a problem. Sometimes physiotherapy records get tied up with the medical records at the end of an episode of care and are stored in the medical records department.

The whole question of the storage and maintenance of medical records is one that is increasingly exercising the minds of the NHS. However this is just another issue that
makes information technology increasingly attractive to clinicians, where large amounts of data can be accurately and securely maintained on systems using a small amount of physical space, and can be readily summoned up if required for use as an information tool for the patient. The development of information technology in industry has been wide and varied, and it is only at a relatively late stage that the NHS has come to address this issue. It is important to remind ourselves that the IMG strategic vision is that IT can meet management needs at all levels and simultaneously improve clinical care. The basis of this premise is that operational systems are used by clinicians in their clinical work. Here I must remind you that because of the lack of recognition of the IT requirements of the PAM professions the investment in hardware and software is still badly lacking. Also the perceived needs of the small professions does not inspire the software houses to look at our multi-faceted requirements, hence our enthusiasm for the Clinical Terms Project.

Multi-disciplinary records

Within physiotherapy and the professions allied to medicine detailed records are being put together on a daily basis, however none of us work in isolation. We usually work to promote patient benefit as part of a multi-professional team. Much of this work has been highlighted recently in work on multi-skilling and patient care focused initiatives. The advice the Chartered Society gives to its members involved in such initiatives is, that if the record is able to cope with the amount of information required legally and professionally then we have no difficulty in supporting such activity, be it paper-based or computer held. However, increasingly the multi-disciplinary record is being used as a synonym for a multi-disciplinary care profile. We have no problems with this, but everyone needs to be very clear we are talking about a care profile and not a record.

Care profiles, protocols, anticipated recovery pathways, what ever one cares to call them, are going to be of increasing importance as the patient-focused care approaches are evaluated and the work of the Case Mix Office is brought forward. However these are unlikely to be full records.

So what progress have we made? I became aware, with colleagues, of the work being done by Dr James Read almost four years ago. We had quite informal links with him then, looking at our terms requirements for sometime prior to the setting up of the Clinical Terms Project. We were therefore very pleased to be involved with the other PAMs in October 1992, in the development of the PAMs terms. Similar work being done by SAGNIS and NPIG.

My involvement has been at the PAMs Board level, where all the professions mentioned earlier are represented. For each of the professions, research workers, specialty working groups, teams etc have been working hard. We are all looking forward to completing our work ready for the integrated launch in 1995. Within the last few months the Clinical Professions Information Advisory Group has been formed as a focus for the IMG in respect of these PAMs. This group is heavily involved in the wide range of projects linked to the Clinical Terms Project and the IMG initiatives, such as the Enabling Clinical Systems Programme Board, the Clinical Terms Review Panel and the IM&T Education and Training Initiative. We have also been involved in the Integrated Clinical Work Station Project which looks at the specification of user requirements for the PAMs. The first part of this work has now been completed. I would like to thank Professor Stewart Orr for his tremendous
work in listening to six different professions and putting together an extremely useful document. This has been widely disseminated throughout the profession. Work is continuing on this project.

The presentation of clinical information

I would like to highlight some of the user requirements that have been identified by the professions and Professor Orr. These are required not only for the Clinical Workstation itself, which is of increasing importance to us as this is the main interface between the therapist and the data and what we can get out of it, but will facilitate the production of data which can be usefully used in such activities as health-related groupings, research, audit and outcome measures. These will enable the PAMS to identify more clearly when appropriate and timely interventions are required; when work is effective, efficient and efficacious; and how our scarce resource can be used more effectively within the NHS to enhance patient care.

These user requirements include the responsibility for being accountable and that includes adhering to codes, standards and rules of professional conduct, and ensuring that employers expectations are clearly expressed in protocols and the reporting of untoward incidents. The need for partnership with patients, including the requirement for full information to ensure patients are empowered to play the partnership role identified earlier. To recognise circumstances where care is jeopardised by deficient resources or by actions. The requirement of partnership with other healthcare professionals, the principles of teamwork and the objectives of the team, the role of the named practitioner, the requirement for knowledge of and competence of other members of the team. The conveying of or transmitting of messages on behalf of other team members and giving consideration of the problems and difficulties of a team member. We need to identify and assess needs and problems, observe the circumstances and states of patients, to read and consider the records made by other team members. To carry out the physical, functional and psychological measurements and tests, and to continue to observe and analyse throughout the time of responsibility for the patient.

The responsibility for advising the patient and for gaining informed consent to treatment. We need a plan to give treatment, care and support and therefore there is a requirement to consult and agree the objectives of care and treatment. To implement interventions and other treatments, to request care, treatments and investigations for the patient from other carers. To provide teaching and other aids to the patient's ability to cope. And to keep the patient fully consulted and informed of plans and progress.

There is a need to monitor and control the response to treatment. There is the need to keep and use the clinical record. That means making the records available to authorised management, audit, evaluation and research processes and also for improving the clinicians own professional competence. To maintain advanced knowledge and skills and to recognise limits to professional competence and identify development requirements.

These user requirements are important to the system. The Clinical Terms System arising from it should enable future clinicians, be they physiotherapists, dieticians, nurses, medical practitioners or managers, to clearly identify patients requirements and needs and to match them with the most efficient and most effective way of delivering them within the resource allocation allowed.
Discussion

Hugh Fisher
NHS Information Management Centre

I have two questions. One is, do you give any IM or IMT training to students as part of their course for the Chartered Society qualification? The other is that you talk of professional standards, are you having to collaborate with European physiotherapists to align standards across Europe?

Penny Robinson
First of all, IT is now within the core curriculum for physiotherapy. What we are doing as part of the IM&T training programme that is being undertaken by the NHSTD is a survey of both undergraduate and post-graduate information technology programmes across all the PAMS, that also includes radiographers and MLSOs. There is a big project going on at the moment. The person responsible for the undergraduate questionnaire is Robin Shutt, from the University of East Anglia, who is a physiotherapist. An occupational therapist from Cardiff is doing the post-graduate work.

Now standards. The Chartered Society of Physiotherapy produces a handbook on standards for clinical practice which covers routine standards in respect of rules of professional conduct, informed consent and others. All our twenty clinical interest groups have set down standards in respect of various key areas. That can be anything involving a technique such as acupuncture or manipulation, through to client based groupings such as paediatrics or care of the elderly. We have a wide range.

Our standards do not have to comply with European standards. However we do belong to the World Confederation of Physical Therapy and the Standing Liaison Committee of Physiotherapists in Europe. There is certainly some bench marking going on. One thing I need to mention is that it is very clear in physiotherapy, and I think it applies to some of the other PAMS, that a physiotherapist is not a physiotherapist throughout the world. We all come from very different roots. In this country our roots come from nursing and massage in nursing. The profession is one hundred years old this year. Whereas in Europe they come from bath masters and spas. The different background gives a different emphasis on the physiotherapy they give. For example if you go to Germany the physiotherapy will not be the same as you would get in this country.