Advanced Musculoskeletal Physiotherapy Operational Framework
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Foreword

The Victorian Government is committed to achieving the best health and wellbeing for all Victorians. In achieving this goal, the government recognises the critical role that health workforce plays in the delivery of high-quality sustainable health services.

The ageing population and increasing burden of chronic disease present new challenges to health service delivery in Victoria. Similarly, evolving technologies and models of care also generate new opportunities for us to develop and grow our health system for the future.

Improved utilisation of the skills of allied health professionals through advanced scope of practice roles is one aspect of a suite of activities designed to support workforce sustainability and improve the system’s capacity to meet the community’s current and future healthcare needs.

Advanced musculoskeletal physiotherapy services are widely established in the United Kingdom and Canada, and have been shown to improve patient and service outcomes. In Victoria, advanced musculoskeletal physiotherapy services across public health organisations have been steadily evolving in response to need.

This commenced with the physiotherapy led orthopaedic screening clinics and the Osteoarthritis Hip and Knee Service (OAHKS), and now includes roles in other medical service delivery streams such as the post-arthroplasty review clinics, the physiotherapy led neurosurgery spinal screening clinic, physiotherapy led paediatric orthopaedic clinic and chronic pain clinics.

These roles have strong support from the key medical units involved. They improve relevant organisational key performance indicators (KPIs), and enhance patient and staff satisfaction.

The successful implementation of advanced musculoskeletal physiotherapy services requires significant organisational preparation, including developing operational policies and procedures, clinical governance mechanisms and ensuring the capability of the advanced musculoskeletal physiotherapist. This has been identified as a barrier to their wider uptake and limits the full potential benefits that these roles can bring to the health system.

In response, the Department of Health (the department) has funded Alfred Health to develop the Advanced Musculoskeletal Physiotherapy Operational Framework (the framework), which provides information and guidance to enhance the utilisation of advanced musculoskeletal physiotherapy services in health services throughout Victoria.

The framework has been developed as a step-by-step guide for organisations to develop and establish advanced musculoskeletal physiotherapy services. It describes the operational aspects of implementing a new service and should be reviewed alongside the Advanced Musculoskeletal Physiotherapy Clinical Education Framework and the Advanced Musculoskeletal Physiotherapy Evaluation Framework.

Together, these three frameworks and supporting resources address the constituent elements of the Victorian Clinical Governance Policy Framework for clinical governance of advanced musculoskeletal physiotherapy services.
This framework was developed and refined in close consultation with clinicians from a range of health services and other key stakeholders. It is recognised that not all elements of this framework will apply to all healthcare environments and settings, and that different organisational structures, policies and procedures will require local adaptations.

In closing, I would like to thank all those who participated in the consultation process and who provided input and feedback in the development of the framework. Your time, effort and expertise is appreciated and greatly valued by the department.

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Introduction

In recent years, there has been an increase in the introduction of advanced musculoskeletal physiotherapy (AMP) services in Victoria. These services utilise the expertise of experienced musculoskeletal physiotherapists with postgraduate training, to work in roles traditionally undertaken by medical staff, who manage musculoskeletal conditions presenting to emergency departments, orthopaedic and neurosurgical outpatient clinics.

Advanced practice is defined below, according to the Australian Physiotherapy Association definition:

**Advanced scope of practice** – A role that is within the currently recognised scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role may require additional training, as well as significant professional experience and competency development.¹

One objective of the AMP services is to provide a high quality service to patients in a timely manner. Another objective is to work collaboratively with healthcare teams to reduce the burden of increasing demand, enabling doctors to treat patients who are acutely unwell or require surgical intervention.

The musculoskeletal physiotherapists undergo competency assessment, then work more autonomously with close consultation. Working in the area of AMP, the physiotherapists conduct a thorough clinical assessment, providing a working diagnosis and comprehensive management plan for patients presenting with musculoskeletal conditions. When necessary, they interpret investigations such as plain film imaging, and they liaise and refer to specialist medical teams, general practitioners (GPs) and other health professionals.

Until recently, there have been no recognised or standardised supporting frameworks for the implementation of AMP services that define:

- the operational policies and procedures
- the clinical and educational training pathways for physiotherapists
- competency and credentialing for these roles
- clinical governance of these services
- the process for monitoring, evaluating and reporting service delivery.

The Advanced Musculoskeletal Physiotherapy Operational Framework (the framework) has been developed as a step-by-step guide for organisations in implementing AMP services (Figure 1). It describes the operational aspects of implementing a new service and should be reviewed alongside the Advanced Musculoskeletal Physiotherapy Clinical Education Framework and the Advanced Musculoskeletal Physiotherapy Evaluation Framework.

These three frameworks and supporting resources provide the components for clinical governance of AMP services as they fit within the Victorian Department of Health Clinical Governance Policy Framework. The Advanced Musculoskeletal Physiotherapy Evaluation Framework is based on the Victorian Innovation and Reform Impact Assessment Framework (VIRIAF – Figure 4), which was developed by the Victorian Department of Health to understand and measure the impact of new workforce models.

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This operational framework is based on the experiences of implementing AMP services in one major metropolitan organisation. It has been developed and refined in close consultation with key stakeholders from a range of health services.

It is recognised that not all elements of this framework will apply to all healthcare environments and settings. Different organisational structures, policies and procedures need to be considered, and local adaptations should be made accordingly.
Figure 1. Advanced Musculoskeletal Physiotherapy Frameworks

Victorian Department of Health Clinical Governance Framework

- Clinical Governance Guideline
- 4 Domains of Quality and Safety
- Consumer Participation
- Clinical Effectiveness
- Effective Workforce
- Risk Management

Operational Framework
- Conceptual Stage
- Planning Stage
- Implementation Stage
- Evaluation Stage
- Operational Guideline (Template)
- Orientation Manual (Template)

Clinical Education Framework

- Model of Care
- Scope of Practice
- Service Description
- Job Description Template
- Governance Structure
- Risk Register
- Adverse Event Management

Evaluation Framework
- Ethics
- VIRIAF*
- Key Outcomes / Indicators
- Monitoring / Review of Service Processes

Supporting Resources
- Consumer Participation Policy
- Patient Education Handouts

- Pathway to competence in the work-place
- Competency Standard
- Learning Needs Analysis
- Learning/Assessment Plan
- Learning Modules
- Supervision and Mentoring Program
- University Subjects^
- Competency Assessment

* Victorian Innovation and Reform Impact and Assessment Framework
^ If required by the local organisation
Background

Over the past decade, AMP services have been established in the United Kingdom (UK) and Canada. In the UK, significant healthcare reform in the NHS has led to the evolution of advanced practice to include extended scope of practice (for example, limited independent prescribing). Consequently, much of the evidence for these physiotherapy services originates from the UK.

The Victorian Public Healthcare system is facing similar increasing demands experienced by the National Health Service in the UK, particularly in the outpatient and emergency departments. While there are some elements of healthcare delivery that differ between the National Health Service and the Victorian public healthcare sector, particularly in the size of population being serviced, the close alignment in professional physiotherapy practice between the UK and Australia provides an ideal opportunity for Australian physiotherapists to learn from the work done to date in the UK in the area of AMP services.

The success in the UK of AMP services in improving patient and service outcomes, such as decreased waiting times, has been widely reported with findings that 60 to 63 per cent of referrals to an orthopaedic outpatient clinic were appropriate for non-surgical management and could be managed safely by a physiotherapist.

Furthermore, there is emerging evidence that advanced physiotherapy roles provide equal or better than usual care, in comparison to physicians in terms of diagnostic accuracy of soft tissue injuries, treatment effectiveness, healthcare resources utilisation, economic costs and patient satisfaction.

Although physiotherapy practice in Australia is well aligned with the UK, the published evidence supporting the implementation of AMP services needs to be considered in the context of a different healthcare system servicing a different demographic.

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In Victoria, AMP services across public health organisations have been steadily evolving in response to need from the initial physiotherapy led orthopaedic screening clinic to include roles in a number of other medical service delivery streams. These services include the:

- AMP service in the emergency department (ED)
- Osteoarthritis Hip and Knee Service (OAHKS)
- Post-arthroplasty review (PAR) clinic
- Physiotherapy led neurosurgery spinal screening clinic
- Neurosurgery post-operative physiotherapy review clinic
- Emergency department soft tissue review clinic
- Physiotherapy-led rheumatology screening clinic
- Physiotherapy-led paediatric orthopaedic clinic.
- Development dysplasia of the hip ultrasound clinic (paeds)
- Chronic pain clinics.

The value of AMP roles is demonstrated by the strong support provided from the key medical units involved with these services, by improvements in relevant organisational key performance indicators (KPIs), and with patient and staff satisfaction surveys consistently indicating high levels of satisfaction.

These roles are now established at several Victorian public health services and are embedded in standard service delivery. However, further work is required to unlock the full potential of these roles in improving quality and access to services, to ensure their sustainability and to facilitate their uptake across all Victorian public health services.

Establishing standardised operational policies and procedures to establish and support AMP services, and articulating the required training pathway and competency assessments are key steps in supporting the successful integration of these roles into usual service delivery in health services and ensuring best health outcomes.

A standardised approach to the delivery of AMP services across the Victorian public hospital network is important to:

- Support high-quality care while minimising risks to patients
- Ensure that consistency of practice between organisations prevents confusion for non-physiotherapy healthcare professionals and patients
- Ensure education and training for physiotherapists that is recognised and transferable between organisations
- Define workplace competency assessments that are recognised and transferable between organisations
- Maintain a highly skilled workforce and greater critical mass of physiotherapists to support the sustainability of services
- Report and monitor consistent outcomes, creating opportunity for a statewide evaluation of services that identifies opportunities for future service development.
Scope of practice
The Australian Physiotherapy Association (APA) definition of advanced practice\(^\text{12}\) has been used in this framework and applied to AMP services. The framework refers to AMP and does not include extended scope of practice.

Purpose
The framework provides a guide for the implementation of an AMP service.

The framework will support organisations to implement AMP roles using a standardised approach and by providing an understanding of the underpinning processes (including education, training, and evaluation) required to establish a new AMP service.

The framework supports the provision of high-quality care, encourages a model of care that supports transferability of physiotherapists working between AMP roles and promotes sustainability of these services into the future.

The framework applies to the implementation of AMP roles. However, it may be of use in other advanced physiotherapy roles.

Audience
- Musculoskeletal physiotherapists working in the public hospital sector
- Managers of physiotherapy
- Directors of allied health
- Relevant staff of emergency and outpatient departments

\(^\text{12}\) The following is taken from the Australian Physiotherapy Association (APA) position statement titled Scope of Practice (2009). The terms ‘extended scope of practice’ and ‘advanced scope of practice’ are often used interchangeably, which leads to some confusion when discussing these issues. Unfortunately, there are no agreed definitions within health professions in Australia regarding how these terms are defined. The Australian Physiotherapy Association (APA) supports the following definitions:

**Advanced scope of practice** – a role that is within the currently recognised scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role may require additional training, as well as significant professional experience and competency development.

**Extended scope of practice** – a role that is outside the currently recognised scope of practice and one that requires some method of credentialing following additional training, competency development, and significant professional experience, as well as legislative change.
Four stages of the framework

The four stages of the operational framework are the:

1. conceptual stage
2. planning stage
3. implementation stage
4. evaluation stage.

The key to implementing successful AMP services is to allocate the necessary time and effort required for the conceptual and planning stages. It is recommended that a senior, experienced physiotherapist (grade 3 or 4 job classification), with extensive clinical expertise in the musculoskeletal area, and experience in service delivery and evaluation, drives the implementation of the service.

Choosing the right staff member for the job is critical for success and a team approach to service delivery is essential when establishing AMP services.

Key questions to consider are listed for each stage of the framework. The questions can be used as a checklist to guide progress throughout the four stages. Organisations with AMP services already in place may not need to work through every stage. These stages are shown in Figure 2.
Advanced Musculoskeletal Physiotherapy Operational Framework

Figure 2. Stages of the operational framework

1. Conceptual Stage
   - Establish the evidence to support the need
   - Review of current practice – local, national and international
   - Establish best evidenced based practice
   - Proposed model of care/service and benefits
   - Identify Barriers and Enablers

2. Planning Stage
   - Victorian Clinical Governance Policy Framework
   - Project plan / Operational guidelines
   - Clinical Education Framework – education and training
   - Recruitment according to selection criteria

3. Implementation Stage
   - Orientation program and commence service
   - Monitor, review and change accordingly
   - Achieve competency of physiotherapist(s)

4. Evaluation Stage
   - VIRIAF*
   - Patient outcomes
   - Organisational outcomes
   - Clinician outcomes

   Evaluation template – baseline, interim and final (inclusive of ethics submission)

   Identify, Engage and Consult with Key Stakeholders

   Secure funding for the service
   Ongoing development and future directions/planning

* Victorian Innovation and Reform Impact Assessment Framework
1. Conceptual stage

The conceptual stage outlines the steps to establish the service need and justify the implementation of AMP services.

Key considerations

1.1 Establish evidence to support need
• Is there a need for this service that aligns with:
  – patient priorities?
  – organisational priorities?
  – broader healthcare priorities?
• What is the evidence to support this?

1.2 Review of current practice
• What models of care are currently in place in your organisation?
• Are there similar models of care utilising the advanced physiotherapy model already in place elsewhere – within your organisation, locally, nationally and internationally?

1.3 Evidence-based practice
• What is considered best practice?
• Is this model of care evidence based?

1.4 Model of care: service description and benefits
What is the proposed model of care and service?
• What are the benefits?
• Who will provide this service?
  – What are their roles and responsibilities?

1.5 Barriers and enablers
• What are the potential and real barriers and enablers to implementation?
  – What is the likelihood these barriers can be overcome?
• How will change be managed?

1.6 Key stakeholders
• Who are the key stakeholders?
• Are they supportive?
• Is there a clinical champion?

1.7 What are the funding opportunities to support the service?
1.1 Establish evidence to support need

The service needs to be aligned with a range of factors.

**Patient priorities**

- The proposed service should be directed at meeting the needs of the patient.
- Identify where there are unmet patient demands and populations that will benefit from the proposed service. Include:
  - long waiting times
  - high presentations of musculoskeletal conditions.
- Identify changes in patient needs that have not been recognised.

**Example**

Taylor et al.\(^\text{13}\) reported experienced primary contact musculoskeletal physiotherapists working in ED had decreased waiting times and length of stay for patients without adverse effects.

**Actions**

- Familiarise yourself with relevant literature (for example, Lau et al.\(^\text{14}\))
- Determine the best method to demonstrate the service need from the patient’s perspective.

**Organisational priorities**

To ensure recognition by the organisation, accurate definition of the gap in service provision is required by:

- identifying the organisational priorities
- considering the organisation’s KPIs
- defining the gaps in service delivery, for example, delays in access to services
- highlighting changes to the demographic profile that may have contributed to increases in demand.

**Example**

The literature has reported that doctors least prefer to treat patients with back pain in the ED – this results in long waiting times for back pain patients and creates a gap in the service delivery that can be filled by a musculoskeletal physiotherapist.\(^\text{15}\)

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Broader healthcare priorities

The case for building AMP services can be supported by the broader issues impacting healthcare services. Consider that:

- the World Health Organization has extended the Bone and Joint Decade to carry over into this decade\(^\text{16}\)
- the rising burden of musculoskeletal disease has been recognised on an international stage. With the increasing obesity epidemic and ageing population in Australia, the demands on public healthcare are projected to rise dramatically nationally\(^\text{17}\)
- healthcare reform in Australia is currently high on the policy agenda. Workforce changes are required to cope with the increasing and changing demand\(^\text{18}\)
- Medical workforce shortages are expected to rise.\(^\text{19}\)

It is important to be well informed of the issues outside of physiotherapy and the individual organisation. The burden of musculoskeletal conditions is topical at present, as it is projected to worsen with associated health service impact.\(^\text{16}\) This creates an ideal opportunity for musculoskeletal physiotherapists who can offer solutions to some of these wider healthcare issues.

Action

Familiarise yourself with state and national healthcare issues. Additionally, keep up to date with what is going on overseas, for instance, with advanced and extended scope physiotherapy roles in the UK.

Key resources


Useful websites highlighting musculoskeletal disorders as a national health priority for Australia include:

- www.bjd.org.au

\(^\text{16}\) Bone and Joint Australia, What is the Bone and Joint Decade?, accessed March 3, 2013. <www.bjd.org.au>


\(^\text{19}\) Ibid
What is the evidence to support the need for the service?

If there is no data to establish and quantify that there is an unmet need, it is unlikely the service will be funded. Data is required as evidence for the service and to form the baseline data to evaluate the impact of the service. The evaluation template provides examples of what data could be collected (see Appendix A), which include:

- gathering available quantitative data to support the service need
- requiring the clinical lead appointed to the role to be up to date with all relevant literature
- reviewing clinical and non-clinical information from other health services that have already implemented similar services
- having extensive clinical knowledge in the proposed area of practice, which is essential to gain confidence and respect from the medical key stakeholders
- identifying relevant evidence-based guidelines to support how the proposed service will operate.

Actions

- Investigate what routine information your organisation collects and reports on. Who is the key contact person to provide this information?
- Familiarise yourself with key references relevant to the model of care and service being proposed.

Key resources


Additional resources


1.2 Review of current practice

**What is the current model of care?**

A review of the current model of care provides useful information that contributes to establishing the need for the new service and will be utilised in the planning stage. This review should:

- identify the team of people involved, their defined roles, who will need to be consulted and what impact a service change might have on them
- recognise strengths and weaknesses of the existing service
- investigate the IT and administrative services supporting existing services
- identify the process for ordering investigations, referrals and outpatient appointments
- utilise existing data routinely collected
- include process mapping and map out the patient’s journey and needs
• determine where bottlenecks and inefficiencies are occurring
• identify if best practice is occurring
• analyse existing protocols and guidelines, and whether they need to be updated
• identify where resources exist to support the service, for example, patient information
• identify the geographical layout of the ED or outpatient services and the location of where the physiotherapist will be based (inclusive of office space).

Action
Review NHS process mapping, analysis and redesign.20

Are there alternative models of care already in place?
If a thorough background literature search has been done, then similar models of care should have been identified, from within the organisation, locally, nationally and internationally. Other professions, such as nursing, have implemented advanced practice roles and have excellent resources from both here in Australia and the UK, which can be adapted to support the AMP role.

In addition to peer-reviewed publications, seek out other relevant publications and contact colleagues from other health services to discuss their experiences. Consider:
• learning from others by liaising with other health organisations and clinicians who have similar services or models of care already in place
• visiting other hospitals and observe clinics in operation. This encourages networking with other health professionals and can save considerable time in the planning stages
• networking with other musculoskeletal physiotherapists currently working in advanced musculoskeletal roles through the APA advanced practice special interest group, APA ED special interest group, and the OAHKS special interest group.

Key resources


Advanced Practice Physiotherapy in Canada (arthroplasty) <http://sunnybrook.ca/content/?page=Focus_MSK_Prog_HKAP_APP_Home>

Arthroplasty Care Practitioners Association (UK) <http://acpa-uk.net/>

1.3 Evidence-based practice

What is considered best practice?

Ensure the proposed model of care adheres to evidence-based guidelines and provides examples, such as for low back pain.

An important responsibility of the AMP role is to accurately identify which presentations require specialist referral or conservative management. For many common musculoskeletal conditions (such as shoulder pain), conservative management is considered best practice, supporting the presence of AMP services. Additionally, it has demonstrated that for some specific musculoskeletal conditions, like mechanical low back pain, the first point for primary care can be non-medical.21

Safe and appropriate orders for diagnostic investigations (for example, imaging) need to be based on evidence-based practice guidelines. Establishing good working relationships and early consultation with the radiology department is important in facilitating this process.

Key resources


National Institute for Health and Clinical Excellence (NICE) guidelines:

- The care and management of osteoarthritis <http://www.nice.org.uk/CG59>
- Low back pain <http://www.nice.org.uk/CG88>

For best practice in ordering of imaging:

Ottawa ankle rules:


Ottawa knee rules:


Canadian C spine guidelines:


Western Australia – imaging guidelines:


1.4 Model of care: service description and benefits

What is the proposed model of care and service?

The proposed model of care should capitalise on the clinical expertise that a musculoskeletal physiotherapist can bring to the organisation. The AMP service should aim to reduce the demand on medical staff, while maintaining high-quality care and improving access for the patient.

The proposed model should highlight how the musculoskeletal physiotherapy role can effectively manage musculoskeletal conditions, thereby enabling medical staff to treat patients who are acutely unwell or have more complex conditions.

Physiotherapy roles in the public hospital sector have traditionally operated as secondary care healthcare providers. However, physiotherapists are trained as primary contact healthcare providers and have the clinical diagnostic and decision-making skills that complement the requirements for AMP roles. These skills sets and training should be highlighted when proposing the model of care and service to be implemented.

When developing the model of care and service to be implemented:

- map out on a flow chart of how the service will operate, so key stakeholders can be well informed from the beginning (see Appendix B)
- define and document the accountability and responsibilities of the advanced musculoskeletal physiotherapist. In most cases, the physiotherapist with clinical responsibilities on the day will be under supervision of a consultant from the relevant medical team, while overall accountability will sit within physiotherapy. Clearly outline how this will work operationally in the particular service context, relative to the local organisational structure. This should be detailed further in the clinical governance framework for the service (see Appendix C).

What are the benefits?

- Benefits to the patient:
  - are demonstrated by many examples of improved patient satisfaction, improved patient flow and access to services.22,23
- Benefits to the organisation:
  - should be reflected in the service evaluation and target the KPIs that are important to the organisation including:
    - National emergency access target (NEAT)
    - outpatient waiting times
    - reduced admission rates
    - reduced orthopaedic clinic referrals.

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• Benefits to the workforce:
  – are reflected in highlighting current ED medical workforce shortages\textsuperscript{24}
  – include identifying opportunities to share knowledge and expertise in musculoskeletal conditions with training of junior medical staff
  – include improved satisfaction for both medical and physiotherapy staff.
• Benefits to the wider healthcare community:
  – include improved links with GPs, community centres and services
  – are achieved when involvement of the healthcare community in evaluation of these services raises awareness, encourages networking between health professionals and improves access to the appropriate healthcare for patients.
• Benefits to the physiotherapy profession:
  – include improved workforce retention
  – are achieved with improved career structure and career opportunities.

Examples
See Appendix D for an example of how the patient’s journey could be improved with service changes to current models of care.

Action
Utilise examples from other health services.

Who will provide this service and what are their roles and responsibilities?
Consider the different roles that may be required to establish a new service.

Musculoskeletal physiotherapist – clinical lead/service implementation (preferably grade 4)\textsuperscript{25}
This role has responsibility for leading the service change across all four stages, from the conceptual stage, through the planning stage, implementation stage and finally the evaluation stage. They are the key person liaising with stakeholders and developing working relationships critical to the success of embedding the new service.

The clinical lead, in addition to being responsible for service implementation and delivery, will also be responsible for education and training of new staff, competency assessment, ongoing service development, and evaluation once the service is established. Time must be allocated to allow the physiotherapist to complete the non-clinical tasks associated with service implementation.

The key attributes essential to the clinical lead are:
• excellent communication skills
• excellent negotiation skills and conflict resolution
• experience with change management and service evaluation
• strong clinical expertise and knowledge of the service area proposed
• ideally, already established working relationships with key stakeholders
• skills in research and quality projects.


\textsuperscript{25} Classification as per Health Professional Services – Public Sector – Victorian Award
Musculoskeletal physiotherapist – service delivery (grade 3)²⁶

This role predominantly involves provision of a high-quality musculoskeletal physiotherapy service. The physiotherapist may be in the process of developing their advanced skills and expertise. The degree of supervision required initially will be established based on a learning needs analysis and the physiotherapist’s years of experience. This role supports the clinical lead, allowing the clinical lead non-clinical time, without interrupting service delivery. The allocation of these roles may vary between organisations.

The physiotherapists responsible for establishing new AMP services should be integrated into the existing musculoskeletal physiotherapy outpatient team. The location of the emergency department or medical outpatient clinics can be geographically remote from the physiotherapy department and limit interaction with physiotherapy colleagues.

The recommended approach is to have more than one physiotherapist trained to work across the different AMP services. A team approach provides additional opportunities for continuing education, with shared learning, peer support, weekend and leave cover (for ED services), and ensures a sustainable service.

Consideration of staffing cover for planned and unplanned absences should be outlined early in the process. As mentioned previously, a service provided by a solo physiotherapist not integrated into the physiotherapy department is not sustainable.

See Appendix E for an example of a musculoskeletal physiotherapist position description.

1.5 Barriers and enablers

What are the barriers and can they be overcome?

Identify the likely barriers to implementation early. Barriers may be:

- geographical and physical issues, such as:
  - available space
  - limitations with IT systems for requesting imaging or outpatient scheduling of appointments
- professional issues, including:
  - concerns regarding patient safety and quality of care
  - lack of understanding of proposed role
  - concerns regarding professional boundaries and legal accountability
  - concerns regarding impact on medical training
  - traditional custom and practice
- general resistance
- concerns regarding impact on workloads
- staffing issues related to:
  - clerical or outpatient administrative support
  - weekend work
  - reorganisation of existing roles
  - funding limitations.

²⁶ Classification as per Health Professional Services – Public Sector – Victorian Award
Managing change

Effectively managing change is an essential part of implementing any workforce innovation or reform. It requires careful consideration of which change management strategy will be the most appropriate for the particular size and scope of the project. Further information about change management is available in the paper Successfully Implementing Change.27

Example

With the introduction of the post-arthroplasty review clinic, there may be some resistance from orthopaedic surgeons who are unsure about having their patients reviewed by physiotherapists. It may be necessary to introduce this service gradually, and start by reviewing patients at later post-operative review appointments scheduled for six or 12 months. In the first instance, this might be only for those surgeons who are comfortable with the new service.

As the service is implemented, confidence usually grows in the clinic and once the evaluation and outcomes have been promoted to staff, the clinic can often be expanded. It might then include earlier post-operative reviews such as at six weeks, and surgeons who were initially reluctant may be happier at this stage to allow for their patients to be included.

Involving the surgeons in aspects of the evaluation can also be helpful. For instance, when choosing patient outcome measures to use, it can be useful to consult with the surgeons as to which outcome measures they would like to see being used for their patients. This information can then be provided back to them, which may be particularly useful when new prosthesis or surgical techniques are being trialled.

When colleagues are resistant to change, opportunities to engage in further dialogue about the proposed changes should be sought. This will provide the chance to listen to their concerns, explore the issues in greater detail and address any concerns. Effective communication is essential in facilitating change.

Actions

- Review useful models of change, including the:
  - ADKAR Model
  - Beckhard (and Harris) Equation
  - Lewin Change Theory
  - Change Approach©
  - Kotters 8-step Model.
- Decide on a change management strategy.

Key resources


1.6 Who will be the key stakeholders and are they supportive?

Key stakeholders need to be consulted and engaged from the start. Their support is critical to success. Stakeholders may be directly or indirectly involved with the proposed service, internal or external to the organisation. The degree of consultation required with stakeholders will vary according their role, influence and level of authority.

Other stakeholders may need to be consulted, because they will be directly impacted by the service changes, such as clerical staff at triage. This consultation may occur closer to implementation, but should not be overlooked.

As gaining support from key stakeholders is pivotal for success, being well prepared is important. Prior to consultation with key stakeholders, consider the impact of the proposed service. Openly seek opportunities for dialogue and constructive feedback about the proposed service. Establish and articulate clear role boundaries and responsibilities of the proposed service, with particular attention to management of clinical risk and accountability. Barriers raised by stakeholders may create valuable opportunities for more detailed discussions. Be prepared by anticipating the concerns they may raise.

Barriers are inevitable and should not discourage the ongoing progress of service development. However, they can be minimised by ensuring key stakeholders have a clear understanding of what is proposed. Seek key stakeholders who have demonstrated a commitment to improving service delivery and who embrace innovative changes. It is helpful to gain support for the concept from these stakeholders early and involve them in working parties.

Consider the impact of the proposed service on key stakeholders. This will be different depending on their role. Therefore, the focus of consultation with the stakeholder, (the ‘pitch’) will need to vary according to the needs of stakeholders.

A communication strategy that identifies the different stakeholders, their likely concerns and their relative importance to the project, outlines the timing and level of consultation required, how this will be approached and what the key messages are, is a valuable tool to guide thinking and activity. Developing a clear communication strategy at the beginning of the conceptual stage is recommended.

Consider if the service proposed will be perceived by some stakeholders as extra work that may impact their staff. Additional resources may need to be allocated if this is the case.

Examples of key stakeholders to be consulted for implementing AMP services such as in ED may include:

- internal stakeholders, such as:
  - physiotherapy management and staff
  - allied health managers and upper level management
  - relevant medical directors – emergency, orthopaedics, neurosurgery, plastics, rheumatology
— relevant directors and managers of supporting departments — radiology, outpatients, pharmacy, non-physiotherapy allied health
— IT services
— administrative clerical staff

• external stakeholders, such as:
  — patients and their family or carers
  — government organisations involved in health policy and funding
  — supporting organisations (for example, rehabilitation centres)
  — community organisations
  — GPs
  — professional, regulatory and industrial bodies (APA, APHRA, Union Services)
  — Department of Health.

Action
Develop a contact list of all stakeholders — names, titles, contact details — and prepare a communication strategy to guide stakeholder consultation early in the process. Always be well prepared prior to meetings and provide an agenda. Focus presentations to stakeholders on what matters to them the most.

Key resources

1.7 What are the funding opportunities to support the service?
The funding process is usually very competitive within organisations. Success requires strong evidence to support the service need, and to convince those who provide the funding of the benefits of implementing the service at an organisational level. Even if no current funding is available, it is worth having well-prepared projects ready and waiting as funding opportunities frequently arise with little notice.

Prepare business cases prior to budget reviews and continue to build the evidence for your project. Spend time building professional relationships with key stakeholders by initiating interdisciplinary quality and research projects.

Example
Business case template — see Appendix F.

Key resources
2. Planning stage

Once a need for the proposed service has been established, and there is potential for funding and support from the organisation and key stakeholders, then the planning stage for implementation can commence. Much of the work commenced in the conceptual stage will continue into the planning stage.

The planning stage requires the development of:

a) **a project plan** that outlines the proposed service, and overall key requirements around implementing a new AMP service. The audience for the project plan comprises the key stakeholders, that is, those responsible for funding the project and those in positions of authority with the greatest influence on continuation and future funding of the service. The plan should be a concise document that includes overarching principles regarding implementation of the service, with particular focus on the systems and processes that address clinical governance, such as risk, key deliverables and outcomes (refer to Appendix N)

b) **an operational guideline** that delineates the day-to-day requirements to make the service function effectively. While there is some overlap with the content of the project plan, the information is written for a different audience with more detail. The audience for the operational guidelines is made up predominantly of the physiotherapists, the medical unit directly involved, and supporting departments, such as radiology and outpatients. These guidelines should be developed in close consultation with the relevant medical director or designated consultant on the working party. Many organisations have an intranet to publish guidelines relating to services. A two-page summary of the operational guidelines (see Appendix G) creates an easy, useful reference that can be stored on the hospital's intranet. A more detailed operational guidelines working document should be developed to support physiotherapists directly involved in service delivery. See Appendix L for an example of an Operational Guideline Template.
## 2.1. Project plan

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## 2.2. Operational guidelines

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2.1 Project plan

2.1.1 What is the background for the project?

This has already been established in the conceptual stage. Summarise what the problem is, why and what needs to improve. What is proposed to address this problem? Highlight the benefits of the proposal that justify why the project should be supported. Benefits could include:

- improved access to safe and quality care when it’s needed
- more efficient management of an ever-increasing workload for the medical team
- improved staff retention, job satisfaction and career development
- provision of a flexible, responsive workforce that meets the ever-changing demands of the healthcare system.

2.1.2 What are the aims and objectives?

AMP services make a positive difference to the delivery of healthcare. It is about providing the right people with the right skills at the right time. The project aim should address the problem area that has been identified.

Focus the aims and objectives to:

- demonstrate an understanding of the needs of patients and their families or carers
- measure outcomes that are meaningful to the patient, the organisation and healthcare professionals
- deliver safe, high-quality care that meets the needs of patients
- create a stimulating interdisciplinary working environment that encourages staff to learn, reflect and actively contribute to ongoing improvements and sustainability of the care they provide.

The aims and objectives should demonstrate a clear vision and understanding of the service to be implemented.

2.1.3 Is the scope of practice clearly defined and compliant with all regulatory authorisation and legislation?

Scope of practice should be well defined and the use of the terminology ‘advanced practice physiotherapy’ should be consistent with the APA definition provided within the ‘Definition of roles’.

Regulatory and legislative requirements include that:

- the scope of practice defined must comply with codes of practice, regulatory and legislative requirements
- if not, professional legal advice should be sought prior to implementation
- typically, AMP roles don’t extend across legislative boundaries, but can extend across professional boundaries.

Professional requirements include that:

- support of the organisation should be clearly documented, with organisational policies and procedures signed off prior to implementation
- a formalised supervision and mentoring program from the relevant medical team is recommended until competency has been demonstrated. A commitment to this should be documented clearly in the project plan.
• protocols and guidelines are recommended when traditional physiotherapy roles are expanded into new territory, requiring new skills and knowledge
• insurance and liability issues should be considered – include possible discussions with the organisation’s legal counsel.

Example
APA statement of ‘scope of practice’.

Action
Become familiar with the APHRA website and relevant codes of conduct.

Key resources

2.1.4 What are the role requirements and responsibilities?
The project plan should outline the key positions required to implement the AMP service. Refer to section 1.4 for role definitions and see Appendix F for examples of job descriptions.

Role requirements
It is important to reassure key stakeholders of the safety and quality of the proposed service, and to minimise clinical risk by stating in the project plan that only experienced and appropriately trained physiotherapists will be recruited for the role.

Often, existing senior experienced musculoskeletal physiotherapy outpatient staff are underutilised and already possess skills and knowledge ideal for AMP roles. Review existing positions and look for opportunities for role re-design to optimise the potential of these staff to be involved in AMP services. For example, what elements of a Grade 3 outpatient physiotherapy role could be completed by a Grade 2 outpatient physiotherapist, which would enable the Grade 3 to deliver AMP services.
Responsibilities
Advanced musculoskeletal physiotherapists work in collaborative partnerships with medical teams. Therefore:

• it should be clear to whom the physiotherapist reports on the day and in what circumstances
• a key responsibility of the physiotherapist is to identify during their assessment if the patient’s needs fall outside their scope of practice and if there are any ‘red flags’. Red flags identified by the physiotherapist during assessment trigger the need for consultation with the supervising medical consultant
• the degree of autonomy and supervision of the physiotherapist should also be clearly identified prior to implementation.

Example
Red flags in general\textsuperscript{28} (may indicate non-musculoskeletal conditions), include:

• significant trauma, such as falls from a height or high-energy motor vehicle accidents
• unintended weight loss
• history or possibility of cancer and malignancy
• osteoporosis
• fever, chills, malaise, night sweats
• drug use, for example, alcohol, narcotics (especially intravenous)
• steroid use
• if the patient is aged over 65 years
• severe unremitting night-time pain
• pain that gets worse lying down
• bowel or bladder symptoms
• increasing neurological deficit
• pulmonary or neurovascular compromise
• unexplained deformity or swelling
• HIV infection, immunosuppression, prolonged use of corticosteroids
• dizziness or nausea
• tinnitus, dysphagia, dysarthria, diplopia, drop-attacks,(vertebro-basilar insufficiency).

Actions

• Define the concept of red and yellow flags in the project plan in further detail. The full list of red and yellow flags should be included in the operational guideline.
• Outline how the role will be integrated into the existing team and not be working in isolation.

Key resources
A guide to assessing and managing red and yellow flags for workers compensation patients

2.1.5 What additional education and training, and competency assessment is required?

An overall summary of the education and training pathway, and competency assessment should be summarised in the project plan. Further information should be included in the operational guidelines and linked to the Advanced Musculoskeletal Physiotherapy Clinical Education Framework, which provides more detail.

The education and training required for advanced musculoskeletal physiotherapists will depend on:

1) scope of practice to be undertaken
2) the amount of experience of the physiotherapist, combined with the results of a learning needs analysis
3) the amount of supervision available, such as whether the physiotherapist will be working in a team-based environment with direct supervision or working autonomously.

There are several common skill domains required for AMP roles that are not covered in sufficient depth in the traditional undergraduate and postgraduate physiotherapy training.

These include:

- interpretation of diagnostic investigations such as radiology (imaging such as plain film) and pathology (blood tests and urine analysis)
- pharmacology
- advanced differential diagnosis – diagnosis and initial management of non-musculoskeletal conditions
- management of comorbidities of patients that need to be considered in combination with musculoskeletal conditions, for example, diabetes.

In addition, there is advanced clinical knowledge specific to the area of AMP practice that must be acquired. For the AMP service in the ED, this would include:

- plastering skills
- knowledge of fracture management and joint reductions
- wound assessment skills and knowledge regarding management – such as the need for tetanus injections or antibiotics.

In a postoperative arthroplasty review clinic, this would include:

- knowledge of prosthesis and surgical procedures specific to hip and knee joint replacements
- assessment of imaging of prostheses
- assessment findings for joint infections and prosthetic loosening.

In an orthopaedic shoulder screening clinic, this would include:

- knowledge of shoulder surgical techniques, risks and benefits of injections and hydro-dilatations, etc.
- skills to interpret shoulder imaging.
Both external (university) and internal education and training in these areas are currently available. However, the content and rigour of the education and training is variable. A workplace competency standard and assessment are provided in the Advanced Musculoskeletal Physiotherapy Clinical Education Framework. Clinicians will require dedicated education and training time. The terms of support for the clinician’s education and training time must be agreed with the organisation and included in the project plan.

2.1.6 What is the Clinical Governance Framework?

Clinical governance is described as:

‘a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.’

A clinical governance guideline should be developed for new AMP services. Firstly, identify what the organisation’s clinical governance framework is, and whether there is a clinical governance unit within the organisation that can help in this area. Check for existing policies and procedures to assist with development of a service clinical governance guideline that aligns with the clinical governance framework of the organisation.

The clinical governance guideline should be a standalone document that is referred to in the project plan and operational guidelines. A diagram of the governance structure should also be included (see Appendix O). This will need to be discussed with the director of allied health and relevant medical director.

The Victorian Clinical Governance Policy Framework is a useful document to guide the development of new services that promote the provision of safe and high-quality care. The four domains of quality and safety to address are patient participation, clinical effectiveness, effective workforce and risk management. There are examples of clinical governance activities to put in place for AMP services.

Patient participation examples include:

- engaging a patient representative on the working party or for review of resources and patient information for the service
- provision of patient information about the service, but also written information to encourage self-management of their musculoskeletal conditions
- timely response and appropriate management of complaints, as well as collation of compliments
- that the physiotherapist must communicate clearly to the patient that they are seeing a physiotherapist and not a doctor to avoid misunderstandings
- evaluation of the patient’s experience through surveys and interviews.

Clinical effectiveness examples include that:

- regular clinical audits need to occur and utilise a multidisciplinary approach (for example, the clinical audit assessment form in the audit guideline. See Appendix P)

all physiotherapists are responsible for high standards of documentation and will be required to participate in regular record-keeping audits (for example, the record-keeping audit assessment form in the audit guideline. See Appendix Q). Ensure that:
- discussions with the medical team are documented
- handovers meet the required standards
- orientation programs are developed and implemented for all new staff. Refer to the orientation checklist template (see Appendix R)

- resources developed for AMP services, such as operational guidelines, education and learning programs, and competency standard must be endorsed by key stakeholders
- clinical practice guidelines, endorsed by key stakeholders, need to be developed for new tasks not within the standard practice of an experienced musculoskeletal physiotherapist (see Appendix H for imaging and pharmacology)
- a regular reporting structure (KPI’s and other outcomes) to the director of allied health and the relevant medical director should be in place.

Effective workforce examples include that:
- musculoskeletal physiotherapists must meet the selection criteria for recruitment and be registered to practice
- they must be committed to completing the education and learning program, and be prepared to undertake a workplace competency assessment
- the musculoskeletal physiotherapist is expected to comply with professional standards, regulatory and legislative requirements, competency requirements, documentation standards and to be accountable for their ongoing professional development and self-learning needs. This will be assessed in the workplace competency assessment
- a team-based approach is adopted for service delivery to ensure the service is sustainable
- a multidisciplinary team approach is adopted for both service delivery, and for education and training of the musculoskeletal physiotherapist. The commitment to provide mentoring and supervision by the relevant medical team should be formalised and documented in the project plan
- a mentoring program must be in place with either a medical consultant or an experienced advanced musculoskeletal physiotherapist (see the AMP mentoring program in Appendix S).

Risk management examples include that:
- the process for managing adverse events, risks or complaints should be outlined and include directions for monitoring. It should be transparent, include practical examples and be well understood by all involved (see Appendix I). All staff should be familiar with the organisation’s risk management policy
- to identify risks, consider conducting a risk assessment and forming a risk register (see Appendix T)
- training in radiation safety must occur prior to requesting of imaging
- develop a review process for interpreting radiographs
- there must be accountability within the organisational structure, with managerial and clinical reporting lines documented.

**Example**
The key deliverables supporting advanced physiotherapy services across the three frameworks, as they fit within these four domains of clinical governance, are outlined in Figure 3.
### Figure 3. Advanced Musculoskeletal Physiotherapy Clinical Governance – Framework Integration

<table>
<thead>
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<td>Patient Education Handouts</td>
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<td>Clinician Outcomes / Monitoring and review of training and development needs</td>
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<td><strong>Job Description Template</strong></td>
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<td>Orientation Manual</td>
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<td>Pathway to competence in the work-place</td>
<td><strong>Learning Modules</strong></td>
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<td>Learning / Assessment Plan</td>
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<tr>
<td><strong>Risk Register</strong></td>
<td><strong>Monitoring effectiveness of Risk Strategy, Review of all Policies and Procedures and Risk Management Strategies</strong></td>
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<tr>
<td>Adverse Event Management</td>
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<tr>
<td>Governance Structure</td>
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</table>
Key resources


2.1.7 Have all key stakeholders been engaged and consulted?

Initial links with key stakeholders should already have been established in the conceptual stage (Section 1.6). Now their support needs to be formalised in the project plan prior to implementation. Consider:

• that the support and co-operation of stakeholders is critical to the success of implementation and sufficient time must be allocated to ensure that this occurs

• less obvious stakeholders who will be affected by the service change, such as administrative staff. They will need to be informed prior to implementation and recognised in the project plan

• that the communication strategies for consulting with key stakeholders need to be outlined and documented in the project plan (for example, regular meetings, quarterly reports and email updates).

For future reference, keep documentation of all formal and informal invitations and meetings, and emails to key stakeholders. To avoid any misunderstandings and to formalise action statements within the desired timeframes, record and confirm details of the minutes of meetings with stakeholders. Ensure that stakeholders who are unable to attend meetings are provided with the minutes.

During the process of gaining key stakeholder support, you must understand the likely time constraints of key stakeholders. Provide adequate time in advance to schedule meetings and allow reasonable turnaround time for responses to emails and review of draft documents, such as the project plan. Include the date you would like a response by in the subject line of emails. It is common to underestimate the timeframes required for key resources to be reviewed and endorsed by stakeholders.

Actions

• Prepare presentations to give to key stakeholders and their staff that summarise and promote the project plan. Presentations will be different depending on stakeholder interests.

• Ensure that all stakeholders receive a draft of the project plan and are encouraged to provide feedback and input into the final document.
2.1.8 What are the potential barriers to implementation and how may they be overcome?

Barriers to change are not unexpected. Challenges may be physical (for instance, space issues), technical, team and people based, or specific to the organisation. Understand the concerns, expectations and impact of the service change on those who are resistive.

Consider the problem from their perspective and address the issues that are important to them. These will be outlined in the communication strategy developed in the conceptual stage. They include:

- engaging those who are supportive to help where possible
- becoming informed on change management processes
- enquiring about re-design units or support within your organisation and engaging their help
- ensuring there is clarity and understanding regarding the proposed role and service to reduce confusion
- barriers can create opportunities for dialogue that facilitates a better understanding and a more thoughtful approach – barriers can be turned into enablers.

**Action**

Identify major barriers to change and the plan to address these barriers in the project plan. Utilise change management resources and references. Refer to section 1.5.

2.1.9. What are the milestones, deliverables and timeframes for implementation?

A project schedule detailing timeframes for key milestones should include:

- start and finish dates of implementation
- writing and submission of ethics applications (for evaluation)
- recruitment of staff (if necessary)
- duration of orientation, education and training programs
- duration of supervised practice
- time allocated to review and achieve competency
- duration of the evaluation period
- development of resources and toolkits supporting the service, for example, patient information.

The frequency of reporting, proposed meeting structure and communication strategies should all be clearly outlined in the project plan.

2.1.10 How will the service be evaluated and improvement made?

Evaluation is a key quality improvement tool that will identify areas for further development or refinement, and measure the impact of the service to provide key evidence to support the continuation of the service.

‘To fully evaluate the influence of a new or extended role for allied health professionals, measures should be chosen which evaluate the service from all stakeholders’ perspectives. This includes the patient’s perspective (Am I improving?), the clinician’s perspective (Is this the most effective way to get an improvement?), and the healthcare provider’s perspective (Is this the best use of healthcare resources?).’

It is important to note that any evaluation process involving patients and staff will require an ethics application. Liaise with your local Human Ethics Committee (HEC) regarding ethical requirements early in the project. Ethics approval must be received before any results may be published. Depending on the involvement, this may be a quality improvement or low-risk ethics application, or a full ethics application. Liaise with your organisation’s research and ethics department very early in the planning stage to determine what level of ethics is required.

The Victorian Innovation and Reform Impact Assessment Framework (VIRIAF) is a standardised evaluation framework developed for use with workforce redesign and reform initiatives in the Victorian context. It is based on the national Impact Assessment Framework (IAF) developed by Health Workforce Australia (HWA) to provide meaningful translation of the IAF to work on the ground in Victoria. It is suitable for evaluation of advanced practice roles and its use is encouraged to allow comparability between reform projects.

More detail on what is required for a full evaluation is provided in the evaluation stage of this framework. For a list of data elements that could be used, see Appendix A. The Review of primary contact physiotherapy services in emergency departments evaluates existing services in ED and is a useful resource.

It is important to note that evaluation is a continual process and is essential for good clinical governance. It does not just happen at the end of the project. In the project plan, a summary of the evaluation process should be provided, with further detail documented in the operational guideline. Consider the following when deciding on how the service will be evaluated.

Patient perspective

- Validated and reliable, timely and easy to use, patient-rated functional outcome measures can be collected to provide a measure of service improvement from the patient’s perspective. Consider how this information will be collected and used, and what expertise is required to analyse the data. Furthermore, decide what measures are best to use and at what timeframes they are to be applied, for example, at initial and discharge appointments.

- A patient’s experience of the service can be measured by patient satisfaction surveys that are easy to administer pre and post-implementation. Consider the need for translation into other languages (for patient and staff satisfaction tools, see Appendix K). Semi-structured in-depth interviews are a descriptive way to capture the patient’s perspective.

- Consider mapping the patient’s journey – how long they stay in the waiting room, how long they take to receive treatment, how many different practitioners they see, whether written information is provided and if follow-up services are provided.

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Clinician perspective

- Data relating to the inter-referral of patients between physiotherapists and the medical team can be collected. Examples of data items include:
  - a count of the number of patients who required a medical consult, in addition to the physiotherapy consult, and their outcomes
  - a count of the number of patients who required referral on to medical management, surgery, or who required additional investigations
  - conversion rates to surgery for surgical consultants
  - the number of patients who did not wait for care or failed to attend (FTA).
- Complaints and compliments should be recorded and feedback provided to clinicians.
- Achievement of competency of the physiotherapist should be recorded.
- Staff satisfaction surveys need to be conducted.

Healthcare provider perspective

Possible key performance indicators include:

- waiting times to appointments
- waiting times to be seen on the day
- number of patients seen per shift or clinic
- number of referrals to surgical services, discharges, etc. (outpatient (OP) services)
- number of admissions for musculoskeletal conditions
- number of patients who FTA or did not wait
- length of stay (ED services)
- per cent conversion rates to surgery for surgical consultants
- per cent achieving four-hour length of stay KPIs (NEAT, ED services)
- per cent achieving KPIs for outpatient services
- number of new patients seen by medical consultants.

Actions

- Refer to Victorian Department of Health Report 33.
- Determine if an ethics application is required for your evaluation. If results are to be published then it is likely an ethics application will be necessary.
- Refer to the evaluation template for examples of data to collect for evaluation.
- Meet with the person in your organisation who is responsible for data and KPI reporting to learn more about how and what data is collected and reported.

Key resources


33 Victorian Department of Health, OpCit., 2010
2.1.11 How will the results of the evaluation be disseminated?

Opportunities to disseminate the results of the evaluation should be sought at all levels. Document in the project plan how you plan to disseminate the results and remember the value of quantitative data for the reporting back. Include:

- regular reporting to stakeholders:
  - participation in medical unit quarterly and annual audits
- presentations to key stakeholders and staff:
  - verbal, written – flyers and posters, bulletins
- professional bodies continuing development programs
- conferences and publications
- information regarding the service to orientation manuals for medical staff.

Constructive feedback and comments should be noted and encouraged for ongoing evaluation and service development.

2.1.12 What is the budget?

The proposed budget needs to be realistic to cover the proposed service change and must be clearly documented in the project plan.

Consider:

- salaries and wages – must include non-clinical time and support
- project consumables
- professional support – for example, IT support for database systems
- administration costs
- costs associated with education and training (internal and external training programs)
- impact on supporting services – administration, radiology, outpatient staff.

2.1.13 What are the future directions and implications for the project?

The project plan should address the future directions from the broader perspectives of the service. The future directions should be consistent with the organisation’s vision and anticipated increasing demands.

If finite funding is provided initially, stakeholder engagement and discussion regarding ongoing service provision should commence early and continue as the project progresses, with work beginning early to develop the business case to secure continued funding and resources for the service.

Sustainability of ongoing services needs to be considered early in the planning stages. Avoid implementing services with a solo physiotherapist trained for the role – a team-based approach provides sustainability to a service, particularly during planned or unplanned absences.
2.2 Operational guidelines

2.2.1 What is the model of care, including service description and format?
Outline the overall model of care to be implemented and highlight the key service changes that distinguish it from the existing model of care.

The model of care should highlight the importance of utilising the right person with the right skill mix for the role in a team-based approach. Physiotherapists recruited for AMP services must have specialised knowledge, expertise and experience.

Recruitment
It is recommended that physiotherapists recruited to work in the AMP roles meet certain selection criteria, including:

• having a minimum of five to seven years of experience working in the musculoskeletal field
• having completed a Master of Musculoskeletal Physiotherapy or currently enrolled in postgraduate training, or alternatively is an APA Titled Musculoskeletal Physiotherapist who has achieved titling through the experiential pathway\(^34\)
• having excellent communication skills to effectively liaise with medical consultants and form strong working relationships outside of physiotherapy
• demonstrating a commitment to undertake workplace competency assessments and complete the education and training requirements, through structured and self-directed learning
• demonstrating an ability to recognise their limitations and have a clear understanding with regard to their scope of practice.

See Appendix E.

Scope of practice
• Define the scope of practice. For example, in the ED, the musculoskeletal physiotherapist’s scope of practice will target musculoskeletal conditions, triaged as category 3, 4, or 5. In the PAR clinic, the musculoskeletal physiotherapist’s scope of practice will target all post-operative primary hip or knee joint arthroplasty without major post-operative complications.
• The inclusion and exclusion criteria, or clinical parameters, will further define the scope of practice.
• The degree of supervision required by the medical consultant will be determined by the learning needs analysis of the physiotherapist and successful completion of the workplace competency assessment, for example, supervision with interpretation of imaging and referral to medical units.
• Review the scope of practice regularly as the skills and expertise of the physiotherapist develop and competency is achieved. For example, physiotherapists who are enrolled in the Master of Musculoskeletal Physiotherapy may have a more defined scope of practice compared to physiotherapists who are experienced and have completed their master’s degree.
• Ensure the scope of practice is within legislative and regulatory requirements.

Red and yellow flags
• The presence of red and yellow flags often indicates a discussion with a consultant is required. A shared-care approach or handover to the medical team for ongoing review may be required for these patients.
• A list of red and yellow flags should be included in the operational guidelines.
• While lists of red and yellow flags are available in the literature, like the inclusion/exclusion criteria, there may be some organisation-specific red and yellow flags that will need to be identified and discussed within the working party, and approved by the relevant medical director.

Key resources
Godges J, Red flags for potential serious conditions in patients with knee, leg, ankle or foot problems, accessed via <http://xnet.kp.org/socal_rehabspecialists/ptr_library/08KneeRegion/01MedicalScreening-KneeLegAnkleFootRegions.pdf>


Service flow chart
• In the early stages, medical consultants may need to oversee the supervision of the physiotherapist with every patient:
  - The physiotherapists needs to have the communication skills to present cases concisely to consultants and inpatient medical teams.
• The process for handing over patients identified by the physiotherapist as outside their scope of practice, or at end of shift, or when discharging from the clinic, should be identified.

Examples
PAR flow chart, see Appendix B
ED flow chart, see Appendix M

What is the format of the service?
The logistics of establishing a new service can be extensive, so it is important to be thorough in this process. Consider how the AMP service will integrate with existing musculoskeletal physiotherapy services. Create opportunities to train and orientate more than one physiotherapist at a time, and timetable professional educational opportunities with the existing musculoskeletal physiotherapy team.

In order to implement a sustainable service, be mindful of how staff are rostered over weekends to avoid burnout (ED services), facilitate service continuity in the event of staff leave and clearly articulate a staff succession plan.

Service hours should be based on the most relevant data available. This could include when musculoskeletal conditions are most common, for instance, inclusive of the weekend due to increased participation in winter sport (ED services). In comparison, service hours of specialist outpatient medical services may determine when the AMP service operates.
What supporting processes need to be established?

- Review the IT system in use and the process for requesting imaging or outpatient referrals. Identify whether the physiotherapist’s system log-in can:
  - assign patients to a clinician from triage (ED services)
  - authorise requests for imaging
  - refer for specialist medical appointments
  - access necessary clinic information
  - complete discharge summaries for the GP
  - discharge patients from the clinic
  - authorise referrals to local services
  - schedule outpatient appointments as required.
- Define the processes to be taken for providing WorkCover and sick certificates.
- Identify office space available for the physiotherapist to do non-clinical work.
- Review documentation guidelines for recordkeeping.
- Define how statistics will be captured. This may involve creating a database or electronic clinical log for collection of relevant data that is not routinely collected by the scheduling system in place (for example, patient functional outcome measures and secondary consults). Using an electronic clinical log can contribute to establishing a professional practice portfolio and provide an excellent educational resource.

Working party

A working party should be developed early in the planning process. The working party should include a medical consultant who understands the role and is supportive of the physiotherapy service. A nursing representative may also be included, depending on local organisational structure and practices.

All members of the working party must be able to commit the time required, particularly in the early stages of implementation. A broader steering committee may also be appointed if necessary:

- Determine the working party composition.
- Establish a meeting and communication structure for the working party.
- Develop templates for agendas and recording of minutes.

Change management strategies

- Identify where barriers and challenges may occur.
- What is the communication strategy?
- Consider the change management strategies to be adopted, which may include:
  - planning time to promote the service to staff prior to implementation with flyers, emails and presentations by:
  - providing information about the service to staff and ensuring there is an opportunity for questions and concerns to be raised by staff early in the process
  - encouraging the engagement of staff in the process of implementing the new service, to promote a culture of accepting positive change, and taking responsibilities and ownership of the service.
- Identify which key stakeholders may assist in the change management process.
• Gain assistance from the organisation’s redesign workforce unit or other similar supporting department.
• Refer to section 1.5 for resources on managing change.

Patient and staff information
When introducing a new service or role, it is important that staff and patients are well engaged prior to implementation. Consider:

• presentations to the relevant departments to provide an opportunity for staff to ask questions and provide input
• listening to constructive feedback from staff concerned about implications of service implementation and responding appropriately
• information sheets for GPs and other health professionals, that can be sent with patient correspondence like GP letters or inpatient discharge summaries, to promote the service to the wider healthcare community
• flyers that can be used to inform stakeholders of upcoming changes. These can be placed in waiting rooms for patients or in clinical settings for staff
• email reminders that can be sent out to staff closer to implementation
• contributions that can be made to hospital newsletters.

What patient education resources are required?
Well-informed patients are able to take more responsibility for their own health. Encouraging patients to understand and to proactively manage their own health is an important objective for all health professionals. AMP services primarily focus on obtaining an accurate diagnosis and making clinical decisions regarding the best pathway of management for the patient.

Clear, easy-to-read, written patient educational resources in appropriate languages encourage self-management, and provide reassurance to patients about their condition and management options. Providing good education to patients has always been a strength of traditional physiotherapy management and should continue to be a focus in AMP services.

Ensure the information contained in the patient education resources is evidence based and endorsed by relevant medical units and a patient representative.

Clinical guidelines
Most AMP services involve new skills and tasks not traditionally undertaken by physiotherapists. To ensure good clinical governance, and patient and clinician safety, clinical guidelines should be written in collaboration with the medical team and formally endorsed by relevant stakeholders. However, guidelines are time consuming to develop, so focus only on what is needed.

Physiotherapists are not protocol driven in their assessment and management of musculoskeletal conditions, so guidelines need to address areas of practice with attendant clinical risk that are new to the physiotherapist to guide their practice. As roles and services develop, these guidelines will need to be monitored, reviewed and updated. A schedule for review should be established at the onset.

In addition, clinical guidelines may take the form of mapping typical patient pathways, including red flags, and the need for imaging and specialist referrals. Consistencies in patient pathways can streamline care and minimise inefficiencies.
Action
Identify where there are new skills or tasks required or specific patient populations that may involve clinical risk, and develop a clinical guideline to be endorsed by relevant stakeholders. Check if the organisation uses a specific protocol regarding clinical guidelines and what process is required to get it endorsed.

Example
Analgesia guidelines, see Appendix H.

2.2.2 What is the clinical governance framework?
- Refer to the project plan (section 2.1.6) for further information.
- Include the organisation’s structure for clinical governance relating to lines of reporting and accountability for both managerial and clinical requirements.
- A link to the clinical governance document should be included in the operational guidelines and all staff should be familiar with this.

2.2.3 What are the education and training competency requirements?
Orientation
An orientation manual for staff should be developed as a supporting document to the operational guidelines (for an orientation checklist template, see Appendix R). The development of an orientation checklist, along with a detailed manual, provides a useful tool for ongoing recruitment and introduction of new staff to the service.

The checklist may include:
- introductions to all relevant team members
- review of organisational structure, such as who reports to who
- observation sessions with medical consultants or physiotherapists who are already practicing, relevant in advanced practice roles
- orientation of supporting IT systems, databases and administration procedures
- orientation to the geographical layout and equipment storage
- available supporting resources, for example, patient information handouts
- documentation and assessment standards
- processes for making referrals and imaging requests
- processes for reporting and managing adverse and unplanned events
- processes for writing discharge letters
- use of outcome measures within the clinical setting
- issuing certificates, medical sick certificates, WorkCover and TAC
- rostering and scheduling requirements
- processes for managing planned and unplanned absences
- meeting structures and timetables
- continuing education and training timetables
- general orientation as per the organisation’s requirements with:
  - compulsory annual training requirements (if new staff), such as CPR, manual handling, hand-washing and infection control, fire and safety training
  - performance reviews and expectations.
Education and training requirements

The education and training requirements are described within the Clinical Education Framework. The Clinical Education Framework underpins the assessment of competency.

Education and training requirements will vary from person to person, depending on their previous experience, formal level of training and role requirements. To be deemed competent to practice autonomously in advanced practice roles, essential elements of the education and training requirements need to be met.

In most advanced practice roles, implementation can commence before competency for autonomous practice has been achieved, providing the staff in those roles are working under supervision in a supportive environment, as agreed with the relevant medical team.

The program for education and training, and the timeframe to achieve competency, should be determined prior to commencing implementation.

Recruitment of experienced musculoskeletal physiotherapists to the role reduces the need for education and training in the common presentations of musculoskeletal conditions, allowing education and training to focus on the clinical skills and knowledge that are not routinely included in undergraduate or formal postgraduate physiotherapy teaching.

Further information regarding specific learning objectives in the key areas of education and training is detailed in the Clinical Educational Framework, and includes resources to support:

- a learning needs analysis to identify gaps in physiotherapists knowledge (refer to the AMP Clinical Education Framework Self Assessment Tool Part A and B for an example of this)
- an education and training program with learning modules to address the learning needs analysis
- a mentoring program with either an experienced advanced practice musculoskeletal physiotherapist or a medical consultant.

The main areas for education and training focus on:

a) diagnostic investigations such as:
   - radiology (imaging such as plain film):
     i. safety
     ii. indications
     iii. requesting
     iv. interpreting
   - pathology (blood tests, urine analysis)
   - vital signs
     b) pharmacology
   - c) non-musculoskeletal differential diagnosis
     d) areas related to specific needs of advanced practice services, for example, fracture management in ED.

The allocation of non-clinical time to support the physiotherapist’s education and training requirements should be documented in the operational guideline.
The key areas to be addressed are:

a) diagnostic investigations, including:

- training needs to include patient and staff safety issues relating to radiology and radiation exposure, for example, pregnant women and x-rays. This training needs to occur prior to any physiotherapist ordering imaging (see Appendix J)
- a guideline should be written for the process of ordering investigations, such as x-rays, and endorsed by the radiology department
- the importance of correct, detailed documentation when ordering the request needs to be emphasised and documentation audits conducted
- evidence-based guidelines to be used when requesting radiology (refer to section 1.3)
- if ordering plain films, the physiotherapist must have interpretation skills, which require additional education and training
- an expectation that the physiotherapist is responsible for following up any investigations requested and dealing with discrepancies in reporting of results (see Appendix I)
- that often, physiotherapists will discuss other imaging needs with supervising consultants (MRI, CT scans). The physiotherapist will require further education and training regarding the safety and use of imaging other than x-rays if patients under the primary care of physiotherapists require additional investigations
- that the physiotherapist will often discuss the indication for pathology tests required for their patients with the medical team. To do this, they need additional training in the ordering and interpretation of routine blood tests.

b) pharmacology, including that:

- under current legislation physiotherapists are unable to prescribe however, in some circumstances (such as the ED), the local organisation may authorise physiotherapists to provide a single dose of over the counter analgesia such as paracetamol and ibuprofen. A clinical practice guideline should be developed for this which is formally endorsed by the organisation, ED, pharmacy departments and legal counsel (see Appendix H)
- training must be undertaken to understand pharmacodynamics and pharmacokinetics, indications, drug interactions and dosages of analgesics, anti-inflammatory and local anaesthetics
- additional knowledge of commonly prescribed medications and drug interactions should be included and be relevant to local guidelines, state legislation and registration requirements in relation to medications
- staff need to refer to the state’s Drugs, Poisons and Controlled Substances Act 1981.35

c) non-musculoskeletal differential diagnosis, being that:

- one of the primary objectives of the advanced practice musculoskeletal physiotherapist should be to differentiate true musculoskeletal presentations from conditions that can present masking as a musculoskeletal presentation

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35 Victorian Legislation and Parliamentary Documents, Drugs, Poisons and Controlled Substances Act 1981
• examples may include:
  – arm pain – differential cardiac
  – calf pain – differential DVT
  – joint pain – septic arthritis
  – back pain - visceral referral (such as kidneys or ectopic pregnancy)
• knowledge should include what additional investigations maybe required and a basic understanding of how to interpret the results, for example, pathology, ECG, Doppler US
• the physiotherapist needs to be competent in taking and recording vital observations, full neurovascular assessments and blood sugar testing, when indicated and when nursing staff are unavailable
• the physiotherapist needs to be able to identify the priority and urgency for a medical review when a non-musculoskeletal diagnosis is suspected, and escalate it when indicated.

d) areas specific to needs of advanced practice services include that:
• different AMP services will have different educational and training needs. For example, physiotherapists working in OAHKS will require a detailed knowledge of osteoarthritis, the criteria for joint replacement surgery, and the evidence-based management of osteoarthritis. Whereas physiotherapists working in physiotherapy-led neurosurgical services will need a good understanding of spinal conditions, spinal injections and surgical techniques, and chronic pain management
• workplace competency standards reflect these specific areas of knowledge and skills that are required, while also covering the generic knowledge and skills required across all AMP services.

Competency
The education and training requirements should be a combination of formal and informal education. Completion of both is important in the assessment of competency. A formal assessment by independent examiners, such as university institutions, provides evidence and consistency in standards of practice that can be recognised externally to the organisation.
Informal, in-house education and training are easier to organise, more cost efficient and contribute to the development of interprofessional working relationships.

Work-based competency standards developed for AMP services are provided in the Clinical Education Framework.

What mentoring and supervision program will be required?
In the early stages of service implementation, supervised practice is recommended. If possible, document what elements of the role require supervision from the medical consultant or clinical lead physiotherapist. This may include discussions at the time of the clinic or service for patients with red flags, image interpretation, further imaging requirements and for patients who need to be admitted. For an example of a mentoring program for the AMP service in the ED, see Appendix S.

2.2.4 What are the steps in the evaluation process?
Refer to the project plan in stage two (see section 2.1.10) for evaluation and see stage four for evaluation details.
Once the evaluation process is identified, prepare an ethics application early in the process.

Outcome measures to be collected include:
- baseline, interim and final measures
- patient, clinician and organisational outcomes.

Contact the clinical performance or health informatics unit (or equivalent) within your organisation. Meet early in the process to identify what data is routinely collected, easy to access and is relevant to support the evaluation of the service. Additional data collection maybe required and IT support may be needed to set up the process to collect this additional data.

The evaluation process needs to be developed and started during the planning stage (baseline measures), continued throughout the implementation stage (interim) and completed in the evaluation stage (final). Ongoing service monitoring post-evaluation is recommended, and many of the same indicators can be utilised. Reporting back to medical units at regular quarterly and annual audits continues to promote the service, once it moves beyond the implementation stage.

2.2.5 What research and quality opportunities can be undertaken to support the role?

A well-thought-out evaluation plan not only supports the likelihood of successful implementation, but also provides an opportunity to publish the results. This can contribute to raising the profile of the role, locally and to a wider audience externally.

Throughout the implementation phase, opportunities for research and quality projects should be identified and pursued if they are possible and appropriate, remembering that the organisation's first priority is quality service delivery.

These projects can complement the service evaluation. If you plan to publish the results, in most circumstances, you will need to complete an ethics application. Consult with colleagues with research expertise or ask your research and ethics department for advice.

2.2.6 How will succession planning and sustainability be secured for the future?

Refer to the project plan for how it is proposed that the service will continue once funding finishes. Ongoing evaluation of the service, training and education of new staff, further expansion of scope, and confidence and competency of the musculoskeletal physiotherapist, needs to be established before the project or initial funding ends.

Consider the long-term vision for the service and how it fits into the organisational priorities, including:
- how the service will be maintained during staff absences
- what would happen to the service if the lead musculoskeletal physiotherapist left
- how the service will be monitored and how effectiveness will be evaluated on an ongoing basis
- whether there is room for further growth and development of the service
- whether the physiotherapist will continue to be supported post-implementation
- whether a business case need to be developed if external funding is used to establish the service
- what the future opportunities are for research and quality projects, growth and development of the service
- how ongoing competency of staff will be assessed and monitored.
3. Implementation stage

3.1 Orientation

Is the orientation program (section 2.2.2) adequate?

• Test the orientation program on staff involved in the service.
• Review the contents of the orientation program and modify them throughout implementation to improve program for future staff.
• Add to the orientation program as changes to service arise.
• Ensure introductions to all relevant people are made and continue to remind staff about the service:
  – particularly regarding the differences between primary and secondary contact roles.
• Schedule observational sessions and buddying up with clinicians prior to the date scheduled for implementation.
• Orientate new non-physiotherapy staff to the AMP service. For example, present information about the service to new rotating doctors every six months at the registrar’s orientation program of the relevant medical units.

3.2 Commencement of service

What is working well? What could be improved? What are the ongoing requirements?

• Regular working party meetings will be required more frequently in the initial stages of implementation, therefore:
  – ensure agendas and minutes are used, documented and distributed
  – discuss how the role and service is progressing, how the service is being perceived and what areas require further development
  – identify problems early and actively, and troubleshoot with the working party, physiotherapist and medical team for possible solutions.
• Continue to build working relationships with staff.
• Send reminders informing staff and patients about the new service and roles regularly and frequently, and:
  – identify when medical staff rotations occur and use orientation sessions to promote the service and include the information in staff orientation manuals
  – continue to use patient and staff information handouts.
• Take opportunities to be involved in intra-departmental meetings, educational opportunities and quality initiatives that encourage integration into the team.
• Continue to proactively promote the service to staff, ensure communication strategies are effective in achieving desired outcomes, and clarity the service and role, for example, with staff satisfaction surveys.
• Ensure data collection is occurring as anticipated in the planning stage and review it quarterly. Contribute information to the medical unit’s departmental quarterly audits.
• Monitor risk management strategies. Ensure strategies in place are effective, that supervision with medical team is occurring as expected, imaging of patients is being followed up and scope of practice is being monitored.
• Regular meetings with the medical director can provide an opportunity to update on progress, service development and any other issues, and build support for the continuation and development of the service.
• Encourage the physiotherapy team to establish internal and external support networks throughout the implementation.
• Consider whether the strategies for service continuation throughout planned and unplanned leave absences are adequate and appropriate.
• Review the succession plan and make changes as necessary.

3.3 Education and training program

The Advanced Musculoskeletal Physiotherapy Clinical Education Framework should be referred to during the implementation phase.

Is the education and training program addressing the needs of the service?

Is the physiotherapist on track to achieve competency?

• On the job education and training provides the best learning.
• Encourage self-reflective learning and maintenance of a professional practice portfolio that documents formal and informal continuing education.
• Aim for exposure to as many patients as possible, by keeping a clinical log of all presentations seen, radiology reviewed, etc.
• Encourage the follow up of complex cases of people who have been admitted or referred on to specialty services. Write up interesting case presentations as directed in the workplace competency framework.
• Keep on schedule with achieving competency with internal and external education requirements. This will require:
  – meeting regularly with a mentor or supervisor to review competency
  – planning external education opportunities like university radiology and pharmacology modules, well in advance
  – allocating non-clinical time for ongoing education and training.
• Timetable professional education opportunities well in advance. Consider opportunities like attending theatre, internal and external courses directed to other professionals that may be relevant to the role, for example, a wound management course for nursing and inviting non-physiotherapy health professionals (pharmacy, radiology) to present at in-services.
• Determine what the ongoing continuing education requirements are, once physiotherapists complete the workplace competency assessments and are deemed ready to be autonomous with a defined scope of practice.
• Seek feedback from staff regarding the education and training program. Determine whether it is meeting their needs and modify the program accordingly.
4. Evaluation stage

The ability to deliver a robust assessment is a valuable mechanism in an ever-changing health workforce environment. The project plan (2.1.10) describes the plan for evaluation. Stage 4 brings all of the elements together in order to evaluate the service.

**VIRIAF**

The VIRIAF should be used as a basis for evaluating your new service. It provides a straightforward, logical and adaptable model for evaluation of workforce projects, and its use enables comparability between diverse workforce reform projects, as well as meta-analysis of like projects.

The VIRIAF was developed in late 2011 by the Victorian Department of Health with PricewaterhouseCoopers, as a standardised approach to compare and evaluate various workforce reform projects. The VIRIAF is based on the national IAF, developed by HWA, with particular reference to the Victorian health context and priorities.

The key requirement in developing the VIRIAF was that it align closely with the IAF and provide meaningful translation of the IAF principles, concepts and structure to the diverse range of workforce projects undertaken in the Victorian context, given that these vary considerably in scale, scope, setting, rationale and objectives.

In essence, the VIRIAF is designed to link the higher-level national evaluation framework to work happening ‘on the ground’ in Victoria. It is a robust, useful and practical tool for measuring the appropriateness and overall impact of workforce projects and their feasibility for broader roll out. See Figure 4.

Indicators are developed to measure:

- efficiency arising as a result of the workforce project
- effectiveness – the extent to which workforce and patient outcomes achieve project objectives
- sustainability – workforce and structural sustainability, over the longer term
- replicability – the impacts if the project is implemented elsewhere
- scalability – the impacts if the project is implemented many times
- risk – the extent of known risks and how these are managed.
Figure 4. The Victorian Innovation and Reform Impact Assessment Framework

Efficiency

**Inputs**
- Salaries (including on-costs)
- Training costs
- Capital costs
- Supervision costs
- In kind costs (e.g. volunteer resources)
- Administration costs
- Service provision

**Outputs**
- Change in workforce numbers
- Other workforce costs (e.g. change to overtime, casual and agency costs)
- Work Structure
- Indirect impacts to other parties

Effectiveness

Safety and quality of care
Access to care
Workforce capacity
Integrated workforce
Clinician competencies and optimal use of skills
Client satisfaction
Workforce satisfaction
1. Objectives

Sustainability

**Enablers**
- Engagement of stakeholders
- Clear and open communication
- Alignment with national and Victorian health reform initiatives
- Ongoing supervision requirements
- Incorporating the workforce project into standard practise
- Increase levels of awareness from key stakeholders

**Barriers**
- Workforce recruitment and retention
- Workforce mix
- Funding requirements

Data Collection

Assess Appropriateness (on a case by case basis)

- Analyse indicators to determine relative gains and significant elements in efficiency, effectiveness and sustainability
- This may involve balancing big improvements in one dimension against small or no change in others
- Positive consideration should be given to cases where initial implementation costs can be overcome quickly, where there is strong patient and staff feedback and where sustainability is high
- Determine level of appropriateness

Assess Feasibility (on a case by case basis)

<table>
<thead>
<tr>
<th>Replicability</th>
<th>Scalability</th>
<th>Risk</th>
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<tbody>
<tr>
<td>The impacts if the project is replicated somewhere else</td>
<td>The impacts if the project is implemented many times</td>
<td>The extent of known risks and how these are managed</td>
</tr>
</tbody>
</table>

- Analyse enablers and barriers to determine the feasibility of running the project in other settings and on a larger scale
- Analyse the level of risk associated with wider implementation of the project
- Consider if challenges highlighted under ‘appropriateness’ can be overcome if the pilot was extended
- Determine level and bounds of feasibility
Example
See Appendix A.

Ensure there is a reporting structure in place to communicate the results of the evaluation to the relevant stakeholders. Establish an ongoing system for regular reporting of KPIs, safety and performance to allied health management and relevant medical directors.

Key resources


Glossary

**Advanced scope of practice** – is a role that is within the currently recognised scope of practice for that profession, but that through custom and practice has been performed by other professions. The advanced role may require additional training, as well as significant professional experience and competency development.

**Audit** – is an investigation into whether an activity meets explicit standards, as defined in advance, for the purposes of checking and improving that activity. External auditors can carry out the process or it can be carried out internally as a self-review. The knowledge produced is specific to that audit and cannot normally be generalised. The standards used can be external and ready-made, or defined by the service providers for self-audit.

**Change management** – is the process, tools and techniques to manage the people side of change to achieve the required business outcome. Change management incorporates the organisational tools that can be utilised to help individuals and groups make successful personal transitions, resulting in the adoption and realisation of change.

**Competence** – is the performance of particular tasks and duties to the standard of performance expected in the workplace. Also described as what people need to know and do in order to carry out specific work activities. It includes the ability to transfer and apply in the range of situations required, at an appropriate level of safety and quality.

**Competency standard** – defines the essential work outcomes and performance level required for effective performance of a work role or task in the workplace.

**Clinical reasoning and clinical decision making** – is the critical and analytical thinking associated with the process of making clinical decisions.

**Clinical governance** – is the system through which organisations are accountable for continuously monitoring and improving the quality of their care and services, and safeguarding high standards of care and services.

**Documentation** – is the process of recording of all aspects of patient care and management, including the results of the initial examination, assessment and evaluation, diagnosis, prognosis, plan of care, intervention and treatment, response to interventions and treatment, changes in patient status, relative to the interventions and treatment, re-examination, and discharge or discontinuation of intervention and other patient management activities.

**Evidence-based practice (EBP)** – is an approach to healthcare wherein health professionals use the best available evidence from systematic research, integrating it with clinical expertise to make clinical decisions for individual patients. EBP values, enhances and builds on clinical expertise, knowledge of disease mechanisms and pathophysiology. It involves complex and conscientious decision-making based, not only on the available evidence, but also on patient characteristics, situations and preferences. It recognises that healthcare is individualised and ever-changing, and involves uncertainties and probabilities.

**Extended scope of practice** – is a role that is outside the currently recognised scope of practice and one that requires some method of credentialing following additional training, competency development and significant professional experience, as well as legislative change.

**Evaluation** – is the systematic assessment of the implementation and impact of a project, program or initiative.
Grade 3 physiotherapist – is a physiotherapist with at least seven years of experience, possessing specific knowledge in a branch of the profession and working in an area that requires high levels of specialist knowledge, as recognised by the employer. A senior clinician, grade 3, may also be required to undertake administrative work, and manage and supervise staff.\(^{36}\)

Grade 4 physiotherapist – is a physiotherapist with at least 10 years of postgraduate experience, who holds significant educational, administrative and managerial responsibilities, as designated by the employer, and who is at a supervisory level in one or more specific branches of the discipline that require extensive specialised knowledge and performance.\(^{37}\)

Independent practice – is an individual deemed competent against the requirements of the competency standard and working within the usual operational and clinical governance framework for the practice context, without additional monitoring requirements or restrictions.

Learning outcomes – are statements of what a learner knows, understands and is able to do on completion of a learning process, which are defined in terms of knowledge, skills and competence.

Mentor – is a collaborative partner who is a role model and motivator, providing support, help, enthusiasm, inspiration and nurturing in a non-structured learning environment. A mentor is an active listener who will provide a safe, non-judgemental, friendly and creative atmosphere for the mentee.

Mentorship – is the provision of model performance by persons with wisdom, from whom advice and guidance can be sought.

Project management – is the application of knowledge, skills, tools and techniques to project activities to meet project requirements.

Stakeholder – is a person, group or organisation with an interest in a project.

Research – is a systematic activity, which uses scientific methods that are appropriate for discovering valid and generalised knowledge about a particular thing. Research is carried out for the purpose of contributing to scientific knowledge about the subject. There are many different forms of research.

\(^{36}\) Classification as per Health Professional Services – Public Sector – Victorian Award. Skills and attributes for this classification are outlined above

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## List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APA</td>
<td>Australian Physiotherapy Association</td>
</tr>
<tr>
<td>ED</td>
<td>emergency department</td>
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<tr>
<td>FTA</td>
<td>failed to attend</td>
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<td>GP</td>
<td>general practitioner</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<td>IAF</td>
<td>Impact Assessment Framework</td>
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<td>IT</td>
<td>information technology</td>
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<td>KPI</td>
<td>key performance indicator</td>
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<td>NEAT</td>
<td>National Emergency Access Target</td>
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<td>OAHKS</td>
<td>Osteoarthritis Hip and Knee Service</td>
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<td>Post-Arthroplasty Review</td>
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## Appendix A – Evaluation Data Elements/Template

### Example Evaluation Data Elements

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<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Performance Measure</th>
<th>Data Source/Tool</th>
<th>VIRIAF Category</th>
<th>VIRIAF Subcategory</th>
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<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
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<tr>
<td></td>
<td></td>
<td>No. of review patients seen by Musc Physio by OP category per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Type of patients seen by Musc Physio by condition per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. of total patients referred to OP category per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of new patients seen by Medical Consultants per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of reviews seen by Medical Consultants per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. of patients discharged by Musc Physio</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Workforce capacity</td>
</tr>
<tr>
<td></td>
<td>Access (Waiting Times)</td>
<td>Waiting time to appointment by Musc Physio by OP category per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Waiting time to appointment with Consultant by OP category per quarter</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of patients referred to Musc Physio for medical/surgical review</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Conversion rates to surgery from Musc Physio referrals</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No. of patients Musc Physio consults with Medical consultant on the day</td>
<td>Data from departmental systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duration of time spent on the day waiting to be seen by Musc Physio</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Duration of time spent on the day waiting to be seen by Medical Team</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% of patients who FTA Physio appointment (NP/Reviews)</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
<td>Access to care</td>
</tr>
<tr>
<td>1.2 Outcome Indicators</td>
<td>Patient incidents</td>
<td>No. of incidents/errors by type</td>
<td>Data from risk management system</td>
<td>Effectiveness</td>
<td>Safety and quality of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Major/serious adverse events</td>
<td>Data from risk management system</td>
<td>Effectiveness</td>
<td>Safety and quality of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-hospital mortality</td>
<td>All deaths</td>
<td>Data from hospital management systems</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Category</td>
<td>Indicator</td>
<td>Performance Measure</td>
<td>Data Source/Tool</td>
<td>VIRIAF Category</td>
<td>VIRIAF Subcategory</td>
</tr>
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<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Client experience</td>
<td>Consumer feedback/complaints related to care received by Musc Physio</td>
<td>Data from risk management system</td>
<td>Effectiveness</td>
<td>Client satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patient satisfaction with quality of care received by Musc Physio</td>
<td>Survey tool adapted from reference Considine and McClellan Semi structured interviews</td>
<td>Effectiveness</td>
<td>Client satisfaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mapping of patient journey from GP referral, OP services to discharge</td>
<td>Case examples</td>
<td>Effectiveness</td>
<td>Access to care/ Client satisfaction</td>
<td></td>
</tr>
<tr>
<td>Client outcomes</td>
<td>Collection of functional outcomes generic health outcomes such as EQ5D <a href="http://www.euroqol.org/">http://www.euroqol.org/</a> and disease specific functional outcomes such as the Roland Morris, Lower Extremity Functional Index scale</td>
<td>Medical Record/Documentation audit tool'</td>
<td>Effectiveness</td>
<td>Safety and quality of care/Client satisfaction</td>
<td></td>
</tr>
<tr>
<td>Staff experience</td>
<td>Staff satisfaction with quality of service delivered by Musc Physio – Medical, OP staff Musc Physio satisfaction with role requirements</td>
<td>Survey tool adapted from reference Considine and McClellan Semi structured interviews</td>
<td>Effectiveness</td>
<td>Workforce Satisfaction</td>
<td></td>
</tr>
<tr>
<td>2. Clinical Audit (disease or procedure specific)</td>
<td>Documentation Audit</td>
<td>Compliance with documentation guidelines and professional standards</td>
<td>Medical Record/Documentation audit tool'</td>
<td>Effectiveness</td>
<td>Safety and quality of care/Clinician competencies and optimal use of skills</td>
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<td></td>
<td>Clinical Audit</td>
<td>Case Review</td>
<td>Efficiency</td>
<td>Safety and quality of care/Clinician competencies and optimal use of skills</td>
<td></td>
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</tbody>
</table>

- Missed diagnosis
- Major/serious adverse events
<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>Performance Measure</th>
<th>Data Source/Tool</th>
<th>VIRIAF Category</th>
<th>VIRIAF Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Professional Development/ Education and Training</td>
<td>Clinical needs analysis</td>
<td>Review of clinical expertise and knowledge to determine strengths and weaknesses and formulate plan to address gaps</td>
<td>Clinical needs analysis tool(^9)</td>
<td>Effectiveness</td>
<td>Safety and quality of care/Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Clinical Education and Training</td>
<td>Completion and attendance of all clinical and education training requirements Time frame to achieving competency or autonomous practice Cost and access to clinical education and training</td>
<td>Electronic clinical log for portfolio(^11) % of physios who have completed education and training</td>
<td>Effectiveness</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Individual performance improvement</td>
<td>Completion of mentoring program</td>
<td>Documentation from attendance at mentoring sessions(^10)</td>
<td>Effectiveness</td>
<td>Safety and quality of care/Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Clinical Log Maintenance</td>
<td>Number and types of patients seen by musc physios, referrals, imaging and surgical review requests, conversion to surgery and discharge</td>
<td>Electronic clinical log(^12)</td>
<td>Effectiveness</td>
<td>Safety and quality of care</td>
</tr>
<tr>
<td></td>
<td>Work-based competency standards</td>
<td>Achievement of competency No. of physios completed work-based competency standards</td>
<td>Electronic clinical log</td>
<td>Effectiveness</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Musc physio specific Competences</td>
<td>Additional competency standards required specific to organisation/service needs</td>
<td>Local organisation Competency checklist(^13)</td>
<td>Effectiveness</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Annual Performance Appraisal</td>
<td>Yearly performance appraisal with supervisor/manager</td>
<td>Organisation Performance Plan</td>
<td>Effectiveness</td>
<td>Safety and quality of care/Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Professional development</td>
<td>Maintenance of Professional Portfolio</td>
<td>Electronic Professional Portfolio</td>
<td>Effectiveness</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td>Category</td>
<td>Indicator</td>
<td>Performance Measure</td>
<td>Data Source/Tool</td>
<td>VIRIAF Category</td>
<td>VIRIAF Subcategory</td>
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</tr>
<tr>
<td>4. Research &amp; Quality Improvement</td>
<td>Contribution to the profession (knowledge development)</td>
<td>Completion of quality and or research projects relevant to service</td>
<td>Publications, Conference presentations</td>
<td>Effectiveness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contribution to service improvement</td>
<td>Development of effective policies and procedures such as operational guidelines, clinical governance structure</td>
<td>Endorsement of policies and procedures for service by stakeholders</td>
<td>Effectiveness/Sustainability</td>
<td>Clinician competencies and optimal use of skills</td>
</tr>
<tr>
<td></td>
<td>Endorsement of resources and toolkits by stakeholders supporting service sustainability e.g. orientation programs</td>
<td>Endorsement from stakeholders for each resource and toolkits</td>
<td></td>
<td>Sustainability</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B – PAR Flowchart

Physiotherapy Arthroplasty Review
Proposed Model of Care

**Inclusion Criteria:**
- Primary THA/TKA – Dx OA

**Exclusion Criteria:**
- Revision surgery
- Intra-operative fracture
- Wound infections
- Post-op complications
- Primary Dx: Tumor, Paget’s etc.
- Complicated co-morbidities
- Any other patient as identified by the ortho consultant at the time of surgery
- Any patient requesting not to be seen in the PAR Clinic

**Any red flags identified on assessment must be discussed with surgeon**

**Flow chart 1: Previous Post Operative Orthopaedic Outpatient Review Clinic**

- **2 weeks** → Ortho Registrar Review
- **6 weeks** → Ortho Registrar Review
- **6 months** → Ortho Registrar Review
- **12 months** → Ortho Registrar Review
- **2+ years** → Ortho Registrar Review

**Flow chart 2: Proposed Physiotherapy Arthroplasty Review Clinic**

- **2 weeks** → Physio Review
- **6 weeks** → Physio Review Oxford/SF12
- **6 months** → Physio Review Oxford/SF12
- **12 months** → Physio Review Oxford/SF12
- **2+ years** → Physio Review Oxford/SF12

Imaging & Physiotherapy report to be reviewed by Orthopaedic Surgeon
Appendix C – 
Local Clinical Governance Framework

TARGET AUDIENCE
Director of Allied Health, Allied Health Heads of Department, Acute Physiotherapy Services Manager, Medical Director of Emergency, Director of Orthopaedics, Director of Neurosurgery

PURPOSE
The purpose of this guideline is to outline the clinical governance of the following Advanced Musculoskeletal Physiotherapy services:

• Advanced Musculoskeletal Physiotherapy in the Emergency Department
• Orthopaedic Physiotherapy Outpatient Screening Clinic
• Neurosurgical Physiotherapy Outpatient Screening clinic
• Neurosurgical Physiotherapy Post-operative Service
• Physiotherapy Arthroplasty Review (PAR) Clinic
• Osteo-Arthritis Hip and Knee Service (OAHKS)
• Physiotherapy ED Soft Tissue Review Clinic

GUIDELINE
Background
Clinical governance in Australia has been defined by the Australian Council on Healthcare Standards1, (2004) as “the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care”.

This guideline outlines the key components to ensure the Advanced Musculoskeletal Physiotherapy Services deliver safe and sustainable, patient centred, high quality care. This guideline sits under the Allied Health Clinical Governance Framework which refers to the four domains of action from the Health Service Clinical Governance Framework:

1. Clinical Risk Management
2. Clinical Effectiveness
3. Education and Training

This guideline identifies the clinical governance activities specific for the Advanced Musculoskeletal Physiotherapy Services that are included, and in some examples, in addition to the activities listed in the Allied Health Clinical Governance Framework (Table 1). This guideline was deemed necessary because:

• There has recently been significant growth and development of the Advanced Musculoskeletal Physiotherapy Services
• The clinical governance of these services has previously not been well defined
• The role and responsibilities of physiotherapists providing these services, whilst remaining within the scope of practice of physiotherapy, are outside the traditional physiotherapy roles within the public health sector and have previously been done by medical staff.

Table 1 reviews the safety and quality measures in place for the Advanced Musculoskeletal Physiotherapy Services against the four domains of the Health Service Clinical Governance Framework

<table>
<thead>
<tr>
<th>Clinical Governance Element</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>A measure of the extent to which a particular intervention works</td>
</tr>
</tbody>
</table>
| Audits                      | As a requirement of the competency based training and assessment process all musculoskeletal physiotherapists during their training period must:  
  - complete a medical record-keeping audit  
  - participate in a clinical audit  
  Once competency has been achieved annual medical record-keeping audits and regular participation in clinical audits across physiotherapy and the relevant medical unit are required.  
  In addition, the advanced musculoskeletal physiotherapy services participate in the relevant medical unit's quarterly and annual audit by contributing data on performance (KPI's) and safety |
| Research and Development    | Each Advanced Musculoskeletal Physiotherapy Service has a Clinical Lead Physiotherapist appointed with research experience that is responsible for research projects in relevant area of practice.  
  The Clinical Lead Physiotherapist is responsible for coordinating the research being conducted with the research team of the relevant medical unit. |
| Clinical Standards and Policies | Each Advanced Musculoskeletal Physiotherapy Service has the following key supporting documents that have been approved by the relevant medical unit and key stakeholders:  
  - Operational Guideline: this documents the day to day service design and format, scope of practice, model of care, education and training requirements and refers to how the service will be evaluated.  
  - Orientation program for new staff  
  - Clinical practice guidelines where indicated e.g. The provision of a single dose of simple analgesia by the primary contact musculoskeletal physiotherapist in the Emergency and Trauma Centre |
| Clinical Practice Improvement | Each Advanced Musculoskeletal Physiotherapy Service is involved in quality projects which includes but is not limited to:  
  - Service Development initiatives  
  - Developing patient information handouts  
  - Multidisciplinary guideline development e.g. Shoulder dislocation (after reduction) follow up pathway |
| Clinical Risk Management    | Targets preventable adverse events and encourages a systems approach in examining contributing factors leading to these events |
| Incident Response           | A document titled “Managing adverse events for Advanced Musculoskeletal Physiotherapy Services in Public Health” (Appendix 1) has been developed and reviewed by relevant medical unit directors  
  A governance structure for reporting – including managerial and clinical accountability has been developed (Appendix 2) |
<table>
<thead>
<tr>
<th>Clinical Governance Element</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responding to known clinical risks</td>
<td>The clinical education framework for Advanced Musculoskeletal Physiotherapy includes a competency based training and assessment program linked to the main areas of risk, which have been identified to be predominantly clinical risks</td>
</tr>
<tr>
<td>Clinical Risk Identification</td>
<td>The risk assessment tool (Intranet) has been completed when establishing the Advanced Musculoskeletal Physiotherapy Services A risk register has been completed for Advanced Musculoskeletal Physiotherapy Services (Appendix 3) and reviewed by the Director of Allied Health and Directors of the relevant medical units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consumer Participation</th>
<th>Address issues related to the development of processes to ensure the active involvement of consumers and the community in all aspects of health care delivery.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning from complaints</td>
<td>Complaints and compliments received in relation to the Advanced Musculoskeletal Physiotherapy Services will be communicated to the relevant medical units, Acute Physiotherapy Services Manager and for major complaints escalated to the Director of Allied Health All complaints will be dealt with promptly in accordance with procedures set out by Health Service Patient Complaint Policy and Guideline</td>
</tr>
<tr>
<td>Open disclosure</td>
<td>Open disclosure should be delegated to the Director of Allied Health and/or the relevant medical unit director depending on the circumstance.</td>
</tr>
<tr>
<td>Patient information</td>
<td>Patient handouts detailing relevant information about the Advanced Musculoskeletal Physiotherapy Services have been prepared. This information is sent with or included in the patient appointment letter for outpatient services. This clearly outlines to the patient that he will be seeing a physiotherapist and not a doctor and provides them with the option to request a review with a doctor if they prefer. Handouts have been written using plain English and where possible translated into different languages. Patient handouts for education and advice regarding the management of their musculoskeletal conditions have also been prepared.</td>
</tr>
<tr>
<td>Patient Involvement</td>
<td>Annual patient satisfaction surveys are conducted, collated and analysed for the Advanced Musculoskeletal Physiotherapy Services A patient consumer representative has been appointed to be involved in the evaluation of the primary contact musculoskeletal physiotherapy service in the ED and qualitative patient interviews are to be conducted for the evaluation of the service</td>
</tr>
</tbody>
</table>

Education, Innovation and Workforce

The approaches taken to ensure all staff have the appropriate skills and knowledge to perform the tasks that are required of them and a fundamental understanding of safety and quality

| Scope of Practice                           | Scope of practice for all Advanced Musculoskeletal Physiotherapy Services are clearly defined in the operational guidelines for each service and are endorsed by the Director of Allied Health, Acute Physiotherapy Services Manager and directors of the relevant medical units. |
Clinical Governance Element | Activity
--- | ---
Credentialing | All musculoskeletal physiotherapists working in Advanced Musculoskeletal Physiotherapy Services must meet the selection criteria which includes:
- A minimum of five years experience working as a physiotherapist in the musculoskeletal area
- Enrolled or completed a Masters post graduate qualification in the area of Musculoskeletal Physiotherapy or are a titled APA musculoskeletal physiotherapist achieved via the experiential pathway
- Demonstration of a commitment to complete the education and training program, and undergo a competency based assessment process where performance will be measured against the advanced musculoskeletal physiotherapy competency standard

Performance Management and Supervision | In addition to the annual performance review, all new staff working in advanced musculoskeletal physiotherapy roles are under the supervision of a medical consultant until competency has been achieved.
The competency based training and assessment includes:
- a self assessment
- a performance appraisal by a member of the medical unit who has worked closely with the physiotherapist
- multiple work-based observational assessments conducted either by the medical consultant or clinical lead physiotherapist
- an oral appraisal
- written assessments
- case based presentations
- clinical and documentation audits (refer to the Advanced Musculoskeletal Physiotherapy – Clinical Audit and Record Keeping Guideline)
- maintenance of a clinical log and professional practice portfolio (refer to the Advanced Musculoskeletal Physiotherapy Clinical Education Framework for further detail)
Once competency has been achieved the physiotherapist is expected to liaise closely with the medical team and discuss any presentations of concerns or when red or yellow flags² have been identified. Additionally they are expected to maintain competency and participate in the advanced musculoskeletal physiotherapy continuing education program. The clinical lead physiotherapist is also responsible for supervising the musculoskeletal physiotherapist’s overall performance

Patient Safety, Education and Training | All advanced musculoskeletal physiotherapists have to participate in the mandatory training, in addition to the education and training for the relevant advanced musculoskeletal physiotherapy service

Clinical orientation | All advanced musculoskeletal physiotherapy services have an orientation manual and program for new staff that is specific to the service. Additionally advanced musculoskeletal physiotherapy staff contribute to the orientation programs of the new medical staff for education regarding how the services operate and work alongside the medical team
KEY RELATED DOCUMENTS

- Health Service Clinical Governance and Quality Management Framework Guideline
- Health Service Allied Health Clinical Governance Framework
- Victorian Clinical Governance Policy Framework (released May 2009), Victorian Government, Department of Human services
- Advanced Musculoskeletal Physiotherapy Clinical Education Framework
- Advanced Musculoskeletal Physiotherapy Operational Guidelines PAR Clinic
- Advanced Musculoskeletal Physiotherapy Operational Guidelines in ED
- Advanced Musculoskeletal Physiotherapy – Clinical Audit and Record Keeping Guideline
- Heath Service Complaints Management Policy and Guideline

REFERENCES

2 WorkCover Corporation of South Australia, 2012, A guide to assessing and managing red and yellow flags for workers compensation patients

Appendix 1: Managing adverse events for Advanced Musculoskeletal Physiotherapy services in Public Health

Appendix 2: Advanced Musculoskeletal Physiotherapy Governance Structure

Appendix 3: Advanced Musculoskeletal Physiotherapy Risk Register

- Key legislation, acts & standards:
  - Charter of Human Rights and Responsibilities Act 2006 (Vic)¹

AUTHOR / CONTRIBUTORS

* denotes key contact

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Service / Program</th>
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</table>

Endorsed by: Name/Title: Date: 
Approved by: Name/Title: Date: 

Disclaimer: This guideline has been developed within the context of Health Service service delivery. The Health Service shall not be responsible for the use of any information contained in this document by another organisation outside of the Health Service

¹ REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this guideline have an obligation to ensure that all decisions and actions are compatible with relevant human rights.
Appendix D – OAHKS Patient Journey Example

Improving patient flow from the Emergency Department to Outpatients

The implementation of Advanced Practice Musculoskeletal Physiotherapy services have considerably impacted on the patient’s journey through health services. The journey of a patient presenting to the Emergency Department (ED) is mapped out below and compared to a typical patient’s journey that would have occurred prior to the implementation of Advanced Practice Musculoskeletal Physiotherapy services.

**Patient Journey**

The blue line follows an actual patient who presented to a Victorian health service ED on the 31/1/11 with an acute exacerbation of knee osteoarthritis. The patient was assessed by the Musculoskeletal Physiotherapist working in the ED on that day. They were then referred to the OsteoArthritis Hip and Knee Service conducted by a musculoskeletal physiotherapist and received an appointment twenty one days later. The physiotherapist deemed the patient an appropriate surgical candidate, organised the appropriate imaging and an appointment with the surgeon for one month later. Only one consult with the surgeon was required and the patient was listed for a TKR which was scheduled for the 1/8/11. The patient had a routine post-operative review at 6 weeks, 6 months and 12 months, all on time, by the Physiotherapist in the Physiotherapy Arthroplasty Review Clinic. The complete time from the initial presentation to the ED through to the 12 month post-operative review was just under 19 months. This included one medical appointment by the orthopaedic surgeon.

In contrast the red line follows the pathway of a typical patient’s journey presenting to ED with the same condition but in the traditional medical model of care. Time frames are estimated based on available data. The estimated wait time from outpatients receiving the ED referral to seeing a surgeon (prior to OAHKS) was approximately 22 months. The graph only indicates one visit with the surgeon but in reality, several appointments were often required before the surgeon would list the patient.
for surgery. This was often related to the patient presenting with inadequate imaging and therefore needing to return for an additional appointment before the surgeon would list for surgery.

Post-surgery, the patient would be reviewed by the surgeon at 6/52, 6/12 and 12/12. Data is only available for the waiting times for the 12 month KPI. Data prior to the implementation of the PAR clinic, indicated only 18% of orthopaedic patients would receive their 12 month review appointment on time. A conservative estimate of the data suggests patients on average would receive their 12 month review approximately 40 days after their 12 month review was due.

Based on the satisfaction surveys collected from patients, the waiting time on the day has changed significantly from 3-4 hours waiting with the traditional medical model to 15 minutes with the Advanced Practice Physiotherapy Service. The number of medical appointments required with the traditional model is at least 6 appointments, and as indicated on the graph a total overall time from presenting to the ED to 12 month post surgical review is 40 months, over double the time spent by the patient attending the new model incorporating the Advanced Practice Musculoskeletal Physiotherapy services.

**Wait time to first appointment**

![Diagram showing wait time to first appointment](image)

**References:**

1. OAHKS Database, Health service specific
Appendix E –
Musculoskeletal Physiotherapist Job Descriptions

**POSITION DESCRIPTION – Advanced Musculoskeletal Physiotherapist (Clinical Lead)**

**Date revised:**

**POSITION:** Grade 3/4 - Advanced Musculoskeletal Physiotherapist (Clinical Lead)

**AWARD/AGREEMENT:** Health Services Union of Australia

**CLASSIFICATION TITLE:** VC8

**DEPARTMENT/DIVISION:** Physiotherapy

**ACCOUNTABLE TO:** Stream Leader (Musculoskeletal) Manager, Physiotherapy

**OPERATIONALLY ACCOUNTABLE:** Manager, Physiotherapy

**PROFESSIONALLY ACCOUNTABLE:** Manager, Physiotherapy

**DIRECT REPORTS:** <1-3>

**WORKS IN COLLABORATION WITH:** Medical Unit (insert Orthopaedics, Neurosurgery, Emergency etc. as appropriate)

**INSERT ORGANISATION DETAILS AND VALUES STATEMENT**

**JOB POSITION SUMMARY**

This position description is for a Grade 3/4 musculoskeletal physiotherapist who will be clinical lead physiotherapist responsible for the implementation of an Advanced Musculoskeletal Physiotherapy service in the (insert area of practice eg Neurosurgery, Orthopaedics etc.)

The Grade 3/4 clinical lead physiotherapist is responsible for the ongoing development and provision of the Advanced Musculoskeletal Physiotherapy services. The clinical lead is responsible for all operational requirements relating to the service. They will be responsible for maintaining a quality service with key performance data analysed and reviewed to drive service change. They will be responsible for the orientation, education of the physiotherapy team working within the unit. In addition ensuring all staff are assessed for competency and perform according to the Advanced Musculoskeletal Physiotherapy competency standard once the education and training program is completed.

The Grade 3/4 physiotherapist is also responsible for and expected to be engaged in research and/or quality activities within a specialised area of interest, or more broadly for the musculoskeletal physiotherapy service. They will be the key contact for liaising with the Director and staff of the relevant medical unit aligned with the Advanced Musculoskeletal Physiotherapy service.
The Grade 3/4 physiotherapist has an important role contributing to the development of individuals, the clinical team and the physiotherapy service through good leadership, teamwork and communication. They will be required to develop exceptional working relationships with the relevant medical and nursing units related to the provision of advanced musculoskeletal physiotherapy service.

This role requires a clinical leader with exceptional vision to implement and guide a service that is of high quality, sustainable, receptive to innovation and promotes growth into the future. An ability to effectively implement change management and promote a positive working culture will be an essential requirement of this role.

The Grade 3/4 physiotherapist will be expected to participate in the weekend roster providing Advanced Musculoskeletal Physiotherapy to the ED and may be required to work across campuses of the organisation.

**KEY RESPONSIBILITIES**

**Clinical**
- To be responsible for the strategic direction and development of advanced musculoskeletal physiotherapy services.
- To contribute to the provision of other advanced musculoskeletal physiotherapy services across the organisation, and the Physiotherapy Department’s Musculoskeletal Outpatient service, in conjunction with other grade 3 and 4’s and the Musculoskeletal Stream Leader.
- To assist in the development of other advanced roles more broadly within physiotherapy.
- To contribute to the provision and ongoing development of musculoskeletal physiotherapy as requested in consultation with stream leader at the level of a clinical expert.
- Attend unit meetings and contribute to the profile of physiotherapy within the relevant medical unit
- To provide high quality, safe and effective physiotherapy assessment and management for musculoskeletal presentations to the unit.
- Document all assessment, treatment and discharge information in the patient medical history, consistent with departmental and organisations policies.
- Conduct regular documentation and clinical audits required for clinical governance
- Enter all monthly clinical and non-clinical activity using the statistical software, in accordance with departmental policy.
- Provide advice regarding area of expertise to physiotherapy and other staff throughout the hospital and community as required.
- To ensure scope of practice of all musculoskeletal physiotherapists complies with the existing professional code of conduct, professional and legislative regulations.
- To recognise self limitations and limitations of other musculoskeletal physiotherapists in advanced musculoskeletal physiotherapy services in regard to scope of practice and identify when circumstances require consultation and referral on for medical review
- To take a leadership role in complex clinical situations
- Where appropriate and indicated, challenge and develop scope of practice to advance service development
- Maintain a current knowledge of relevant issues, trends and practices i.e. encourage and participate in evidence based practice
- Maintain their own competency according to the Advanced Musculoskeletal Physiotherapy Work-based Competency Standard
• The physiotherapist whilst working in the Advanced Musculoskeletal Physiotherapy clinical setting is accountable to the medical consultant from the relevant unit and is expected to liaise accordingly regarding clinical matters in a timely, appropriate way.

• The physiotherapist is expected to report any serious clinical issues to the Medical Director of the relevant unit and the Physiotherapy Manager.

Education
• To be responsible for their own clinical educational needs and demonstrate by example a commitment to ongoing education as identified by the learning needs analysis and self reflective practice and work-based competency standard.

• To be responsible for training new advanced musculoskeletal physiotherapists with the organisation.

• As the clinical lead, be responsible for conducting and overseeing ongoing education and training programs for advanced musculoskeletal physiotherapists working in the speciality area and coordinate this with the other advanced musculoskeletal physiotherapy services continuing education program.

• Participate in education programs and forums for disciplines outside physiotherapy, as appropriate.

• As scope of practice evolves recognise the need for education, training and competency of new skill sets.

Quality & Research
• To be responsible for the development, implementation and review of quality improvement and research activities within the area of advance musculoskeletal physiotherapy in consultation with the Stream Leader, and with the assistance of others.

• Actively contribute to policy development within the area of advanced musculoskeletal physiotherapy.

• Assist in other departmental, stream or unit quality initiatives.

• Active involvement in the departmental quality planning processes.

• Ensure work place safety for self and others.

• Utilise Riskman in the recording of incidents and near misses in accordance with the organisation’s policy.

• Ensure and facilitate compliance with and involvement in Occupational Health and Safety, Infection Control and Risk Management frameworks for clinical areas of responsibility.

• Present papers/posters at relevant conferences and peer reviewed journals.

Supervision
• Provide regular informal and formal supervision for Grade 3 staff within area of practice.

• Actively participate in formal supervision with Stream Leader and annual performance review as defined by departmental policy.
Professional Development

• To participate and contribute as an expert, in both internal and external continuing education programs (eg. case presentations, in-services, special interest group meetings and professional development events).
• Maintain a professional practice portfolio that contains evidence of learning and practice of new skills sets and competency that is applicable to advanced roles
• To demonstrate a commitment to improving professional performance.
• Assist in the professional development planning of the clinical stream
• Assist in the provision of educational resources, activities and opportunities within the clinical stream.
• Where appropriate mentor new advanced musculoskeletal physiotherapy trainees

Team and Communication

• Develops effective inter-professional relationships with key stakeholders including medical, nursing and relevant departments such as radiology and pharmacology.
• Deputises for stream leader in their absence.
• Ensure adherence to professional behaviours consistent with the organisation’s code of conduct, the Physiotherapists Registration Board of Victoria Code of Conduct for Physiotherapists and the Australian Physiotherapy Association Code of Conduct.
• Promotes effective communication within the team and emphasises the importance of exceptional communication skills by all members of the team, at all times, in all forms of communication.
• To be responsible for a portfolio of the department, consistent with experience and ability.
• To participate in regular relevant medical unit, musculoskeletal clinical stream and physiotherapy departmental meetings.

Other

• Apply knowledge and skills required for effective project management inclusive of overseeing and participating in data collection and analysis, service evaluation and report writing.
• Be effective in change management and the redesign process
• Undertake other responsibilities as directed by the Manager of Physiotherapy Services
• Abide by organisation’s corporate policies and practices as varied from time to time.
• Ensure safe work practices and environment in accordance with organisational policies as varied from time to time.
• In this position you must comply with the actions set out in the relevant section(s) of the OHS Roles and Responsibilities Guideline.

KPIs

• Annual registration with AHPRA (Mandatory)
• Annual attendance and participation in Emergency Procedures Training (Mandatory)
• Annual attendance at Back Smart Manual Handling Training (Mandatory)
• Annual attendance at Basic Life Support Training annually (Mandatory)
PERSON SPECIFICATION

Essential Qualifications:
- Physiotherapist registered to practice in the state of Victoria.
- Post-graduate qualification (Masters Level or Greater) in musculoskeletal field.
- Minimum seven years experience as a physiotherapist in the musculoskeletal area of practice
- Experience in the management of patients within an advanced musculoskeletal physiotherapy service.

Desirable Qualifications:
- Experience in project management and/or service implementation preferable
- Experience in facilitation of change management and/or service redesign preferable
- Completion of the Advanced Musculoskeletal Physiotherapy work-based competency assessment
- Previous presentations/publications record at conferences/peer review journal

KEY SELECTION CRITERIA:

Knowledge
- Expert knowledge in the provision of physiotherapy practice to musculoskeletal patients within the Outpatient, Screening Clinic & Emergency Department settings.
- Advanced knowledge in the areas of leadership, team work / dynamics and effective communication.
- Advanced knowledge in the areas of leadership, team work / dynamics and effective communication.
- Knowledge of the principle of continuity of care and of the links between admission, acute, rehabilitation, community and primary services.
- Knowledge of community and hospital services available on discharge from acute setting/relevant to area of practice.
- Knowledge of scope of practice regarding Advanced Musculoskeletal Physiotherapy services and legislative and regulatory acts relating to this for physiotherapists
- Knowledge of systems for clinical governance including the development of quality improvement activities, risk management, education and training, innovative and effective work practices
- Knowledge of the codes of practice and codes of ethics of physiotherapy.

Skills
- Clinical expertise in the physiotherapy assessment, treatment and clinical reasoning of musculoskeletal patients.
- Ability to thoroughly and effectively assess and manage musculoskeletal patients, through out the continuum of care.
- Ability to work collaboratively with the medical team and as an autonomous practitioner where required
- Ability to plan and manage caseload, to co-ordinate/delegate workloads as appropriate, across the department.
- Capacity to effectively manage issues both up and down the line of accountability.
- Advanced skills in the teaching of physiotherapists, undergraduate students and other staff.
- Ability to effectively lead a team.
- Ability to objectively assess and improve the quality of service being provided.
- Ability to plan and undertake research and to publish such research.
- Ability to plan and lead research relevant to physiotherapy practise.
- Excellent intra and inter personal skills, including time management, verbal and written communication, problem solving, conflict resolution and negotiation skills.
- Provide evidence demonstrating ability to establish and maintain close working relationships with key stakeholders such as medical unit directors
- Proficient in use of Microsoft Office, Excel and PowerPoint.

**Attitudes**

- High Performer
- Customer Focused
- Team Player
- Motivated, Enthusiastic and Dynamic
- Flexible
- Broad Perspective
- Committed to lifelong learning
- Treats people with integrity, in a friendly, caring, trusting and respectful manner
- Responsible and accountable
- Resilient and assertive
- Supportive and encourages

**Position Description authorised by:** , Physiotherapy Manager

Date:
POSITION DESCRIPTION – Grade 3 Advanced Musculoskeletal Physiotherapist (Service delivery)

Date revised:

POSITION: Grade 3 Senior Clinician Physiotherapist

AWARD/AGREEMENT: Health Services Union of Australia

CLASSIFICATION TITLE: VB7 – VC1

DEPARTMENT/DIVISION: Physiotherapy

ACCOUNTABLE TO: Grade 4 Physiotherapist Stream Leader
Musculoskeletal Manager, Physiotherapy

OPERATIONALLY ACCOUNTABLE: Manager, Physiotherapy

PROFESSIONALLY ACCOUNTABLE: Manager, Physiotherapy

DIRECT REPORTS:

WORKS IN COLLABORATION WITH: (insert medical unit and director)

INSERT ORGANISATION DETAILS AND VALUES STATEMENT

JOB POSITION SUMMARY

The Grade 3 physiotherapist is responsible for the ongoing provision of advanced musculoskeletal physiotherapy services and for routine musculoskeletal physiotherapy outpatient services. This position may include the education and supervision of physiotherapy students and the supervision and professional development of physiotherapy staff (Grade 1 and 2), assigned to this area.

The Grade 3 physiotherapist is also responsible for and expected to be engaged in research and / or quality activities within their specialised area of interest, or more broadly for the physiotherapy service. The Grade 3 physiotherapist has an important role contributing to the development of individuals, the clinical team and the physiotherapy service through good leadership, teamwork and communication.

This Grade 3 role is integrated into the Advanced Musculoskeletal Physiotherapy team and the physiotherapist is therefore expected to perform according to the work-based competency standard for Advanced Musculoskeletal Physiotherapy. In addition, they must be committed to participating in the education and training program, and to undergo the work-based competency assessment. Once deemed competent, the requirements for ongoing competency must be met.

This position requires the physiotherapist to work across more than one of the Advanced Musculoskeletal Physiotherapy service (list relevant services), the physiotherapist may be required to work across the organisation’s campuses, and be included on the weekend roster for the Advanced Musculoskeletal Physiotherapy service in the ED.
KEY RESPONSIBILITIES

Clinical
- To be responsible for the provision and ongoing service delivery of advanced musculoskeletal physiotherapy services as requested in consultation with stream leader at the level of a senior clinician physiotherapist.
- Attend unit meetings, contribute to discharge planning and provide physiotherapy intervention for patients of the designated units.
- Actively participate in and contribute to the physiotherapy care team to ensure operational effectiveness.
- Document all assessment, treatment and discharge information in the patient medical history, consistent with departmental and organisation’s policies.
- Enter all monthly clinical and non-clinical activity using the statistical software, in accordance with departmental policy.
- Provide advice regarding area of expertise to physiotherapy and other staff throughout the hospital and community as required.
- Have a good understanding of the Advanced Musculoskeletal Physiotherapy work-based competency standard
- Achieve competency as assessed according to the Advanced Musculoskeletal Physiotherapy work-based competency standard
- The physiotherapist whilst working in the Advanced Musculoskeletal Physiotherapy clinical setting is accountable to the medical consultant from the relevant unit and is expected to liaise accordingly regarding clinical matters in a timely, appropriate way.
- The physiotherapist is expected to report any serious clinical issues to the Medical Director of the relevant unit and the Physiotherapy Manager.

Education
- Leading role in the delivery of physiotherapy education within the clinical stream, as a part of a training organisation.
- Provide education to Undergraduate and Post Graduate Physiotherapy Students as required under the direction of the stream leader.
- Participate in education programs and forums for disciples outside physiotherapy, as appropriate
- Commit to completing the requirements of the Advanced Musculoskeletal Physiotherapy education and learning program, and work-based competency assessment.

Quality & Research
- Lead departmental, stream or unit quality initiatives.
- Active involvement in the departmental quality planning processes.
- Lead research projects with support of others.
- Utilise Riskman in the recording of incidents and near misses in accordance with the organisation’s policy.
- Ensure and facilitate compliance with and involvement in Occupational Health and Safety, Infection Control and Risk Management frameworks for clinical areas of responsibility.
- Present papers/posters at relevant conferences
Professional Development
• To participate and contribute as an expert, in both internal and external continuing education programs (eg. case presentations, inservices, special interest group meetings and professional development events).
• To participate in a mentoring program to promote professional growth and development
• To demonstrate a commitment to improving professional performance.
• Assist in the professional development planning of the clinical stream
• Assist in the provision of educational activities and opportunities within the clinical stream.

Team and Communication
• Provides leadership for sub stream
• Deputises for senior staff in their absence.
• Ensures adherence to professional behaviours consistent with the organisation’s code of conduct, the Physiotherapists Registration Board of Victoria Code of Conduct for Physiotherapists and the Australian Physiotherapy Association Code of Conduct.
• Promotes effective communication within the multi-disciplinary team and in particular with the medical team in a timely, accurate and respectful manner.
• Builds effective working relationships with stakeholders of Advanced Musculoskeletal Physiotherapy services
• To be responsible for a portfolio of the department, consistent with experience and ability.
• To participate in regular clinical stream, medical unit and departmental meetings.

Other
• Undertake other responsibilities as directed by the Manager of Physiotherapy Services
• Abide by organisation’s corporate policies and practices as varied from time to time.
• Ensure safe work practices and environment in accordance with organisation’s policies as varied from time to time.
• In this position you must comply with the actions set out in the relevant section(s) of the OHS Roles and Responsibilities Guideline.

KPIs
• Annual registration with the AHPRA (Mandatory)
• Annual attendance and participation in Emergency Procedures Training (Mandatory)
• Annual attendance at Back Smart Manual Handling Training (Mandatory)
• Annual attendance at Basic Life Support Training annually (Mandatory)

PERSON SPECIFICATION

Essential Qualifications
• Physiotherapist registered to practice in the state of Victoria.
• Post-graduate qualification in relevant field, (or be working towards) or APA Musculoskeletal Physiotherapist title holder (either academic or experiential pathway).
• Seven years’ experience as a physiotherapist
Desirable Qualifications

- Experience in the management of patients within an advanced musculoskeletal physiotherapy service desirable

**KEY SELECTION CRITERIA:**

**Knowledge**

- Advanced knowledge in the provision of musculoskeletal physiotherapy practice to acute musculoskeletal presentations.
- Advanced knowledge in the areas of leadership, team work / dynamics and effective communication.
- Knowledge of the principle of continuity of care and of the links between admission, acute, rehabilitation, community and primary services.
- Knowledge of community and hospital services available on discharge from acute setting/relevant to area of practice.
- Knowledge of scope of practice regarding Advanced Musculoskeletal Physiotherapy services
- Knowledge of systems for clinical governance including the development of quality improvement activities, education and training, innovative work practices and evaluation of service delivery
- Knowledge of the codes of practice and codes of ethics of physiotherapy.

**Skills**

- Clinical expertise in the physiotherapy assessment and treatment of musculoskeletal patients.
- Ability to thoroughly and effectively assess and manage musculoskeletal patients, throughout the continuum of care.
- Ability to plan and manage caseload, to co-ordinate/delegate workloads as appropriate, across the department.
- Excellent clinical reasoning skills
- Capacity to effectively manage issues both up and down the line of accountability.
- Advanced skills in the teaching of physiotherapists, physiotherapy students and other staff.
- Ability to effectively lead a team.
- Ability to provide guidance and support to other staff working within an interdisciplinary framework
- Ability to objectively assess and improve the quality of service being provided, within the stream as delegated.
- Strong assessment skills in the area of clinical risk and an ability to identify and implement strategies to minimise risk
- Plan and lead research relevant to musculoskeletal physiotherapy practice.
- Excellent intra and inter personal skills, including time management, verbal and written communication, conflict resolution and negotiation skills.
- Proficient in use of Microsoft Office, Excel and PowerPoint.
Attitudes

- High Performer
- Customer Focused
- Team Player
- Motivated and Enthusiastic
- Flexible
- Broad Perspective
- Committed to lifelong learning
- Treats people with integrity, in a friendly, caring, trusting and respectful manner
- Responsible and accountable

Position Description authorised by: Physiotherapy Manager

Date:
POSİTİON DESCRIPTION – Grade 2/3* Advanced Musculoskeletal Physiotherapy (Trainee)

Date revised:

POSITION: Grade 2/3* Physiotherapist Musculoskeletal Stream.

AWARD/AGREEMENT: Health Professionals (Public Sector Victoria)

CLASSIFICATION TITLE: Grade 2/3* (advanced musculoskeletal physiotherapy trainee) Musculoskeletal Stream

DEPARTMENT/DIVISION: Physiotherapy

ACCOUNTABLE TO: Physiotherapy Manager, Grade 4 Physiotherapists, and Grade 3 Physiotherapists

 OPERATIONALLY ACCOUNTABLE: Manager, Physiotherapy

PROFESSIONALLY ACCOUNTABLE: Manager, Physiotherapy

DIRECT REPORTS:

WORKS IN COLLABORATION WITH: (insert medical unit and director)

*Grade 2 or 3 to be determined by organisation based on position available, level of expertise of physiotherapist. It may be negotiated that Gr 3 role is offered once training completed or applicant maybe employed at a Gr 2 role and undergo the training but has to wait until a Gr 3 role becomes available before upgrade to Gr 3 can occur – in this situation the applicant should be expected to fulfil the responsibilities of a Gr 2 and work in advanced musculoskeletal physiotherapy services under supervision as a smaller component of their job requirements.

INSERT ORGANISATION DETAILS AND VALUES STATEMENT

JOB POSITION SUMMARY

The Grade 2/3 will be responsible for the provision of a high quality physiotherapy service to musculoskeletal physiotherapy outpatients and patients in advanced musculoskeletal physiotherapy services. They will work with the Grade 3 and 4 physiotherapists to ensure that the physiotherapy service is responsive to the changing needs of the community and works within an interdisciplinary framework to optimise care and minimise risk.

The Grade 2/3 will assist in the operational leadership in the Musculoskeletal stream by becoming involved in portfolios in the areas of clinical, managerial, research and teaching, and performance management. The position requires involvement in the up skilling of junior physiotherapy staff and physiotherapy students within the Musculoskeletal stream.

This position requires the physiotherapist to commit to participation in the education and training program and work-based competency assessment for advanced musculoskeletal physiotherapy services which may require the physiotherapist to work across more than one of the Advanced
Musculoskeletal Physiotherapy service (list relevant services), in addition the physiotherapist may be required to work across the organisation’s campuses, and be included on the weekend roster for the Advanced Musculoskeletal Physiotherapy service in the ED.

KEY RESPONSIBILITIES

Clinical
• To be responsible for the provision and ongoing service delivery of musculoskeletal physiotherapy services as requested in consultation with stream leader at the level of a senior Gr 2/3 musculoskeletal physiotherapist.
• Actively participate in and contribute to the physiotherapy team to ensure operational effectiveness.
• Document all assessment, treatment and discharge information in the patient medical history, consistent with departmental and organisation’s policies.
• Enter all monthly clinical and non-clinical activity using the statistical software, in accordance with departmental policy.
• Maintain an individual clinical caseload and act as a resource in the relevant areas of expertise within the organisation.
• Provide advice regarding in the area of musculoskeletal physiotherapy to other staff throughout the hospital and community as required.
• Commence supervised training in Advanced Musculoskeletal Physiotherapy services as directed by Stream leader.
• Become familiar with the Advanced Musculoskeletal Physiotherapy work-based competency standard.
• Work towards to requirements of the work-based competency assessment.
• The physiotherapist whilst working in the Advanced Musculoskeletal Physiotherapy clinical setting is directly accountable to the supervising physiotherapist who may then liaise with medical consultant from the relevant unit.
• The physiotherapist is expected to report any serious clinical issues to the Medical Director of the relevant unit and the Physiotherapy Manager.
• Help to ensure physiotherapy clinical practice within the Musculoskeletal stream is evidence based, works from the principles of best practice and is tailored to meet the individual needs of clients.
• Be involved in the development and maintenance of systems to review the effectiveness and efficiency of physiotherapy intervention within the Musculoskeletal stream.
• Help stream leaders to develop, implement and evaluate systems to minimise clinical risk and promote these with junior staff.
• Be involved in the supervision and performance management of Grade 1 and AHA staff within the clinical stream.
• Provide support for the Manager of Physiotherapy and senior stream therapists in a range of activities including quality and business planning, representation on internal and external committees and university course development.
• Undertake other responsibilities as required by the Physiotherapy Manager.
Education
- Be committed to the participate in the additional requirements of the Advanced Musculoskeletal Physiotherapy education and training program, and be prepared to undergo the work-based competency assessment.
- Be involved in the teaching of undergraduate physiotherapists through direct student supervision, ongoing review and improvement of clinical placement content with stream clinical educators and stream leader and representation at appropriate clinical school meetings.
- Participate in education programs and forums for disciples outside physiotherapy, as appropriate.

Quality & Research
- Participate in departmental, stream or unit quality initiatives.
- Active involvement in the departmental quality planning processes.
- Participate in research projects with support of others.
- Utilise Riskman in the recording of incidents and near misses in accordance with the organisation’s policy.
- Ensure and facilitate compliance with and involvement in Occupational Health and Safety, Infection Control and Risk Management frameworks for clinical areas of responsibility.
- Contribute to the presentation of papers/posters at relevant conferences with the support of senior staff.

Professional Development
- Continue to develop own clinical expertise across the areas within the clinical stream particularly progressing towards being a competent musculoskeletal advanced practice physiotherapist.
- Demonstrate an interest in undertaking formal post graduate studies in the area of musculoskeletal physiotherapy and preferably be enrolled in post graduate education for purposes of developing into a competent advanced musculoskeletal physiotherapist.
- To participate in a mentoring program to promote professional growth and development.
- To demonstrate a commitment to improving professional performance.
- Work with individual staff that you supervise to further develop clinical, interdisciplinary team and professional skills.

Team and Communication
- Develops effective communication to the level required for advanced musculoskeletal physiotherapy services.
- Ensures adherence to professional behaviours consistent with the organisation’s code of conduct, the Physiotherapists Registration Board of Victoria Code of Conduct for Physiotherapists and the Australian Physiotherapy Association Code of Conduct.
- Promotes effective communication within the multi-disciplinary team and in particular with the medical team in a timely, accurate and respectful manner.
- Begins to develop effective working relationships with key staff involved in Advanced Musculoskeletal Physiotherapy services.
- To be responsible for a portfolio of the department, consistent with experience and ability.
- To participate in regular clinical stream, medical unit and departmental meetings.
Other

- Undertake other responsibilities as directed by the Manager of Physiotherapy Services
- Abide by organisation’s corporate policies and practices as varied from time to time.
- Ensure safe work practices and environment in accordance with organisation’s policies as varied from time to time.
- In this position you must comply with the actions set out in the relevant section(s) of the OHS Roles and Responsibilities Guideline.

KPIs

- Annual registration with the AHPRA (Mandatory)
- Annual attendance and participation in Emergency Procedures Training (Mandatory)
- Annual attendance at Back Smart Manual Handling Training (Mandatory)
- Annual attendance at Basic Life Support Training annually (Mandatory)

PERSON SPECIFICATION

Essential Qualifications

- Physiotherapist registered to practice in the state of Victoria.
- Completion of post graduate courses/continuing education relevant to Musculoskeletal Physiotherapy
- Minimum five years experience as a physiotherapist

Desirable Qualifications

- Experience working in a Gr 2 Outpatient Musculoskeletal physiotherapy role
- Experience in the provision of undergraduate clinical education
- Diverse and recent experience in the public health care setting
- Post-graduate qualification in relevant field, (or be working towards) or APA Musculoskeletal Physiotherapist title holder (either academic or experiential pathway) desirable.

KEY SELECTION CRITERIA:

Knowledge

- Strong clinical knowledge in the outpatient physiotherapy department or in the area of musculoskeletal physiotherapy.
- An understanding of the healthcare environment and future trends in physiotherapy service provision.
- Knowledge of the principle of continuity of care and of the links between admission, acute, rehabilitation, community and primary services.
- Knowledge of community and hospital services available on discharge from acute setting/relevant to area of practice.
- Basic knowledge of scope of practice and operational requirements regarding Advanced Musculoskeletal Physiotherapy services
- Developing knowledge and involvement in research and quality improvement processes
Skills

• Sound clinical skills in the physiotherapy assessment and management of musculoskeletal patients
• Ability to plan and manage caseload, to co-ordinate/delegate workloads as appropriate, across the department
• Very good clinical reasoning/decision making skills in the clinical areas of the designated stream operating within an interdisciplinary team
• Excellent verbal and written communication and negotiation skills.
• Proven ability to work effectively in an interdisciplinary team
• Strong assessment skills in the area of clinical risk and an ability to identify and implement strategies to minimise risk
• Proven ability and commitment to work collaboratively with patients and their carers in a person centred framework
• Experience in the provision of undergraduate clinical education
• Proficient in use of Microsoft Office and PowerPoint

Attitudes

• High Performer
• Customer Focused
• Team Player
• Motivated and Enthusiastic
• Flexible
• Broad Perspective
• Committed to lifelong learning
• Treats people with integrity, in a friendly, caring, trusting and respectful manner
• Responsible and accountable

Position Description authorised by: Physiotherapy Manager

Date:
Appendix F – Business Case Template

Business Case Template – Example

Summary
A brief summary of the business case

Example:
The Alfred Physiotherapy Service seeks funding to commence a Primary Contact Musculoskeletal Service in the Emergency Department.

This initiative is based on other successful models implemented throughout Melbourne.

Objectives
Outline the primary objectives of the initiative.

Example:
The primary objectives of the initiative are:

- To reduce the waiting times for Triage Category 4 and 5 patients, with musculoskeletal conditions, such as soft tissue injuries and back pain.
- To provide rapid and appropriate physiotherapy input and management to these particular patients, thereby reducing representations of such patients.

Strategic Context
The proposal needs to address where it fits within the local strategic plan and framework.

- Outline how the project/service will align with the organisational strategy for meeting its goals and objectives.

Background
Present some background information and any relevant data explaining the reason for the change / initiative.

Example:
This proposal is targeted at improving our 4 Hour LOS for Non Admitted Patients performance. Our performance in 2006-07 for this DHS KPI is summarised in Table 1.

Table 1: 4 Hour LOS for Non Admitted Patients Performance

<table>
<thead>
<tr>
<th></th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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</thead>
<tbody>
<tr>
<td>Non Admitted ED LOS &lt; 4 Hr</td>
<td>70 %</td>
<td>71 %</td>
<td>74 %</td>
<td>68 %</td>
<td>72 %</td>
<td>72 %</td>
<td>67 %</td>
<td>73 %</td>
<td>68 %</td>
<td>70 %</td>
<td>73 %</td>
<td></td>
</tr>
</tbody>
</table>

From the table it becomes quite apparent that there is a great opportunity to improve our performance for this DHS KPI. This proposal will have the desired results of securing a bigger portion of the available bonus grants and improving our overall Performance Monitoring Framework score.
Proposal
Outline the proposal clearly and succinctly.
Include and key partnerships that will be required for the success of the service. Alternative models to be considered could also be proposed.

Example:
- Full model
- Limited model
- Targeted model

Current and Future Costs and Savings
Outline Costs of various proposed models

Example:

<table>
<thead>
<tr>
<th></th>
<th>Full</th>
<th>Limited</th>
<th>Targeted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries Grade 4 Physiotherapist</td>
<td>$84,650</td>
<td>$67,720</td>
<td>$50,790</td>
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<tr>
<td>Salary On-Costs</td>
<td>$16,930</td>
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</tr>
<tr>
<td>Salaries Grade 3 Physiotherapist</td>
<td>$30,050</td>
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<td>$22,540</td>
</tr>
<tr>
<td>Weekend Penalties</td>
<td>$15,030</td>
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<tr>
<td>Salary on Costs</td>
<td>$9,020</td>
<td>$6,760</td>
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<tr>
<td>Leave Cover</td>
<td>$13,000</td>
<td>$10,150</td>
<td>$8,460</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$168,680</strong></td>
<td><strong>$131,980</strong></td>
<td><strong>$109,980</strong></td>
</tr>
</tbody>
</table>

Service Delivery Benefits Expected
Outline clear benefits of the proposed model of care

Examples:
- Reduce waiting times for Triage Category 4 and 5 patients, with musculoskeletal conditions, such as soft tissue injuries and back pain, presenting to the Emergency Department.
- Provision of immediate and appropriate physiotherapy input and management to these particular patients, thereby reducing representations of such patients.

Ease of Integration with Existing Services
Briefly discuss integration of new service
Involvement and Consultation with Key Stakeholders

*Identify key stakeholders who support the proposal*

This proposal has been discussed extensively with:

- Allied Health Director
- Director of Emergency
- Director Of Operations
- Director of Nursing and Ambulatory Care

**Proposed Funding for the Project**

*Outline the source(s) of funds for new/increased expenditure*

**Project Authorisation**

*Outline which authorities have already authorised the new service/project*

**Example:**

- Allied Health Director
- Medical Director
- Director of Operations
Appendix G – PAR Clinic Guideline

EXAMPLE

Guideline Title: Orthopaedic Clinic- Physiotherapy Arthroplasty Review Clinic (PAR clinic)

<table>
<thead>
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<table>
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<table>
<thead>
<tr>
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<th>Rev.: 00#</th>
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<table>
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<tr>
<th>Date Approved:</th>
<th>Review Date:</th>
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</tbody>
</table>

PURPOSE

Establish a working framework to ensure appropriate utilisation of available capacity within the clinic. This will ensure the right patient/clinic/doctor/physiotherapist formula is adhered to, which will enhance the flow and throughput of each clinic.

There will be agreement and support of the clinic templates from both Outpatient manager, Physiotherapy Dept and the Orthopaedic Unit to resource the clinics in accordance with the agreed template.

Guideline

- The PAR clinic is targeting arthroplasty patients following Primary Total knee and Hip replacements. (refer to PAR guidelines for exclusion criteria)
- The PAR clinic is to run concurrently with S.C.C (VMO Clinic) on Thursday/Friday. Two week reviews will be seen on a Tuesday morning.
- Patient recruitment for the PAR clinic is to occur at the Pre Admission Clinic.
- Patients appropriate for the PAR clinic will be identified in Pre Admission Clinic and upon discharge 2 or 6 week requests for appointments will be made for an appointment at the PAR clinic, ensuring that the appointment is made for the same day that their surgeon attends clinic.
- An appointment letter detailing information about the PAR clinic will be sent to patients prior to their appointments with contact information provided.
- Any patient identified at the PAR clinic who requires an orthopaedic consultant will be seen without delay for a review by the operating Surgeon
- A radiology appointment for routine X-Rays will be given on the day of, and prior to the PAR appointment.
- These guidelines are to be used in conjunction with PAR clinical guide

RELATED DOCUMENTATION

Consultant specific capacity guidelines
Overbooking Process
Orthopaedic Outpatient Referral guidelines
PAR clinical guide
Orthopaedic Clinic- Physiotherapy Arthroplasty Review Clinic (PAR clinic) X-ray Referral Guideline
AUTHORISED BY:
(Manager of Physiotherapy)
(Director of Orthopaedics)
(Manager of Outpatients)
(Radiographer in Charge)

REFERENCES
Charter of Human Rights and Responsibilities Act 2006 (Vic)¹

Contact person:
Position: Musculoskeletal Physiotherapy Stream Leader
Email:
Phone:

¹ REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this policy have an obligation to ensure that all decisions and actions are compatible with relevant human rights.
Appendix H – Clinical Guidelines – Imaging and Pharmacology

EXAMPLE

Guideline Title: Over the counter analgesia by Musculoskeletal Physiotherapist in the Emergency Department

PURPOSE

The health service is committed to ensuring that the best possible timely service is provided to all patients attending the Emergency Department. This guideline provides a framework for musculoskeletal primary contact physiotherapists practicing in the Emergency Department to prescribe and administer analgesia (unscheduled) in the Emergency Department that is otherwise available over the counter.

The objective of this guideline is to improve the efficiencies of patient care for those patients whom the primary care giver is a musculoskeletal physiotherapist. The musculoskeletal physiotherapist regularly liaises closely with the Nurse Practitioners and Emergency Consultants. This guideline to support the prescribing and administration of over the counter analgesia by musculoskeletal physiotherapists will minimize the need for multiple consultations with the Emergency Department Consultants and ensures the patient receives safe, timely, appropriate analgesia that will avoid prolonging their stay in the Emergency Department.

GUIDELINE:

This guideline will only apply to physiotherapists who meet and abide by the following criteria:

- The physiotherapist holds a post graduate Masters degree in Musculoskeletal or equivalent physiotherapy
- The physiotherapist has a minimum of 7 years experience in the musculoskeletal field and demonstrates a high level of assessment and clinical reasoning skills in routine practice.
- The physiotherapist has completed the E&TC physiotherapy credentialing competency checklist that includes completion of The University of Melbourne Pharmacology module: Pharmacology & Therapeutics 1
- The physiotherapist must demonstrate extensive knowledge and awareness of the mechanism of action, clinical indications, drug interactions and dosage of the drugs listed.

The physiotherapist must act in accordance with the “Guidelines for physiotherapists regarding medicines” issued by the Physiotherapy Board of Australia (July 2010)
INDICATIONS

This Guideline will apply for patients with musculoskeletal conditions seen by a musculoskeletal physiotherapist working in the Advanced Practice Musculoskeletal Physiotherapy (Emergency Department) role that present with mild pain (pain score 1-4). Patients with a pain score greater than 4 will require analgesia prescribed by an Emergency doctor or Endorsed Nurse Practitioner.

This guideline will only include analgesia available over the counter such as at supermarkets – paracetamol and ibuprofen (see table below)

<table>
<thead>
<tr>
<th>Indications</th>
<th>Medication</th>
<th>Precautions and Contra-Indications to be documented</th>
</tr>
</thead>
</table>
| Simple analgesia required for musculoskeletal presentations presenting to the E&TC | Paracetamol 500mg: 1 or 2 tablets orally 4-6/24, not to exceed 8 tablets in 24 hours | • Known allergies  
• Analgesia (including cough medicines) taken prior to arrival to E&TC  
• Patients with chronic liver disease and/or excessive alcohol intake |
| Pain scale 1-4 | Ibuprofen 200mg: 1-2 tablets every 4-6 hours, not to exceed 6 tablets in 24 hours | • Known allergies  
• Analgesia taken prior to arrival to E&TC  |

Contra-Indications:
• Aspirin or NSAID insensitivity  
• Stomach disorders  
• Ulcers  
• Renal Impairment  
• Cardiac failure  
• Pregnancy  

Precautions:
• Asthma  
• Prolonged use  

Drug Interactions:
• Antihypertensive  
• Diuretics  
• Lithium  
• Methotrexate  
• Anticoagulants  

AUTHORISED
(Physiotherapy Manager)  
(Director of the Emergency and Trauma centre) (Director of Pharmacy)  
(Allied Health Director)
RELATED DOCUMENTATION
Primary Practice Musculoskeletal Physiotherapist in the Emergency and Trauma Centre Orientation Manual

The Health Service Physiotherapy competency standard for Advanced Practice Physiotherapy clinics


REFERENCES
Charter of Human Rights and Responsibilities Act 2006 (Vic)¹

Mims online: https://www.mimsonline.com.au

Contact person:

Position: Musculoskeletal Physiotherapist

Email: Phone:

¹ REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this policy have an obligation to ensure that all decisions and actions are compatible with relevant human rights.
Appendix I – Managing risk/adverse events

MANAGING ADVERSE EVENTS FOR ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY SERVICES IN PUBLIC HEALTH

GUIDELINES
These guidelines should be read in conjunction with the local risk management policy of the organisation, local risk management guidelines, incident management guidelines of the local health organisation as well as a local open disclosure policy and guidelines following an adverse event.

PURPOSE
The aims of incident management are to
1. Minimise harm to patients, staff, visitors and the organisation
2. Provide information and support to patients, staff, visitors, who are affected by incidents, in a timely and factual manner
3. Identify opportunities for improvement in systems and practices
4. Comply with statutory requirements

BACKGROUND
Physiotherapists working in advanced musculoskeletal physiotherapy roles take on a higher level of risk than in usual occupation, associated with patient management where it is essential to have incident management guidelines in place. The advanced musculoskeletal physiotherapy and local service benefits from effective systems for reporting, and investigating incidents that can potentially cause harm. Reporting all incidents, hazards and near misses provides an opportunity to analyse trends, identify risk and implement risk strategies to improve safety. Understanding the principle of open disclosure following an adverse event enables appropriate communication in managing the adverse event.

DEFINITIONS
INCIDENT
An unintended event or outcome with the potential to, or that has caused harm to a person(s) or loss or damage to the organisation. It applies to all events that result in actual or potential harm, including near misses. It applies to patients, staff, visitors, volunteers, contractors, equipment and the organisation

ADVERSE EVENT
An unintended injury or complication, which results in disability, death or prolonged hospital stay and is caused by the health care organisation rather than the patients’ condition

NEAR MISS
A situation in which there is potential for an incident or adverse event to occur.

MEDICATION INCIDENT
Occurs during prescribing, dispensing, storing and/or administration of the drug.
ADVERSE DRUG EVENT
Medication incident that causes patient harm.

ADVERSE DRUG REACTION
A particular type of adverse drug reaction which includes side effects associated with medication.

SENTINEL EVENT (CLINICAL INCIDENT)
Relatively infrequent clear cut event that commonly reflects hospital system and process deficiencies and results in unnecessary extreme adverse outcomes for patients

NOTIFIABLE EVENT (OHS)
An incident at the workplace resulting in, or exposing people to risk of serious injury or death.

OPEN DISCLOSURE
An open consistent approach to communicating with patients following an adverse event. It involves an expression of regret for what has happened, the provision of information about what happened and feedback about investigations of the adverse event. Discussions with the patient should also refer to what will be done to prevent a similar event from recurring. (Australian Council for Safety and Quality in Health Care. National Open Disclosure Standard July 2003)

EXPRESSION OF REGRET
An expression of sorrow for the harm experienced by the patient. It is not an admission of liability.

CLINICALLY APPROPRIATE
When the treating medical consultant or equivalent deem the adverse event (regardless of outcome) to warrant a high level response.

INCIDENT MANAGEMENT PROCESS

IMMEDIATE MANAGEMENT
The staff member’s first priority is to manage the situation to ensure the safety of all persons who are directly involved or will be potentially affected by the incident.

The need for medical assessment is determined and organised.

The incident must be reported to the most appropriate senior staff member at the time (likely physiotherapy manager and head of specialist unit)

After safety is ensured the incident must be reported on the incident reporting system ie Riskman type programme endorsed by the organisation. A grouped incident function may be used to manage several reports for one incident pertaining to the staff member and the patient. This reporting should occur as soon as practicable.

All incidents involving patients should also be reported in the patient information management system.

SENTINEL EVENTS
Must be notified immediately to the Clinical Governance Unit and the Chief Medical Officer
INCIDENT RATING PROCESS

All incidents are assessed for severity via a scale supported by the local organisation. This assists in determining the level of risk, urgency of response and subsequent responsibility for action. An example is the system adopted by the Health Service, Incident Ratings 1-4 from the Department of Health where the assessment process provides a numerical rating based on consequence.

Incident Severity Rating 1/ISR 1: these incidents result in preventable death or permanent disability to a person, substantial financial loss or adverse publicity.

Incident Severity Rating 2/ISR 2: These incidents result in serious harm and must be notified to senior managers who are responsible for establishing a management plan. These include injury with a long term effect, impact on the function of the hospital, potential for adverse publicity or financial loss.

Incident Severity Rating 3/ISR 3: These incidents are medium adverse outcomes and may be dealt with at a local level. This includes events that result in a person having an unexpected or unplanned health impairment requiring increased treatment but not increased length of hospital stay, or long term consequence. These include non-individual incidents that may create an interruption to function or minor financial loss.

Incident Severity Rating 4/ISR 4: These incidents are low risk and are managed by routine procedure. They may include patient incident without injury, complaints or equipment failure without consequence.
## Degree of Severity

<table>
<thead>
<tr>
<th>Degree of Severity</th>
<th>Clinical Patient/Client/Resident</th>
<th>OHS Staff/Volunteer/Visitor Contractor/Student</th>
<th>Security Property</th>
<th>Organisational</th>
</tr>
</thead>
<tbody>
<tr>
<td>ISR1 Extreme</td>
<td>An unexpected death not related to the natural course of the patient's illness or underlying condition or sentinel event.</td>
<td>Death of a staff member, volunteer, contractor, student or visitor due to an incident.</td>
<td>Large financial loss &gt; 3 million leading to disruption of business.</td>
<td>Significant adverse publicity. Department of Health and/or other regulatory authority investigation. Extended service closure.</td>
</tr>
<tr>
<td>ISR2 Major</td>
<td>Permanent disfigurement or disablement not related to the natural course of a patient's underlying illness or condition.</td>
<td>Disfigurement or disablement causing inability to work in the future.</td>
<td>Damage between $1–2.9 million.</td>
<td>Local adverse publicity. Temporary closure of service. Serious complaint anticipated.</td>
</tr>
<tr>
<td>ISR3 Moderate</td>
<td>Healthcare service required as a result of incident.</td>
<td>Healthcare service required as a result of incident.</td>
<td>Damage between $100000–$0.99 million.</td>
<td>Complaint anticipated.</td>
</tr>
<tr>
<td>ISR4 Minor</td>
<td>No additional healthcare required or minor first aid.</td>
<td>First aid treatment only.</td>
<td>Damage $100000–$90000 or no financial loss or loss of any utility without adverse outcome to persons.</td>
<td>Local investigations and risk treatments.</td>
</tr>
</tbody>
</table>

### RESPONSIBILITIES

**STAFF MEMBER INVOLVED OR IDENTIFYING THE INCIDENT IS RESPONSIBLE FOR ENSURING:**

- Immediate intervention to ensure injury is treated and/or no further harm occurs to injured person or others
- The person in charge is notified immediately
- Incident is reported as soon as practical on the reporting system
- Details of any patient incident are recorded in the medical record including a documented reassessment of risk, where appropriate.

**PERSON IN CHARGE AT TIME OF INCIDENT IS RESPONSIBLE FOR ENSURING:**

- Immediate incident management
- Medical review has occurred for any incident involving harm to a patient or staff member and/or where there is potential for harm.
- Monitoring and additional observations are completed for patients.
- Appropriate managers are notified for incidents resulting in an extreme or major adverse event (ISR 1 & 2) or as per local requirement.
Advanced Musculoskeletal Physiotherapy Operational Framework

Family members are notified as appropriate
The incident has been recorded on the reporting system and all documentation has been completed.

LINE MANAGER IS RESPONSIBLE FOR ENSURING:

- The appropriate line managers are notified in keeping with local policy for incidents resulting in an extreme or major adverse outcome ISR 1 & 2
- Appropriate and timely intervention and action has been taken including further review where necessary eg case review
- Feedback is provided to staff about the outcome of the incident
- Staff receive training for incident reporting procedures and management

DIRECTORS ARE RESPONSIBLE FOR ENSURING:

- The Chief Medical Officer, Chief Nursing Officer, Chief Executive, Clinical Governance unit and senior staff are notified of all extreme events in keeping with local policy.
- A timely and appropriate response has occurred
- Debriefing for staff has occurred as necessary.
- Peer support offered to staff
- Appropriate incident management and risk minimisation strategies

CLINICAL GOVERNANCE UNIT IS RESPONSIBLE FOR ENSURING:

- All incidents with an extreme outcome have been notified to the Chief Executive, Executive Directors and General Counsel in keeping with local policy.
- Appropriate incident investigation has occurred.
- Review the appropriate classification of all incidents.
- A root cause analysis or case review has occurred for any incident resulting in serious injury or death.
- All incidents entered on local incident reporting system are reviewed, appropriately classified and rated and then posted into the database.
- That data and trends are provided to appropriate committees.
- All incidents are reported to Victorian Managed Insurance Authority (VMIA).
- Coordination of incident reporting and management.

OCCUPATIONAL HEALTH AND SAFETY UNIT IS RESPONSIBLE FOR ENSURING:

- Immediate verbal notification and written report within 48 hours to Worksafe or other relevant statutory of all notifiable incidents.
- Appropriate incident investigation has occurred.
- A root cause analysis or case review has occurred for any incident resulting in serious injury or death.
- Data and trends are provided to appropriate committees.
- Review the appropriate classification of all OHS related incidents.
OPEN DISCLOSURE/COMMUNICATION WITH PATIENT FOLLOWING AN ADVERSE EVENT

Open disclosure facilitates open communication with patients and their support person after an adverse event has occurred. This will include an expression of regret that the event has occurred and a factual explanation of what happened.

The open disclosure process commences with the recognition that a patient has suffered unintended harm during treatment or when deemed clinically appropriate. The process varies according to the nature of the adverse event.

- A “low level response” is warranted for adverse events with an incident severity rating of minor (ISR4) or moderate (ISR3).
- A “high level response” is warranted for adverse events with an incident severity rating of major (ISR2) or extreme (ISR1).

The relevant unit head may direct staff to follow a high level response for an incident if deemed clinically appropriate.

MANAGEMENT OF A LOW LEVEL ADVERSE EVENT

In most cases where a low level response is indicated, the process will be completed with a discussion with the patient.

MANAGEMENT OF A HIGH LEVEL ADVERSE EVENT

Relevant executives as dictated by local policy should be notified within hours of an extreme outcome.

FIRST RESPONSE DIRECT PATIENT CARE & NOTIFICATION

The first priorities after an adverse event resulting in an extreme outcome are prompt and appropriate clinical care, prevention of further harm and notification to stakeholders, including patient, family, treating medical consultant and the head of the treating unit. The head of unit is responsible for ensuring that open disclosure has occurred.

PRELIMINARY TEAM DISCUSSION

A multidisciplinary team, including the most senior health care professional directly involved in the care of the patient should meet as soon as practical after the event. This should be facilitated by site Risk Coordinators. The team convened by Head of Unit should be responsible for

- Establishing the basic facts
- Identifying the person responsible for coordinating the investigation process
- Identifying the person responsible for coordinating the disclosure process
- Consider the process of engaging support for the patient, ideally a family member
- Identify immediate support needs for the staff
- Reach consensus on the approach to disclosure that will ensure consistency
- Consider legal and insurance issues both for the organisation and the health care professional
- Identify the person who will act as a liaison for the patient and his/her support in the post disclosure phase
- Document in the medical record the open disclosure meeting and plan of care
INITIAL INTERVIEW WITH PATIENT AND PATIENT SUPPORT

- Consider timing in that the initial discussion should occur as soon as possible after the event with availability of key staff and considering patient preference.
- Identification of appropriate individual to make the disclosure; ideally a senior clinician who is known to the patient, of sufficient seniority to be credible, with training in open disclosure and who is able to offer a medium to long term relationship with the patient in offering assurance and feedback to the patient and their support person.
- Junior healthcare professionals should not be solely representing medical staff in open disclosure and a senior health care professional should always be present.
- Legal implications should be carefully considered in both acknowledgement of regret vs admission of liability to acknowledge the adverse event, express regret, provide factual information, indicate investigation and provide contact detail for person who will provide ongoing care. The health care professional should not admit liability for harm caused to patient; admit liability of another or the health service. Communication and documents (including emails) produced in response to an adverse event may need to be disclosed later in any legal proceeding so this evidence must be verifiable clinical facts and be accurate. Documents should not attribute blame nor opinions unless they are expert and they shouldn’t contain statements which are or are likely to be defamatory.
- Content of initial discussion with patient should include an introduction of all people attending, an expression of regret and empathy for the harm that has occurred, discussion of the clinical facts as agreed by the team, an opportunity for the patient/and or support to be heard, plus an overt statement that the patients views and concerns are being heard and considered seriously.
- Support for clinicians and staff following an adverse event should be immediately following the event and ongoing as required. It should be in the form of advice and guidance from professional, legal and indemnifying bodies with an understanding of the systemic nature of adverse events. There should be confidence in the investigation and improvement process.

FOLLOW UP INTERVIEW WITH PATIENT AND PATIENT SUPPORT

The senior health care professional involved in the initial meeting with patient should be involved in the follow up discussion. Feedback should be given re: the investigation process. There should be no speculation or attribution of blame and a written record of discussion should be kept in the medical record.

COMPLETING THE PROCESS

- Communicating with the patient after the investigation is completed; the feedback may take form of a face to face interview, a letter or both. There should be reference to the clinical and other relevant facts, reference to details of any concerns or complaints expressed by patient/and or support person, an expression of regret, a summary of factors contributing to the adverse event, and information on what has been/will be done to avoid repetition and how these improvements will be monitored.
- Documentation of the open disclosure meeting and outcomes recorded in the medical record
- Recommendations for system improvements should be monitored, follow up and reported in accordance with local policy
CASE EXAMPLES

1. An advanced musculoskeletal physiotherapist in the Emergency Unit interprets plain film imaging for a patient as having no bony injury. When the physiotherapist returns the following day and checks the reporting of the imaging it is determined that there is in fact a bony injury that requires management. What is the next course of action for the physiotherapist?

   • Determine if via the existing local results review process the abnormal pathology has been identified and the case managed
   • Liaise with the Emergency Physician/Consultant in charge on the clinical floor and determine appropriate further management
   • Contact the patient, discuss the findings, explain their potential implications and advise re-presentation to the Emergency Department for further management where clinically relevant.
   • Notify triage/streaming nurse of pending re-presentation of the patient
   • Facilitate proposed treatment to enable effective and efficient management of the patient on re-presentation
   • Record the sequence of events in medical record.
   • Use local hospital reporting systems to record the event and progress, as directed by the ED consultant if implication of the event is considered significant.
   • Review case as an opportunity for focussed education re: identification of bony injury

2. A physiotherapist working in an advanced musculoskeletal physiotherapy clinic records incorrect patient identifying detail after receiving approval by surgeon for further MRI investigation. An incorrect patient turns up for an MRI investigation and the radiology staff phone the physiotherapist in their routine screening tests to determine whether a mistake has been made. What is the next course of action for the physiotherapist?

   • Immediately stop the procedure taking place until details are verified and ensure the procedure does not take place if not indicated.
   • Explain the source of error to radiology staff and ask for the patient to return home with a follow up phone call
   • Phone the patient on their arrival home to apologise for the inconvenience and explain the source of the error.
   • Phone the Head of Unit to explain the error as well as the Physiotherapy Department manager
   • Use local hospital reporting systems to record sequence of events

REFERENCES

Australian Council for Safety and Quality in Health Care 2004
Heath Service Incident Management Guideline
Charter of Human Rights and Responsibilities Act 2006 (Vic)
MANAGING ADVERSE EVENTS FOR ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY SERVICES IN PUBLIC HEALTH

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CLINICALLY APPROPRIATE
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INCIDENT MANAGEMENT PROCESS
IMMEDIATE MANAGEMENT
The staff member’s first priority is to manage the situation to ensure the safety of all persons who are directly involved or will be potentially affected by the incident.

The need for medical assessment is determined and organised.

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Incident Severity Rating 4/ISR 4: These incidents are low risk and are managed by routine procedure. They may include patient incident without injury, complaints or equipment failure without consequence.
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<td>Death of a staff member, volunteer, contractor, student or visitor due to an incident.</td>
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<tr>
<td>ISR2 Major</td>
<td>Permanent disfigurement or disablement not related to the natural course of a patients underlying illness or condition.</td>
<td>Disfigurement or disablement causing inability to work in the future.</td>
<td>Damage between $1-2.9 million.</td>
<td>Local adverse publicity. Temporary closure of service. Serious complaint anticipated.</td>
</tr>
<tr>
<td>ISR3 Moderate</td>
<td>Healthcare service required as a result of incident.</td>
<td>Healthcare service required as a result of incident.</td>
<td>Damage between $100000-$99 million.</td>
<td>Complaint anticipated.</td>
</tr>
<tr>
<td>ISR4 Minor</td>
<td>No additional healthcare required or minor first aid.</td>
<td>First aid treatment only.</td>
<td>Damage $10000-$99000 or no financial loss or loss of any utility without adverse outcome to persons.</td>
<td>Local investigations and risk treatments.</td>
</tr>
<tr>
<td><strong>No adverse event</strong></td>
<td><strong>Near miss</strong></td>
<td></td>
<td></td>
<td></td>
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</table>
RESPONSIBILITIES

STAFF MEMBER INVOLVED OR IDENTIFYING THE INCIDENT IS RESPONSIBLE FOR ENSURING:

- Immediate intervention to ensure injury is treated and/or no further harm occurs to injured person or others
- The person in charge is notified immediately
- Incident is reported as soon as practical on the reporting system
- Details of any patient incident are recorded in the medical record including a documented reassessment of risk, where appropriate.

PERSON IN CHARGE AT TIME OF INCIDENT IS RESPONSIBLE FOR ENSURING:

- Immediate incident management
- Medical review has occurred for any incident involving harm to a patient or staff member and/or where there is potential for harm.
- Monitoring and additional observations are completed for patients.
- Appropriate managers are notified for incidents resulting in an extreme or major adverse event (ISR 1 & 2) or as per local requirement.
- Family members are notified as appropriate
- The incident has been recorded on the reporting system and all documentation has been completed.

LINE MANAGER IS RESPONSIBLE FOR ENSURING:

- The appropriate line managers are notified in keeping with local policy for incidents resulting in an extreme or major adverse outcome ISR 1 & 2
- Appropriate and timely intervention and action has been taken including further review where necessary eg case review
- Feedback is provided to staff about the outcome of the incident
- Staff receive training for incident reporting procedures and management

DIRECTORS ARE RESPONSIBLE FOR ENSURING:

- The Chief Medical Officer, Chief Nursing Officer, Chief Executive, Clinical Governance unit and senior staff are notified of all extreme events in keeping with local policy.
- A timely and appropriate response has occurred
- Debriefing for staff has occurred as necessary.
- Peer support offered to staff
- Appropriate incident management and risk minimisation strategies

CLINICAL GOVERNANCE UNIT IS RESPONSIBLE FOR ENSURING:

- All incidents with an extreme outcome have been notified to the Chief Executive, Executive Directors and General Counsel in keeping with local policy.
- Appropriate incident investigation has occurred.
- Review the appropriate classification of all incidents.
- A root cause analysis or case review has occurred for any incident resulting in serious injury or death.
• All incidents entered on local incident reporting system are reviewed, appropriately classified and rated and then posted into the database.
• That data and trends are provided to appropriate committees.
• All incidents are reported to Victorian Managed Insurance Authority (VMIA).
• Coordination of incident reporting and management.

OCCUPATIONAL HEALTH AND SAFETY UNIT IS RESPONSIBLE FOR ENSURING:
• Immediate verbal notification and written report within 48 hours to Worksafe or other relevant statutory of all notifiable incidents.
• Appropriate incident investigation has occurred.
• A root cause analysis or case review has occurred for any incident resulting in serious injury or death.
• Data and trends are provided to appropriate committees.
• Review the appropriate classification of all OHS related incidents.

OPEN DISCLOSURE/COMMUNICATION WITH PATIENT FOLLOWING AN ADVERSE EVENT
Open disclosure facilitates open communication with patients and their support person after an adverse event has occurred. This will include an expression of regret that the event has occurred and a factual explanation of what happened.

The open disclosure process commences with the recognition that a patient has suffered unintended harm during treatment or when deemed clinically appropriate. The process varies according to the nature of the adverse event.
• A “low level response” is warranted for adverse events with an incident severity rating of minor (ISR4) or moderate (ISR3).
• A “high level response” is warranted for adverse events with an incident severity rating of major (ISR2) or extreme (ISR1).

The relevant unit head may direct staff to follow a high level response for an incident if deemed clinically appropriate.

MANAGEMENT OF A LOW LEVEL ADVERSE EVENT
In most cases where a low level response is indicated, the process will be completed with a discussion with the patient.

MANAGEMENT OF A HIGH LEVEL ADVERSE EVENT
Relevant executives as dictated by local policy should be notified within hours of an extreme outcome

FIRST RESPONSE DIRECT PATIENT CARE & NOTIFICATION
The first priorities after an adverse event resulting in an extreme outcome are prompt and appropriate clinical care, prevention of further harm and notification to stakeholders, including patient, family, treating medical consultant and the head of the treating unit. The head of unit is responsible for ensuring that open disclosure has occurred.
PRELIMINARY TEAM DISCUSSION
A multidisciplinary team, including the most senior health care professional directly involved in the care of the patient should meet as soon as practical after the event. This should be facilitated by site Risk Coordinators. The team convened by Head of Unit should be responsible for

- Establishing the basic facts
- Identifying the person responsible for coordinating the investigation process
- Identifying the person responsible for coordinating the disclosure process
- Consider the process of engaging support for the patient, ideally a family member
- Identify immediate support needs for the staff
- Reach consensus on the approach to disclosure that will ensure consistency
- Consider legal and insurance issues both for the organisation and the health care professional
- Identify the person who will act as a liaison for the patient and his/her support in the post disclosure phase
- Document in the medical record the open disclosure meeting and plan of care

INITIAL INTERVIEW WITH PATIENT AND PATIENT SUPPORT

- Consider timing in that the initial discussion should occur as soon as possible after the event with availability of key staff and considering patient preference.
- Identification of appropriate individual to make the disclosure; ideally a senior clinician who is known to the patient, of sufficient seniority to be credible, with training in open disclosure and who is able to offer a medium to long term relationship with the patient in offering assurance and feedback to the patient and their support person
- Junior healthcare professionals should not be solely representing medical staff in open disclosure and a senior health care professional should always be present.
- Legal implications should be carefully considered in both acknowledgement of regret vs admission of liability to acknowledge the adverse event, express regret, provide factual information, indicate investigation and provide contact detail for person who will provide ongoing care. The health care professional should not admit liability for harm caused to patient; admit liability of another or the health service. Communication and documents (including emails) produced in response to an adverse event may need to be disclosed later in any legal proceeding so this evidence must be verifiable clinical facts and be accurate. Documents should not attribute blame nor opinions unless they are expert and they shouldn’t contain statements which are or are likely to be defamatory.
- Content of initial discussion with patient should include an introduction of all people attending, an expression of regret and empathy for the harm that has occurred, discussion of the clinical facts as agreed by the team, an opportunity for the patient/and or support to be heard, plus an overt statement that the patients views and concerns are being heard and considered seriously.
- Support for clinicians and staff following an adverse event should be immediately following the event and ongoing as required. It should be in the form of advice and guidance from professional, legal and indemnifying bodies with an understanding of the systemic nature of adverse events. There should be confidence in the investigation and improvement process.
FOLLOW UP INTERVIEW WITH PATIENT AND PATIENT SUPPORT

The senior health care professional involved in the initial meeting with patient should be involved in the follow up discussion. Feedback should be given re: the investigation process. There should be no speculation or attribution of blame and a written record of discussion should be kept in the medical record.

COMPLETING THE PROCESS

• Communicating with the patient after the investigation is completed; the feedback may take form of a face to face interview, a letter or both. There should be reference to the clinical and other relevant facts, reference to details of any concerns or complaints expressed by patient/and or support person, an expression of regret, a summary of factors contributing to the adverse event, and information on what has been/will be done to avoid repetition and how these improvements will be monitored.

• Documentation of the open disclosure meeting and outcomes recorded in the medical record

• Recommendations for system improvements should be monitored, follow up and reported in accordance with local policy

CASE EXAMPLES

1. An advanced musculoskeletal physiotherapist in the Emergency Unit interprets plain film imaging for a patient as having no bony injury. When the physiotherapist returns the following day and checks the reporting of the imaging it is determined that there is in fact a bony injury that requires management. What is the next course of action for the physiotherapist?

• Determine if via the existing local results review process the abnormal pathology has been identified and the case managed

• Liaise with the Emergency Physician/Consultant in charge on the clinical floor and determine appropriate further management

• Contact the patient, discuss the findings, explain their potential implications and advise re presentation to the Emergency Department for further management where clinically relevant.

• Notify triage/streaming nurse of pending re presentation of the patient

• Facilitate proposed treatment to enable effective and efficient management of the patient on re-presentation

• Record the sequence of events in medical record.

• Use local hospital reporting systems to record the event and progress, as directed by the ED consultant if implication of the event is considered significant.

• Review case as an opportunity for focussed education re: identification of bony injury
2. A physiotherapist working in an advanced musculoskeletal physiotherapy clinic records incorrect patient identifying detail after receiving approval by surgeon for further MRI investigation. An incorrect patient turns up for an MRI investigation and the radiology staff phone the physiotherapist in their routine screening tests to determine whether a mistake has been made. What is the next course of action for the physiotherapist?

- Immediately stop the procedure taking place until details are verified and ensure the procedure does not take place if not indicated.
- Explain the source of error to radiology staff and ask for the patient to return home with a follow up phone call
- Phone the patient on their arrival home to apologise for the inconvenience and explain the source of the error.
- Phone the Head of Unit to explain the error as well as the Physiotherapy Department manager
- Use local hospital reporting systems to record sequence of events

REFERENCES
Australian Council for Safety and Quality in Health Care 2004
Health Service Incident Management Guideline
Health Service Risk Management Policy
Health Service Risk Management Guideline
Health Service Open disclosure Guideline
Occupational Health & Safety Act 2004
Charter of Human Rights and Responsibilities Act 2006 (Vic)
Appendix J – Radiology safety

Understanding Imaging for Advanced Musculoskeletal Physiotherapists

PRACTICE CONTEXT
This learning module has been developed in the practice context of an experienced musculoskeletal physiotherapist working according to the defined scope of practice in the Emergency Department (ED) setting. It should be read in conjunction with the organisation’s policy and procedures for imaging requested by physiotherapists and the operational guidelines for advanced musculoskeletal physiotherapy services. The learning included in this module supports the physiotherapist working in a primary contact role where they can request plain film imaging only for the management of musculoskeletal conditions.

In circumstances where red flags are identified, and/or non-musculoskeletal conditions are suspected on initial assessment, handover to the medical team will occur in a timely manner. When imaging ordered for a suspected musculoskeletal condition suggests red flags or a potential non-musculoskeletal cause, the physiotherapist will liaise with the ED Consultant before proceeding any further. To support their ability to do this, the learning module addresses a basic knowledge of radiological imaging for non-musculoskeletal presentations. The physiotherapist should be able to identify the clinical significance and limitation of their scope of practice in regards to imaging and management of non-musculoskeletal conditions if they arise and act appropriately to ensure a timely referral onto the medical team.

THEME 1 Radiation safety

LEARNING OBJECTIVES
1. To understand the key principles of ionizing and non-ionizing radiation and the commonly used modalities within each category
2. To understand the importance of guidelines and referral criteria
3. To understand the risks and contraindications with each modality with a focus on plain film imaging
4. To understand radiation safety in relation to pregnancy and protection of the foetus
5. To understand the importance of optimising radiation dose
6. To complete the radiation safety learning module and quiz prior to commencing the ordering of plain film imaging

Click here to view reference
KNOWLEDGE

Ionizing and non ionizing radiation
1. Define each and list modalities categorized as either ionizing or non ionizing.

Guidelines and referral criteria
1. Has it been done before? List advantages and disadvantages
2. Does it need to be done? List advantages and disadvantages.
3. Is it needed? List advantages and disadvantages.
4. Is it needed now? List advantages and disadvantages
5. Is it the best investigation? List advantages and disadvantages
6. Has the problem been adequately described? List advantages and disadvantages
7. Are too many investigations being performed? List advantages and disadvantages

Risks and contraindications of each modality
- Plain film imaging
- CT
- MRI
- Nuclear medicine
- Ultrasound
1. Describe the risk of childhood cancer associated with imaging
2. Who is at risk and what questioning is required to ascertain high risk populations.
3. Understand the relative risks associated with each modality
4. How is risk minimized.

Optimising radiation dose
1. What are the contributing factors that help the referrer understand the magnitude of radiation dose of various investigations
RECOMMENDED RESOURCES

Articles

Resources
- Local Policy: Radiation Safety (ionizing and non-ionising radiation)
- Local Brochure: Pregnancy and Radiation; Information for Pregnant Patients and Families
- RadiologyInfo.org: the radiology information resource for patients. Patient safety http://www.radiologyinfo.org/
- Australian Radiation Protection & Nuclear Safety Agency www.arpansa.gov.au
- Image Gently http://www.pedrad.org/associations/5364/ig/

Check local organizational policies and procedures from intranet
Appendix K – Patient and staff satisfaction

Patient satisfaction survey example

Musculoskeletal physiotherapists in ED

The Physiotherapy Department recently received funding to increase the Musculoskeletal Physiotherapy service in the Emergency Department. We are interested in your experience of being treated by the physiotherapist in ED.

We would be very grateful if you could take a few minutes to complete this survey. This survey is anonymous so please be honest with your answers. Please place your completed survey in the secured box provided labeled “physiotherapy satisfaction surveys”.

If you have any questions about this survey, please contact Add Name (project manager) on 9999 9999 or any of the advanced musculoskeletal physiotherapists located in the fast track area of the ED.

Thank you for your time to complete the survey.

Add name
Project Manager

Please return your completed questionnaire to box provided

Date: ________________________________
Location: ________________________________

Please tick the box which best reflects your feelings:

1. I felt I received good advice and information about my condition
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

2. I was given enough time to ask questions and discuss my injury.
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

3. I felt confident that the physiotherapist could deal with my condition.
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

4. I felt confident that the physiotherapist would have got a second opinion if necessary
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

5. The physiotherapist explained the results of their assessment.
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

6. The physiotherapist explained what would happen next regarding my injury.
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

7. Overall I was satisfied with the treatment that I received.
   Strongly agree - 0 1 2 3 4
   Agree - 0 1 2 3 4
   Uncertain - 0 1 2 3 4
   Disagree - 0 1 2 3 4
   Strongly disagree - 0 1 2 3 4

Please write any comments

Adapted by The Alfred Hospital, Melbourne Victoria


Primary Contact Musculoskeletal Physiotherapy Service in the ED Staff Survey

Dear Staff Member,

The Physiotherapy Department recently received funding to increase the Primary Contact Musculoskeletal Physiotherapy Service in Emergency. As part of the evaluation process, we are interested in the experience and opinions of staff working in the ED, in regards to the Primary Contact Musculoskeletal Physiotherapy Service.

We would be very grateful if you could take a few minutes to complete this survey. Please be honest in your responses as responses are anonymous and data will be presented in an aggregated form in any presentations or publications. Please place your completed survey in the secured box provided labeled “physiotherapy satisfaction surveys”. The survey is anonymous but we would request that you indicate your level of appointment.

*If you have any questions about this survey, please contact Add Name (project manager) on 9999 9999 or any of the primary contact musculoskeletal physiotherapists located in the fast track area of the ED.*

Thanking you in anticipation,

Add Name

**Please return your completed questionnaire to box provided**

Thank you for your time to complete the survey and participation in this project.
<table>
<thead>
<tr>
<th>No.</th>
<th>Role</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
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<tr>
<td>1</td>
<td>Emergency Registrar</td>
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<td>Emergency Consultant</td>
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<td>3</td>
<td>RN / triage</td>
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<td>4</td>
<td>Nurse Practitioner</td>
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<tr>
<td>5</td>
<td>Non clinical staff</td>
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<td>6</td>
<td>Allied Health Team</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>SHMO / JHMO / intern</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. I have a good understanding of the ED Primary Contact Musculoskeletal Physiotherapy role

2. I have a good understanding of how the ED Primary Contact Musculoskeletal Physiotherapy role will function in my ED

3. I have a good understanding of which patients are suitable for management by an ED Primary Contact Musculoskeletal Physiotherapist

4. I have a good understanding of the ED Primary Contact Musculoskeletal Physiotherapist scope of practice

5. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to provide appropriate emergency care to specific patient groups

6. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to provide appropriate education to specific patient groups

7. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to appropriately refer specific patient groups to medical outpatient and specialty clinics

8. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to initiate diagnostic plain film imaging

9. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge prescribe medication from a limited formulary of drugs

10. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to discharge patients from the ED

11. The ED Primary Contact Musculoskeletal Physiotherapist has the skills and knowledge to refer patients to inpatient Registrars for assessment for admission

12. The ED Primary Contact Musculoskeletal Physiotherapist will make the ED team more effective

13. The ED Primary Contact Musculoskeletal Physiotherapist will improve access to emergency care

14. I am comfortable with being approached by the ED Primary Contact Musculoskeletal Physiotherapist for advice regarding patient management

15. Emergency Physicians are the most appropriate personnel to supervise and/or mentor the ED Primary Contact Musculoskeletal Physiotherapist regarding patient management issues

Any additional comments:
Appendix L – Operational Guideline

OPERATIONAL GUIDELINES TEMPLATE

TITLE: ADVANCED PRACTICE MUSCULOSKELETAL PHYSIOTHERAPY SERVICES

1. Introduction
   • Provide a brief summary and purpose of the document
   • Audience for document
   • Refer to overarching operational framework

2. Background
   • Background information outlining progress to date
     – Why the service was needed
     – Summarised literature review
     – Process of service development undertaken to date (results of conceptual stage)
     – Proposed service and anticipated benefits
       – Aims and objectives
       – How does it relate to Organisational aims and objective
     – Consultation and support of stakeholders to date

3. Model of care: service description and format
   • Outline key elements of model of care
   • Define scope of practice
     – Inclusion/exclusion criteria
     – Red and yellow flags
     – Flow chart of service
     – Attachment of job descriptions for recruitment
   • Describe format of new service
     – Days and hours of operation
     – Rostering
     – Demonstrate integration with existing musculoskeletal physiotherapy team
   • Working party to be established
     – Define roles and responsibilities
     – Meeting and communication structure
   • Establish IT and administration requirements
     – Additional log in requirements?
     – Procedures for requesting of imaging
     – Referrals for outpatient specialist services
     – Electronic discharge letters
     – Scheduling systems
     – Recording of statistics
     – Documentation guidelines
• What change management strategies are required?
  – Plan for promotion of service
  – Communication with staff – flyers, email, presentations
  – Patient information flyer
• Supporting resources to be developed
  – Clinical guidelines for new tasks e.g. pharmacology, requesting imaging
  – Patient educational resources

4. Clinical governance framework
• Stakeholder consultation
• Accountabilities and reporting structure
• Measures in place to address four domains of quality and safety
  (Victorian Department of Health – Clinical Governance Framework)
  1. Consumer participation
  2. Clinical effectiveness
  3. Effective workforce
  4. Risk management

* Clinical governance should also be addressed in project plan to wider stakeholders and organisational executives

5. Education, training and competency requirements
Refer to Clinical Education Framework
Include brief summary of:
• Education and training pathway
• Orientation program – manual and timetable
• Learning needs analysis to be undertaken
• Learning and assessment plan
• Work-based competency standard and assessment
• Mentoring and supervision program

6. Evaluation
Prepare ethics application for evaluation

Refer to the Evaluation Framework
Review VIRIAF* and describe assessment in terms of:
• Effectiveness
• Efficiency
• Sustainability
Summarise evaluation process
- Baseline, interim and final measures
- Patient, clinician and organisational outcomes
- Time lines, deliverables

Prepare templates required
- Satisfaction surveys – patient/ staff
- Spreadsheets for data collection etc

7. Research and Quality
Identify opportunities for research and quality projects

8. Future Directions
Describe succession planning and plans for sustainability, future growth and areas for development of service
Template Appendix M – ED Flowchart

Musculoskeletal Physiotherapist Working Under Supervision
Emergency Department

TRIAGE/RITZ: Patient fits inclusion criteria. Physiotherapist allocates name to patient.

Routine Physio Muse Ax. (exclude red and yellow flags)

Liaise with ED consultant re: Ax, imaging, analgesics and Mx plan

Red flags present - may require handover to ED consultant or team approach (yellow flags +/- referral to AH team).

Imaging required?

Analgesia required?

ORDER XRAY: Discuss results with ED consultant or Radiologist

ED consultant to prescribe meds

Manage as required:
Physio Rx (gait aid, education etc)
POP backslab?
Referral to ortho/trauma or other Fracture Clinic appointment
Discharge

Routine Management
If required organise:
Medical Certificate
Follow-up outpatient referral
LMO, Physio
Discharge

YES

NO
Musculoskeletal Physiotherapist Working in the Emergency Department
Completed Work-place Competency Assessment

1. TRIAGE/RITZ: Patient meets service inclusion criteria
   - YES
   - NO
     - Discuss with ED Consultant if patient appropriate

2. Physio allocates name to patient
   - YES
   - NO
     - Leave patient for Medical Assessment

3. Routine Physio Musc Assessment
   - Red flags present?
     - NO
       - ALL NO
         - Manage as required:
           - Physio Rx (gait aid, education etc)
           - POP backslab?
           - Referral to ortho/trauma or other
           - Fracture Clinic appointment
           - Discharge
     - YES
       - Liaise with ED Consultant
   - Imaging other than plain film required?
     - NO
       - ALL NO
     - YES
       - Needs to be admitted?
         - NO
           - Manage as required:
             - Physio Rx (gait aid, education etc)
             - POP backslab?
             - Referral to ortho/trauma or other
             - Fracture Clinic appointment
             - Discharge
         - YES
           - Liaise with ED Consultant
   - Analgesia other than paracetamol or ibuprofen required?
     - NO
       - ALL NO
     - YES
       - Needs to be admitted?
         - NO
           - Manage as required:
             - Physio Rx (gait aid, education etc)
             - POP backslab?
             - Referral to ortho/trauma or other
             - Fracture Clinic appointment
             - Discharge
         - YES
           - Liaise with ED Consultant
Appendix N – Project Plan Template

Example

TITLE: PRIMARY CONTACT MUSCULOSKELETAL PHYSIOTHERAPY SERVICE IN THE EMERGENCY DEPARTMENT

Introduction
- Provide a brief summary and purpose of the document
- Identify the audience for the document – key stakeholders

2.1.1 Background
- Current model of care
- Identify and quantify the problem, why and what needs to be improved
- What is proposed and what are the anticipated benefits – evidence elsewhere

2.1.2 Aims and objectives of the project
- Right person, right skills, right time

2.1.3 Definition of scope of practice
- Identify population of people project will target
- Acknowledge legislative and regulatory requirements
- Maintenance of professional standards

2.1.4 Role requirements and responsibilities
- Selection criteria for recruitment
- Responsibilities of physiotherapist:
  - Clinical knowledge and expertise
  - Education and training
  - Research
  - Leadership and management

2.1.5 Additional education and training / competency assessment
- Overview of general education and training requirements and competency assessment
  - refer to operational guidelines for detail

2.1.6 How will clinical governance be addressed?
- Provide in detail how a safe, effective service will be delivered
- Line management and accountability
- Risk management
- Clinical guidelines and protocols to be developed to support service
- Service evaluation to include domains of safety, effectiveness, patient involvement, access and efficiencies
2.1.7 Stakeholder engagement and consultation
• Outline the process for stakeholder engagement and consultation
• Who is involved and what is the communication structure?
• Record and document the process
• Commitment to continue throughout project

2.1.8 Barriers and Enablers
• Anticipate barriers and enablers
• Prepare a strategy to deal with barriers and to optimise enablers

2.1.9 Milestones, deliverables and timeframes for implementation
• Set realistic achievable goals
• Project reporting and frequency

2.1.10 How will the service be evaluated
• Provide detail of how the service will be evaluated from an organisation,
  patient and clinician's perspective
• Ethics approval

2.1.11 Dissemination of results
• Outline opportunities to report results to key stakeholders, professional bodies,
  other relevant health professionals and consumers
• Posters, conference presentations and publications

2.1.12 What is the budget
• Realistic and achievable
• Provide commitment to monitor and adhere to budget requirements

2.1.13 What are the future directions and implications for the project?
• Recognise funding limitations and if funding not ongoing plan for
  business case development
• Identify key areas for development and future growth
• Plan for succession planning and sustainability
• Ongoing plans for service monitoring and evaluation
Appendix O – Clinical Governance Structure

Advanced Musculoskeletal Physiotherapy Services
Clinical Governance Structure
Appendix P – Clinical Audit Assessment Form in Audit Guideline

ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY CLINICAL AUDIT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Main areas identified for improvement</th>
<th>Evidence based practice/best practice</th>
<th>Action Plan (As agreed with physiotherapist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis/impression (Clinical Reasoning)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management/Consultations</td>
<td></td>
<td></td>
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<tr>
<td>Follow up plan</td>
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</tr>
</tbody>
</table>

Signature of Assessor: ____________________________________________

Signature of Physiotherapist: ________________________ Date: ____________
# Appendix Q – Record Keeping Audit Assessment Form in Audit Guideline

## ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY RECORD KEEPING AUDIT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Audit date:</th>
<th>Mark as appropriate below, each health record entry against each criteria 1-40: ✓ X N/A</th>
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</thead>
<tbody>
<tr>
<td>Physiotherapist:</td>
<td></td>
</tr>
<tr>
<td>Health record entry number:</td>
<td>1  2  3</td>
</tr>
<tr>
<td>Assessor name (role) for each entry:</td>
<td></td>
</tr>
<tr>
<td>UR Number:</td>
<td></td>
</tr>
</tbody>
</table>

### General

1. Consent requirements met
2. Legible
3. Date of consult
4. Time of consult
5. Physiotherapy heading
6. Signature
7. Printed Name
8. Page has UR sticker
9. Black or Blue pen
10. All notations & abbreviations used are meaningful to those other than PT's
11. Are personable comments excluded from all records
12. Single line through errors
13. Reason for alterations stated
14. Alterations initialled

### Subjective Assessment

15. Allergies noted
16. HOPE
17. Special questions – Red flags, yellow flags, population specific questions assessed
18. Past Medical & Surgical History
19. Current Health Status
20. Medications taken on the day and usual regime
21. Social History
22. Smoker/alcohol/drugs
### Objective Assessment

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>23. Neurovascular status</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>24. Skin integrity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Other observations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Vital signs if indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Palpation findings</td>
<td></td>
<td></td>
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<tr>
<td>28. Functional status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>29. Range of movement</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30. Special tests / Neuro</td>
<td></td>
<td></td>
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<tr>
<td>31. Investigations – referral information adequate, outcome documented, Reviewed by consultant?</td>
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<tr>
<td>32. Working diagnosis /impression</td>
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</table>

### Management

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<tr>
<td>33. Treatment</td>
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<tr>
<td>34. Warnings</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>35. Reassessment/ action taken</td>
<td></td>
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</tr>
<tr>
<td>36. Written information provided</td>
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### Consultations

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<tbody>
<tr>
<td>37. Name, position, outcome of consultation</td>
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### Follow up plan

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<tbody>
<tr>
<td>38. Referrals</td>
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<tr>
<td>39. Discharge letter</td>
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</tr>
<tr>
<td>40. Education &amp; advice to patient</td>
<td></td>
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</tr>
</tbody>
</table>

### OVERALL RESULT: S= satisfactory NS=not satisfactory (80% correct of applicable criteria, required for satisfactory result)

<table>
<thead>
<tr>
<th>S</th>
<th>NS</th>
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<th>NS</th>
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</thead>
</table>

### Signature of assessor:

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<table>
<thead>
<tr>
<th>Main areas identified for improvement (overall)</th>
<th>Action Plan and Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
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</table>

| Subjective Assessment                          |                           |
| Objective Assessment                           |                           |
| Management/Consultations                       |                           |
| Follow up plan                                 |                           |

Date:  

Signature Clinical Lead/Consultant:  
Signature Physiotherapist:
Appendix R – Orientation Template

ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY IN THE EMERGENCY DEPARTMENT

ORIENTATION CHECKLIST TEMPLATE
Consider using existing orientation manuals for the Emergency Department (ED) used for medical and nursing staff.

GEOGRAPHICAL LAYOUT
Should include the following areas with a brief explanation of their functionality (note this will vary from organisation to organisation)

- Triage
- Trauma / Resus
- Short stay unit / local ward
- Area for management of lower category patients where Physiotherapist will work e.g. “Fast track”
- Patient waiting areas
- Key equipment storage areas
- Imaging / Radiology
- IT infrastructure
- Work offices (PT / other)
- Patient flow system? (physical areas adm to d/c)

ED STAFFING STRUCTURE / HIERARCHY
Should include key staff members / contact information that may have interaction / involvement with the physiotherapist. For example:

- ED / Program Director
- Consultants
- Registrars
- Residents / Interns
- Nursing staff (may include NP’s, RN’s, Resource nurse, triage nurses)
- Other Allied health in ED (e.g. secondary contact PT, SW, OT)
- Clerks / Office staff

INTRODUCTIONS TO ED TEAM MEMBERS
Orientation of new physiotherapists will include introductions to ED staff. Any new introduction should clearly define the role of that physiotherapist e.g. primary contact vs secondary contact physiotherapy. Key staff introductions may include:

- ED Director
- ED medical staff
- Nursing staff
- Other allied health

Introductions to ED team members (of the day) should also be completed at the commencement of each shift e.g. Communicating with Triage nurse, Resource Nurse / ED staff coordinator, medical / nursing staff in physiotherapy working area e.g. fast track.
OBSERVATIONAL SESSIONS
As part of an initial orientation new physiotherapy staff should participate in observation of:

- Assessment and management of patients by senior physiotherapist working in ED
- Assessment and management of patients that are relevant e.g. category 4/5 type presentation by consultants working in ED
- Assessment of patients managed by nurse practitioner (if applicable)
- Observation of patients managed in different areas of ED e.g. trauma, resus, cubicle, short stay, triage

IT SYSTEMS
- Includes orientation / familiarisation to the organisations IT system for managing ED patients (organisation specific)
- May also include processes for ordering imaging / tests, onward referrals for services, discharge information
- May also include databases developed for capturing key patient statistical information in regard to physiotherapy management in ED

SCOPE OF PRACTICE
New staff should have a good understanding of the scope of practice of primary contact physiotherapy service, inclusion/exclusion criteria, red/yellow flags, liaising with consultants etc. This information should be included in the operational guideline. New staff need to review this document thoroughly.

DOCUMENTATION STANDARDS
Physiotherapist documentation in ED should be as per the APA standard guidelines. Below are some key examples of documentation in the ED setting:

- Clear documentation of allergies, medications inclusive of what medications have been taken on the day and dosage.
- History of smoking/alcohol intake/time of last food or fluid
- Clearing of red flags
- Documenting absent findings such as no deformity, no redness, skin integrity.
- Clearing symptoms such as neurovascular structures – cap refill etc
- Pain score measurements and reassessment of pain scores is encouraged
- Avoiding the use of physiotherapy abbreviations and
- Record the diagnosis or clinical impression.

When discussing all patients with an ED consultant it must be documented that a discussion has occurred. Specifically who, what and when it was discussed and the agreed plan should be included.

Any imaging results, analgesic requirements and a follow up plan needs to be included. LMO letters need a copy in the history.

Documentation must be legible, signed with printed name at the bottom – and must be completed by end of shift. Time the patient was seen and time discharged should be recorded.

Refer to operational guidelines for more information on documentation.
REFERRALS TO OTHER SERVICES
A number of referrals may be required to be completed by the ED physiotherapist in regard to ongoing patient management. Physiotherapists may refer to operational guidelines to determine when a consult is required from the specialised inpatient units E.g. orthopaedics and plastics. This should include instructions on communication procedures such as discussing with ED consultants prior to contacting relevant specialist units to ensure the referral is indicated. A documentation plan of any such referral e.g. documentation of the time / person, plan and follow up required should also be included.

Any referrals to external organisations / services (e.g. private PT) should include a written letter / d/c summary outlining the patient’s history, management and plan.

The ISBAR system is encouraged for communication and handover of patients to the medical team or referring patients to inpatient medical units.

IMAGING REQUESTS
All requests for imaging will depend on assessment and clinical reasoning. Where appropriate evidence based guidelines should be followed and may be included in the overall operational guidelines such as:

• Ottawa Knee Rules
• Ottawa Ankle Rules
• Canadian C-spine rules

Each organisation may have its own procedure for ordering imaging via radiology. E.g. electronic system or paper based referral. Each organisation should also have a system for follow up / communication / discussion of imaging diagnoses with the radiology department.

ISSUING CERTIFICATES
MEDICAL CERTIFICATES
Medical certificates can be written for patients seen by physiotherapists in the ED providing the certificate is for the condition assessed and treated only. Guidelines for issuing medical certificates should follow the Australian Physiotherapy Association document regarding sick leave certificates.

WORKPLACE CERTIFICATES
Issuing certificates for workplace injuries differs from state to state and depends on local workplace authority directives and should be referred to prior to completing any workplace certificate. For example, in Victoria initial Workcover certificates cannot be signed by a physiotherapist. The ED consultant involved in the discussion of the patient needs to be asked to sign the form i.e. a consultant must assess the patient in order to issue a certificate of capacity. Physiotherapists can then sign for ongoing certificates of capacity.

ROAD ACCIDENT / TRANSPORT CERTIFICATES
Issuing certificates based on any road / transport accident also comes under local (state) organisational directives and should be referred to prior to issuing any certificate. For example, in Victoria TAC (Transport Accident Commission) initial certificates can be signed by Physiotherapists but often this requires a follow up phone call to TAC.
DISCHARGE PROCESSES
For any discharge it is important to ensure that patients are discharged off the ED system in an appropriate timeframe. This is to prevent a patient’s length of stay exceeding the national 4 hour target as well as maintaining an accurate log of patients still present within the ED.

All discharges of patients seen by the physiotherapist should have some form of onward correspondence such as:

- Referral within organisation e.g. orthopaedics
- Discharge letter to referrer (if appropriate)
- Discharge letter to LMO

As part of the discharge process there should be a system for follow up of any imaging ordered by the physiotherapist. Any follow up of imaging reports should be completed within 48 hours of presentation.

MANAGEMENT OF ADVERSE / UNPLANNED EVENTS
Any unplanned event / adverse event that occurs in regard to the physiotherapist working in ED (e.g. missed fracture on x-ray, patient fall / injury, medication anaphylaxis) must follow a process for reporting / managing / follow up of the event according to organisational procedures. (Refer to Managing adverse events document and local organisations risk management policies and procedures)

PATIENT RESOURCES
A number of patient resources are available to assist with education / management by physiotherapists in the ED. These are often paper based but also can be electronic resources. Resources could include:

- Plastering information sheets
- Injury specific sheets e.g. acute low back pain, ankle sprain
- Medication information sheets
- Links to websites such as: Better Health Channel, local state health website
- Contact information for any onward referrals e.g. PT dept, local private PT Include in the orientation program how to access these resources.

ROSTERING AND SCHEDULING
All staff working in ED should be orientated to a roster that is available and easily accessed by all staff. Specifically, the following needs to be considered:

- Early planning of a roster to account for future staff leave and availability
- Staff contact information included on roster in case of replacing and notifying of unplanned absences / sick leave
- ED coordinator to have copy of roster as notification of individual physio presence in ED
  Coordination of roster must consider other staff roles and clinical requirements outside of ED shift hours e.g. fracture clinic, ED review clinic
- Consideration / negotiation of rostering any public holidays for staff.
- Weekend shifts may be coordinated with wider PT dept roster

(? Refer to operational guidelines for further details)
USE OF OUTCOME MEASURES

A number of outcome measures may be used in the ED. This is an important process that contributes to service justification and overall development/improvement of the service provided. Some examples of ED outcome measures are:

- ED LOS (hours)
- Number of patients seen
- Type of patients seen (primary contact / secondary contact)
- Frequency of imaging
- Discharges vs admissions
- Referral frequency and type

Staff should be aware of the National Emergency Access Targets (NEAT) and why this is important and what other routine datasets are collected for service evaluation.

Orientate new staff to the electronic clinical log to develop professional practice portfolio and to capture relevant information for service evaluation.

A number of other standard physiotherapy specific outcome measures may also be used to assist with patient management e.g. START back tool, LEFS etc.

CONTINUING EDUCATION AND TRAINING TIMETABLES

Staff should be aware of the education and training commitment required for this role and the competency assessment to be undertaken. Refer to the Clinical Education framework and Education and Training Curriculum for more information. Examples of the education and training sessions that staff will need to attend include:

- Internal (in house) sessions
- Clinical supervision in ED
- Prac sessions e.g. plastering
- Case presentations
- Other ED staff (e.g. Medical) presentations
- External program – Awareness of PD sessions offered by APA (ED network for example), radiology / pharmacology courses etc.

A regular timetable should be established to include continuing education with consideration of maximising staff availability for these sessions.

Continuing education may also be discussed as part of a staff member’s performance plan/yearly in conjunction achieving competencies relevant to the primary contact role e.g. plastering competency, radiology competency.
Appendix S – Mentoring Program

ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY MENTORING PROGRAM

INTRODUCTION

A mentoring program can assist the physiotherapist to improve their understanding of advanced musculoskeletal physiotherapy roles and in particular how they differ from traditional physiotherapy roles. Mentoring can support the development of professional practice, extending physiotherapists to meet their full potential in a supportive environment. It is recommended Musculoskeletal Physiotherapists new to advanced roles should participate in a mentoring program. Although mentoring is separate, and in addition to clinical supervision, it may involve elements of clinical supervision as outlined in the advanced musculoskeletal physiotherapy education and training program.

Mentoring is typically ‘a one on one relationship between a more experienced and a less experienced clinician and is based on encouragement, constructive comments, openness, mutual trust, respect and a willingness to learn and share.’ Whereas clinical supervision takes place in an educational context and focuses on ‘progressing clinical practice through reflection and the provision of professional guidance and support.’

DEFINITIONS/GLOSSARY

Mentee
A person who is looking to gain knowledge and skill through personal and professional growth and development.

Mentor
A person who supports the growth and development of another person at a professional and personal level.

Mentoring
A mutually beneficial relationship which involves a more skilled or experienced person helping a less skilled or experienced person to achieve their goals.

Clinical supervision
Is the process of two or more professionals formally meeting to progress clinical practice through reflection and the provision of professional guidance and support.

Advanced Musculoskeletal Physiotherapist
A role that is within the currently recognised scope of physiotherapy practice, but that through custom and practice has been performed by other professions. The advanced role may require additional training as well as significant professional experience and competency development.

Work-based competency standard
Defines the essential work outcomes and performance level required, for effective performance of a work role &/or task in the workplace.

Work-based competency assessment
The process of collecting evidence and making judgements on whether competence has been achieved, to confirm an individual can perform to the standard expected in the workplace, as expressed in the competency standard.

WHAT IS MENTORING?
“Mentoring is a relationship which gives people the opportunity to share their professional and personal skills and experiences and to grow and develop in the process”3
A mentoring program can offer benefits to the organisation, the mentee and the mentor by increasing skills and knowledge whilst enhancing morale and enthusiasm and the provision of a supportive work environment.

THE MENTORING RELATIONSHIP – ROLES AND RESPONSIBILITIES
The mentor and mentee need to agree on the purpose of the mentoring program in light of the identified needs of the mentee. For mentoring success the following key elements are required:

• Trust – honest and open when sharing experiences and providing feedback in a constructive way
• Respect respect each others time and commitment
• Commitment
• Accessibility
• Flexible and adaptable
• Professionalism
• Broad Problem solving skills used
• Active listening
• Mutual goal setting
• Formulation of action lists to achieve goals

Mentoring is not primarily about providing education and may not be an appropriate setting for all needs and/or issues to be resolved.

THE MENTOR
A mentor is someone who ‘takes an interest in a colleague’s career development and experience in the workplace, and helps them to decide on and achieve their goals.’4 The mentor should ideally not be involved in the summative work based competency assessment of the mentee.

3 Spencer, OpCit., p.5
The skills, experience and attributes of the mentor for the advanced musculoskeletal physiotherapy roles need to include the following:

- Minimum two years experience working in advanced musculoskeletal physiotherapy roles or be a medical consultant working in the clinical specialty
- Approachable and trustworthy with good interpersonal skills
- Genuinely committed to being a mentor and able to commit the time it requires
- Enthusiastic with a positive attitude
- Able to provide feedback in an encouraging, honest, constructive, respectful manner
- A good listener who is objective and non-judgemental
- Challenges, analyses and evaluates
- Able to identify opportunities
- Knowledge of the advanced musculoskeletal physiotherapy work based competency standard and assessment

The mentors role and responsibilities should be openly discussed with the mentee from the beginning. This may require the mentor to:

- Coach and support the mentee
- Share knowledge, information and previous experiences
- Provide guidance, direction, feedback and if indicated a different perspective
- Maintain mutual trust and respect
- Attend scheduled meetings and encourage good documentation of the meetings by the mentee
- Lead by example
- Highlight areas requiring development and support mentee in addressing shortfalls
- Direct mentee to appropriate resources

THE MENTEE

A mentee must be willing, open to new ideas and mature in their approach to professional growth and development. The mentee needs to have a good understanding of the mentoring program and in particular take the initiative for identifying their needs, goals and for driving the mentoring program. Similar to the mentor, the mentee must discuss with the mentor their role and responsibilities from the beginning of the program. This may include:

- Identifying their clinical needs by completing the learning needs analysis prior to the first session with their mentor
- Taking responsibilities for goal setting, career planning, decisions and actions
- Respecting time and commitments of their mentor
- Communicating effectively with mentor
- Being open to receiving advice and constructive feedback
- Actively seeking guidance and advice regarding their performance
- Respecting confidentiality and maintaining mutual trust and respect
- Organising and attending all scheduled meetings and completing documentation requirements
- Demonstrating a positive attitude and commitment to personal development
INITIAL MENTORING SESSION

At the initial meeting the mentorship program should be talked through systematically. Areas to be covered in the initial meeting should include:

- Roles and responsibilities of the mentor and mentee
- Clarify the objectives of the mentoring program and agree on the duration for which the mentoring will run
- Ground rules and arrangements for resolving problems
- Frequency of meetings, dates and duration
- Process for communication eg via email/phone
- Discussion of results of learning needs analysis
- Goal setting and development of learning and assessment plan with time frames that reflect the results of the learning needs analysis. Goal setting should be consistent with requirements of the work based competency standard
- The mentee should have completed Self Assessment Tool part A and B and bring this to the first mentoring session (refer to the Work based Competency learning and assessment plan)
- Specific action plan with time frames
- Clear and legible documentation of mentoring session signed and dated by both mentor and mentee

ONGOING MENTOR SESSIONS

- The mentee should initiate organising the subsequent mentoring sessions
- The mentee should prepare what they would like to achieve from the mentoring session prior to the session and present this to the mentor
- Goal setting and action plans should be reviewed at each session to assess progress
- Regular review of the learning and assessment plan in relation to the work based competency assessment
- Prepare the mentee for the work based competency assessment using formative assessments
- Set agenda for next session
- Regular review of mentoring relationship – trouble shoot and seek guidance if mentoring relationship not achieving desired outcomes
- Ending the mentoring arrangement should be when both parties agree to end
  - achievements should be documented and ongoing strategies for mentee developed if needed

REFERENCES


1. Mentoring Template – Initial Session

<table>
<thead>
<tr>
<th>Mentee roles and responsibilities:</th>
<th>Mentor role and responsibilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roles and responsibilities of mentoring program:</td>
<td></td>
</tr>
<tr>
<td>Objectives of mentoring program:</td>
<td></td>
</tr>
</tbody>
</table>

Ground rules e.g.:
- mode of communication
- scheduling of meetings
  - time, frequency, location
- conflict resolution
- documentation process
- agenda
- learning styles

<table>
<thead>
<tr>
<th>Key areas to be addressed as identified from learning needs analysis</th>
<th>Action plan to achieve goals</th>
<th>Time frame</th>
<th>Evidence of completion (to be completed at next session)</th>
</tr>
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<tbody>
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</table>
### Short term goals

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<thead>
<tr>
<th>Action plan to achieve goals</th>
<th>Time frame</th>
<th>Evidence of completion (to be completed at next session)</th>
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### Long term goals

<table>
<thead>
<tr>
<th>Action plan to achieve goals</th>
<th>Time frame</th>
<th>Evidence of completion (to be completed at next session)</th>
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</table>

### Next meeting time/date/location:

### Agenda items for next meeting:

### Signature Mentor

Signature Mentee

Date:
## 2. Mentoring Template – Ongoing sessions

<table>
<thead>
<tr>
<th>Name of Mentee:</th>
<th>Date of meeting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Mentor:</td>
<td>Duration of meeting:</td>
</tr>
<tr>
<td>Position of Mentor:</td>
<td>Location of meeting:</td>
</tr>
</tbody>
</table>

- Review of previously documented areas to be addressed, short and long goals: Yes No
- Evidence of completion documented: Yes No

### Key areas to be addressed as identified from learning needs analysis (carried over from previous session)

<table>
<thead>
<tr>
<th>Update of progress</th>
<th>Discussion and feedback from Mentor</th>
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</table>

### NEW key areas to be addressed as identified from learning needs analysis

<table>
<thead>
<tr>
<th>Action plan to achieve goals</th>
<th>Time frame</th>
<th>Evidence of completion (to be completed at next session)</th>
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### Short term goals (only document new goals)

<table>
<thead>
<tr>
<th>Action plan to achieve goals</th>
<th>Time frame</th>
<th>Evidence of completion (to be completed at next session)</th>
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<tr>
<td>Long term goals (only document new goals)</td>
<td>Action plan to achieve goals</td>
<td>Time frame</td>
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Next meeting time/date/location:

Agenda items for next meeting:

Signature Mentor

Date:

Signature Mentee

Date:
Appendix T – Risk Register

EXAMPLE ADVANCED MUSCULOSKELETAL PHYSIOTHERAPY SERVICES RISK REGISTER

This risk register applies to the following advanced musculoskeletal physiotherapy services:

- Physiotherapy Led Orthopaedic and Neurosurgical Screening Clinics
- Physiotherapy Arthroplasty Review Clinic
- OsteoArthritis Hip and Knee Service
- Advanced Musculoskeletal Physiotherapy Service in the Emergency Department
- Physiotherapy Soft Tissue ED Review Clinic
<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>RISK DESCRIPTION</th>
<th>RAW RISK LxC</th>
<th>MITIGATION STRATEGIES</th>
<th>STATUS OF ACTIONS</th>
<th>PERSON RESPONSIBLE</th>
<th>CURRENT RISK (RESIDUAL / INHERENT)</th>
<th>Date Last reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk</td>
<td>Missed diagnosis of a fracture on x-ray in the E&amp;T/ED setting</td>
<td>4x2 Medium</td>
<td>• Process in place for follow up of all abnormal reports • Routine follow up of all radiology reports required for imaging requested by physiotherapist within 24-48 hours • Supervised practice by ED consultant until physiotherapist assessed as competent in x-ray interpretation • Completion of university assessed radiology module • Ongoing involvement of physiotherapists in continuing education regarding x-ray interpretation</td>
<td>ED/Radiology follow up procedure already in place</td>
<td>ED Consultant</td>
<td>3x2 Medium</td>
<td>Mar 2013</td>
</tr>
<tr>
<td>Clinical Risk</td>
<td>Risk of allergies/medication history/medical history not being noted during assessment and communicated to medical team during prescription and administration of medication leading to patient harm</td>
<td>3x3 Medium</td>
<td>• Education and training of physiotherapists • Completion of pharmacology module • Documentation audit</td>
<td>Ongoing</td>
<td>ED Clinical Lead Physiotherapist</td>
<td>2x3 Medium</td>
<td>April 2013</td>
</tr>
<tr>
<td>Clinical Risk</td>
<td>Missed diagnosis by the musculoskeletal physiotherapist of a serious non-musculoskeletal condition requiring medical review • Possible adverse event to patient if medical review is delayed and medical intervention is indicated</td>
<td>3x3 Medium</td>
<td>• Physiotherapists must meet the selection criteria i.e. years of experience and post graduate training to be working in advanced musculoskeletal physiotherapy services • Physiotherapists must complete differential diagnosis learning module and demonstrate through understandings of red and yellow flags on assessment • Physiotherapist work under supervised practice of medical consultant until competency assessment completed • Physiotherapists must demonstrate ability to work in a multi-disciplinary team and liaise closely with medical team when assessment indicates red and yellow flags</td>
<td>Within first three months of commencing role</td>
<td>Physiotherapy Manager Clinical Lead Physiotherapist Musculoskeletal physiotherapist</td>
<td>2x3 Medium</td>
<td>April 2013</td>
</tr>
</tbody>
</table>

- **Clinical Risk**
- **ED Consultant**
- **Musculoskeletal physiotherapist**
- **ED Clinical Lead Physiotherapist**
- **Ongoing**
- **Follow up review organised with GP/specialist if not improving**
- **Refer to Clinical Governance Policy and document “Managing adverse events for advanced musculoskeletal physiotherapy services in public health”**
<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>Is it on Org Register?</th>
<th>RISK DESCRIPTION</th>
<th>RAW RISK LxC</th>
<th>MITIGATION STRATEGIES</th>
<th>STATUS OF ACTIONS</th>
<th>PERSON RESPONSIBLE</th>
<th>CURRENT RISK (RESIDUAL / INHERENT)</th>
<th>Date Last reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Risk</td>
<td></td>
<td>Serious Adverse event to patient: relating to application of plaster/splinting in ED setting</td>
<td>3x3 Medium</td>
<td>• Education and training program for plastering must be completed</td>
<td>Completed within the first three months of commencing role</td>
<td>Musculoskeletal Physiotherapist</td>
<td>1x3 Low</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plaster burns</td>
<td></td>
<td>• Physiotherapists must have plasters assessed by ED consultant, endorsed nurse practitioner or experienced physiotherapist prior to pt being discharged until competency assessment completed</td>
<td>Ongoing</td>
<td>ED Clinical Lead</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pressure areas</td>
<td></td>
<td>• Physiotherapists provide written information to patients re: after care of plasters</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Neurological damage due to constricting cast</td>
<td></td>
<td>• Follow up checks 1/7</td>
<td></td>
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</tr>
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<td></td>
<td></td>
<td>• Loss of positioning of fracture</td>
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<td></td>
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<td>• Immobilisation in sub-optimal position</td>
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<tr>
<td>Clinical Risk</td>
<td></td>
<td>Incorrect patient details on x-ray request forms completed by musculoskeletal physiotherapists Information to be checked:</td>
<td>3x3 Medium</td>
<td>• Staff Education re: importance of double checking information on referral</td>
<td>Ongoing</td>
<td>Clinical Lead</td>
<td>2x2 Low</td>
<td>April 2013</td>
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<td></td>
<td></td>
<td>• Patient name and UR</td>
<td></td>
<td>• Staff orientation must be completed</td>
<td>Orientation completed prior to commencing role</td>
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<td></td>
<td></td>
<td>• Area to be imaged</td>
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<td>• Radiology learning modules must be completed</td>
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<td></td>
<td></td>
<td>• Correct side</td>
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<td>• Audit of imaging requests</td>
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<td>• Correct procedure</td>
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<td>• Complies with patient identification standard</td>
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<tr>
<td>Clinical Risk</td>
<td></td>
<td>Inappropriate referral of patient for x-ray resulting in unnecessary or unsafe radiation exposure</td>
<td>3x3 Medium</td>
<td>• Musculoskeletal physiotherapists must complete radiation safety module prior to commencing practice</td>
<td>Completed before commencing role</td>
<td>Musculoskeletal physiotherapist</td>
<td>2x2 Low</td>
<td>April 2013</td>
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<td></td>
<td></td>
<td>• Pregnant women</td>
<td></td>
<td>• Physiotherapists must routinely ask female patients of child bearing capacity re: pregnancy and breastfeeding in assessment and identify if any previous imaging has occurred</td>
<td>Ongoing</td>
<td>Clinical Lead</td>
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<td></td>
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<td>• Imaging performed recently elsewhere</td>
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<td>CATEGORY: Is it on Org Register?</td>
<td>RISK DESCRIPTION</td>
<td>RAW RISK LxC</td>
<td>MITIGATION STRATEGIES</td>
<td>STATUS OF ACTIONS</td>
<td>PERSON RESPONSIBLE</td>
<td>CURRENT RISK (RESIDUAL / INHERENT)</td>
<td>Date Last reviewed</td>
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| Clinical Risk                   | Deteriorating Patient: Identification of neurological deterioration in spinal and orthopaedic patients  
• Serious adverse event to patient due to delay in diagnosis resulting in permanent injury or prolonged disability | 2x4 Medium | • Physiotherapist conducts thorough neurological assessment and accurate documentation to enable reassessment of neurological status.  
• Spinal and Neurological competency assessment must be completed  
• Physiotherapist liaises closely with orthopaedic and neurosurgical team | Ongoing | Musculoskeletal Physiotherapist  
Neurosurgical Clinical Lead Physiotherapist | 1x4 Medium | April 2013 |
| Clinical Risk                   | Musculoskeletal physiotherapist fails to clearly communicate to patient they are not a doctor  
• Confusion of patient and family | 2x2 Low | • Patient information brochures and letters regarding advanced musculoskeletal physiotherapy services included in appointment letters  
• Staff education re: responsibilities of patient education and communication skills | Completed | Musculoskeletal Physiotherapist  
Clinical Lead Physiotherapist | 2x1 Low | April 2013 |
| Workforce                       | Staffing Levels  
• Inability to provide services in line with best practice without service disruption | 4x1 Medium | • Prioritisation tool  
• Team based approach to service delivery of advanced musc physio services including training of a lead physiotherapist to deliver advanced musc physio service  
• Flexible workforce within dept, ability to cover different clinics by different people  
• Timetable planned well in advance inclusive of TIL, ADO, annual leave and study leave | Ongoing | Musculoskeletal Stream Leader  
Physiotherapy Manager | 3x1 Low | April 2013 |
| Workforce                       | Staff Poor Performance/ Competency Issues:  
• Patient adverse event  
• Staff injury  
• Delayed / ineffective care  
• Loss of confidence of community | 4x1 Medium | • All musculoskeletal physiotherapy staff complete orientation program and period of supervised practice, education and training program documented in the Clinical Education Framework  
• All musculoskeletal physiotherapy staff are appointed a mentor to guide their development  
• All musculoskeletal physiotherapy staff are supported to complete the competency assessment  
• Staff who do not successfully complete the competency assessment are supervised and have a plan put in place  
• Staff with excellent attributes, skills and knowledge are recruited | Ongoing | Musculoskeletal Physiotherapist  
Clinical Lead Physiotherapy Manager | 2x1 Low | April 2013 |
<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>RISK DESCRIPTION</th>
<th>RAW RISK LxC</th>
<th>MITIGATION STRATEGIES</th>
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<th>CURRENT RISK (RESIDUAL/INHERENT)</th>
<th>Date Last reviewed</th>
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</table>
| Workforce | Musculoskeletal Physiotherapist works outside scope of practice  
  • Patients may be put at risk  
  • Breach of legislation and registration | 2x3 Medium | • Education and training of physiotherapists  
  • Assessment of understanding of scope of practice  
  • Scope of practice is monitored via performance appraisals and includes feedback from medical units | Ongoing | Musculoskeletal Physiotherapist Clinical Lead Physiotherapy Manager | 1x3 Low | April 2013 |
| OH&S | Risk of manual handling incidents due to inadequate space to assess and manage patients in the ED setting | 4x2 Medium | • Await new facilities  
  • Maintain space free of unnecessary equipment and clutter | All staff | 2x2 Low | April 2013 |

Rating – cite likelihood first and then consequence i.e. 2 x3 is likelihood of 2 and consequence of 3