William Osler Health System

Physiotherapy Practice Expectations

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Purpose:

To provide consistency in the assessment, planning, treatment and evaluation of patients referred to the physiotherapy program within the William Osler Health System (Osler). The guidelines are the standard care that will be provided to each patient unless otherwise ordered by Physician.

Responsible Team or Care Area:

Physiotherapists (PT)
Physiotherapy assistants (PTA)
Rehab Assistants (RA)

Certification Requirements:

1. All PTs are accountable to ensure they maintain competency by identifying learning opportunities as set out by the College of Physiotherapists of Ontario (CPO).
2. All PTs must roster for relevant practice interventions that they perform as part of their treatment as a PT.
3. It is a recommended that PTs working on the Geriatric Outreach Team (GOT) complete the Geriatric Certificate Program and PTs working in the Seniors Clinic complete Gentle Persuasive Approached (GPA) in dementia care.
4. It is recommended that PTs working in the Rapid Access Clinic (RAC) complete a certificate from the Advanced Clinician Practitioner in Arthritic Care (ACPAC) Program or equivalent certificate. For PT's working in the Early Arthritic Clinic (EAC) the ACPAC certificate is a requirement.
5. PTs must provide their yearly CPO valid to practice registration to the Practice Leader for Physiotherapy.

Policy Statement(s):

1. All PT and PTA/RA at Osler must adhere to corporate policies and procedures.
2. All must abide by the PT and PTA roles and responsibilities and assignment of care (Appendix A).
3. A comprehensive and individualized care plan must be developed and documented in partnership with the patient and family/substitute decision maker (SDM) as appropriate.
4. A patient's health status must be reassessed in partnership with the patient, and any updates are to be documented in the patient record, particularly when there is a change in status.
5. Prior to all interactions with patients, all staff are required to perform "Patient Identification Using Two Client Identifiers" as per Osler policy.
6. It is mandated that informed consent will be obtained prior to any patient interaction. Informed consent will also be obtained prior to any PT service assignment of care to PTA and/or any involvement of students.
7. All workload metrics are to be documented in Meditech within 5 days of completion.
8. PTs will review and apply PT related medical directives appropriately and participate in their biannual review.

Assessment Process

Policy Statements:

1. A physician referral for PT services must be received and/ or acknowledged within 48 hours of order entry (assessments may be completed or marked as inappropriate). For units/department who provide services 5 days a week acknowledgement must be received within 2 working days of order

entry. Acknowledgement can also be in the form of placing a referral on a waitlist as may be the case in the outpatient departments.
2. Inpatient initial assessment will be completed based on prioritization of both (1) patient safety and (2) in accordance with the Physiotherapy Priority Matrix (Appendix B).
3. PT referrals to the Outpatient Rehab Programs can be made in several ways: fax, patient walk-ins, from fracture clinic (orthopaedic PT program), via email (for the Community Outreach Stroke Rehab (COSR) program) and internally from physicians or therapists. These referrals are screened, prioritized and placed on a wait list based on acuity and the clinical area required.
6. EAC referrals are received from a rheumatologist, general practitioners or the emergency department.
7. A PT in the EAC:
    a. is in the extended class
    b. triages their referrals and screening is completed as follows: urgent patients are seen within 1 week, non-urgent, seen within 2-3 weeks, regular referral for injection or assessment are seen within 1-2 months.
    c. can under medical directive, order x-rays and blood work if needed and review management with patient (medical directive #10 100 259 V.2.0)
4. Referrals to the Geriatric Outreach team are completed by Geriatricians and are received by fax or internal e-referral.
5. Referrals to the Musculoskeletal (MSK) clinic are triaged as moderate to severe osteoarthritis (OA) hip or knee and assessed within 2-4 weeks of referral date.
6. A PT in the MSK program:
    a. can under a medical directive, order an x-ray if needed and review management with patient (Medical Directive #10 100 449 V.1.0)
    b. will connect with referring physician regarding the outcome of the assessment and treatment recommendations
    c. will re-direct the patient to their choice of surgeon if surgery is the treatment approach.
7. PT's are responsible for completion of a thorough chart review, including (but not limited to): reason for admission, current orders/restrictions, past medical history, and previous functional status prior to assessment.
8. Inpatient mobility status must be updated in the documentation on Meditech.
9. The patient will be included in the planning of care as appropriate.
10. Reassessment occurs in a timely manner, based on clinic/patient specific requirements.

Interventions

1. PT interventions will be performed at the PT's discretion based on assessment and will adhere to the professional guidelines as outlined by the CPO.
2. Any assignment of care by a PT to a PTA should follow CPO: Working with Physiotherapy Assistant Standards.
3. PT intervention will be developed in collaboration with the patient and/or SDM in order to address therapeutic goals and treatment interventions.

Communication

1. Attend unit and discipline specific rounds/huddles and team meetings.
2. Report changes in patient status that require follow-up to team members as appropriate (i.e. nurses, physicians, etc.)
3. Engage in family/caregiver meetings.
4. Develop client-centered plans in collaboration with patient, and/or SDM, interprofessional team members and other stakeholders.
5. Manage assignment of service to PTAs and students (based on guidelines in CPO: Working with Physiotherapy Assistant Standards and Supervision Standards) with patient informed consent.
6. Documentation must be completed based on the guidelines outlined in the Interprofessional Documentation Policy and as per CPO: Record Keeping Standards
7. Documentation must be submitted under one of the pre-approved electronic assessment forms, a patient care note in Meditech or on a pre-approved hard copy form.

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8. Interpreter services or communication devices along with family/caregiver involvement will be accessed as appropriate during all PT services.
9. If ongoing intervention is recommended, assessment documentation must include a problem list, recommended treatment plan and goals.

Quality improvement

1. The PT and PTA/RA will employ strategies to deliver care in the most effective way to provide care and use techniques that promote patient safety.
2. PTs and PTA/RA will participate in Osler performance reviews every 2 years or as requested by their clinical services manager.
3. PTs will complete CPOs Professional Issues Self-Assessment (PISA) annually.
4. PTs and PTA/RA will complete mandatory Learning Management System (LMS) modules as required by the organization.
5. PTs will participate in College Practice Assessments when requested by CPO.
6. PTs and PTA/RA are expected to participate with the multidisciplinary team in quality reviews as needed to improve the processes of patient care.
7. PTs and PTA/RA are expected to identify personal learning needs and seek formal or informal opportunities to improve their knowledge in relevant areas.
8. PTs and PTA/RA will follow Osler's Therapeutic Wheeled Mobility Equipment Maintenance Policy and Procedure to ensure that wheeled mobility equipment is properly maintained, repaired and regularly audited and supports therapy.

Transfer and Discharge Criteria / Process

1. Discharge planning will be initiated during initial PT assessment and is ongoing throughout the course of hospitalization.
2. A transfer of accountability (TOA) will occur each time a patient is transferred between a PT and/or between programs.
3. Documentation on Meditech *will indicate discharge from PT service and discharge recommendations.*

References:

The Physiotherapy Act, Sept 1, 2011
Regulated Health Professional Act, 1991
General Regulation under Physiotherapy Act, Nov. 19, 2012
The College of Physiotherapists of Ontario Standards
-Record Keeping Standard
-Working with Physiotherapy Assistants Standard
-Supervision Standard
-How to Roster for Controlled Acts

Related Documents:

Musculoskeletal (MSK) Program Rapid Access Clinic Medical Directive #01 For Ordering Hips and Knees X-Ray's - 10 100 449 V.1.0
Early Arthritis Clinic Medical Directive #01 Laboratory and Diagnostic Imaging - 10 100 259 V.2.0
Inter-professional Documentation (PPR514)
Patient Identification Using Two Client Identifiers (PPR381)
Occupational Therapist Assistant and Physiotherapist Assistant Practice Expectations (PPR672)
Appendix A: Physiotherapy Priority Matrix

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Appendix A:

Inpatient Physiotherapy (PT)
Priority Matrix

Patients on all units are prioritized by both (1) *patient safety* and (2) *discharge* considerations. The following matrix is used to prioritize referrals both within and between units, ensuring that the most urgent referrals are addressed in a manner that maximizes both patient well-being and flow through the system. The referral response standards assume that full staffing is available; during staff shortages, clients will be prioritized as indicated below, but response time is likely to increase ex. On Sat & Sun when staffing levels are decreased. Please also note, this priority matrix does not apply to inpatients in the Paediatrics or Mental Health Programs.

Priority Level	Referral Response Standard (Hours from order entry to first documentation) * PT available Monday -Friday	Safety and Discharge Considerations	Patient Profile
High Priority	< 24 hours The Level I priority patient will be screened and assessed within one working day of referral and necessary interventions implemented.	1. Immediate safety concern or medical complications will occur if not seen by an PT 2. Patients expected to be discharged within 48 hours, and discharge is dependent on PT evaluation	• Patients with compromised respiratory status -ineffective cough in neurocompromised patients, - significant atelectasis or segmental/lobar collapse, -secretion retention shown on an X-ray, deteriorating blood gases - all/or any of which, may be responsive to PT treatments). • First day Post-op perative (POD) patients following Upper Abdominal or Thoracic surgery. • POD 1 surgical Orthopaedic patients on care map (THA, TKA) • CPM adjustment • ROM post-manipulation POD 1,2 (POD 3+ will be determined high priority by surgical team consensus) • Initial Assessments and deferred assessments (i.e. secondary to nausea, medical complication) • Patients requiring mobility assessment /prescription of walking devices to facilitate discharge home same day from Hospital or within 24 hours • Assessment and intervention for clients admitted with a recent stroke (administration of Alpha FIM by day 3) • Rehab applications to facilitate same day discharge • Assessment to determine rehab appropriateness (complete rehab goals/rehab applications)
Medium Priority	< 48 hours The Level II priority patient will be **screened and assessed within two working days of referral**. Assessment / treatments for this population usually provided weekdays only	1. Patient is at risk of deterioration without PT intervention 2. Medically stable client whose discharge is not imminent, but requires PT for: a. Assessment re: appropriate discharge destination b. Intervention to attain functional level for successful discharge	• Current PT patients requiring reassessment and/or intervention changes due to a sudden change in status, to prevent deterioration; or new onset risk of falls • New patients requiring mobility assessments to facilitate team interventions • patients identified as at risk of deteriorating function and mobility as assessed by PT • PTA-identified changes in patient status requiring re-assessment by PT • Patients identified as requiring a safety / mobility assessment/ prescription of a mobility device • Severely deconditioned patients with indicators for recovery • Rehab applications where discharge to open rehab bed not pending
Low Priority	As time permits The Level III priority patient will be screened within two working days of referral and be assessed when time/staffing permits.	1. Patient would benefit from PT services but will not deteriorate in the absence of PT intervention, or those who are currently unable to participate due to ongoing medical/surgical issues 2. Discharge is not directly affected by initiation of PT or whose needs can be met in the community after discharge	• Current physiotherapy patients requiring progression of treatment plans • Patients have stable conditions and are at low risk of respiratory or cardiac complications • Patients identified as at increased risk of developing contractures or pressure ulcers • Patients requiring safety review with a mobility device • Patients requiring assistance to implement or reinforce the recommendations made by the Physiotherapist • Patients from Long Term Care (LTC) with chronic compromised mobility, requiring maintenance of preadmission functional level • ALC patients awaiting LTC

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